Report of the
Queensland Ombudsman

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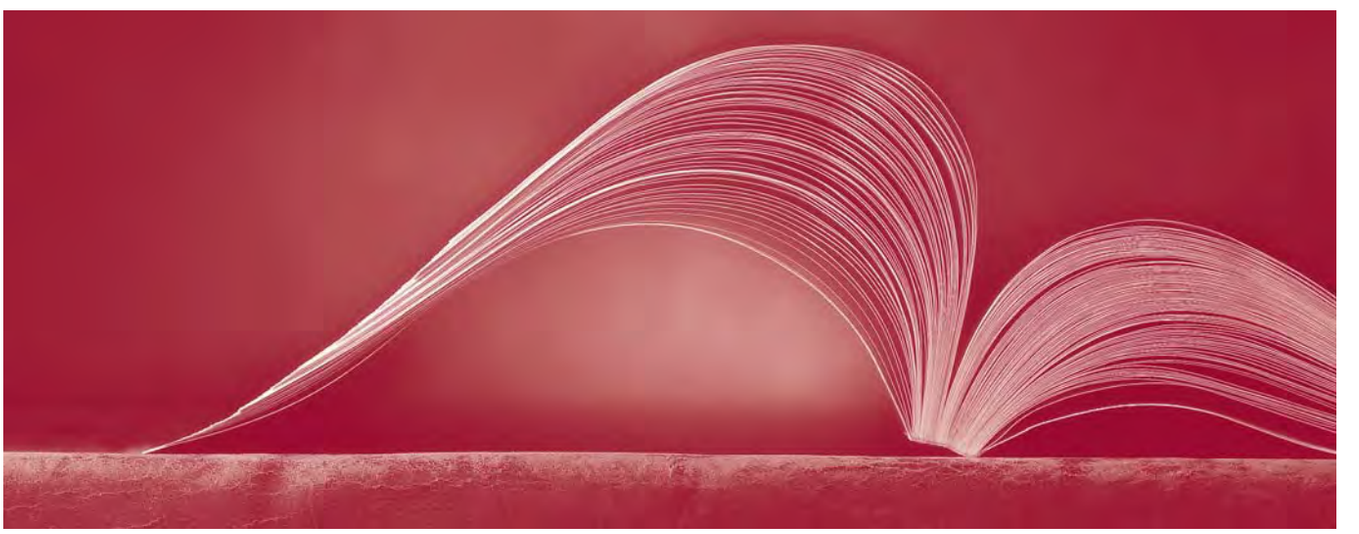

The Workplace Electrocution Project

A report on:

- investigations into the adequacy of the responses of government agencies to nine fatal electrical incidents; and
- an analysis of the effectiveness of changes made to Queensland's electrical safety framework since those incidents occurred.

June 2005

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ISBN 0-9581039-8-4

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30 June 2005

The Honourable Jim Fouras MP
Acting Speaker of the Legislative Assembly
Parliament House
George Street
BRISBANE Q 4000

Dear Mr Fouras

In accordance with section 52 of the *Ombudsman Act 2001*, I hereby furnish to you my report in respect of *The Workplace Electrocution Project – A report on investigations into the adequacy of the responses of government agencies to nine fatal electrical incidents, and an analysis of the effectiveness of changes made to Queensland's electrical safety framework since those incidents occurred.*

The investigation considers the administrative conduct of the Division of Workplace Health and Safety and the Electrical Safety Office now located within the Department of Industrial Relations.

Yours faithfully

D J Bevan
Ombudsman

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Foreword

The Workplace Electrocution Project is the largest project ever undertaken by the Office of the Queensland Ombudsman. It was initiated as a result of a series of complaints the Office received about the response of the Division of Workplace Health and Safety and the Electrical Safety Office to nine incidents that caused the death by electrocution of 12 persons. Seven of those persons died as a result of six incidents at their places of work.

This report summarises our investigations of the administrative actions taken by the agencies following the incidents.

Each investigation was the subject of a detailed report to the Director-General of the department with responsibility for each agency at the time the report was prepared. A copy was also provided to the complainant or complainants in each case.

Those reports included the opinions I formed (or, in respect of the first two cases, my predecessor formed) for the purpose of making recommendations to the department. A total of 92 recommendations were made in the nine reports. Some of these were made to rectify the effect of particular instances of maladministration identified by our investigations while others addressed systemic failures in the way the agencies carried out their regulatory functions.

Those reports and recommendations have been a significant catalyst for major changes in Queensland's electrical safety system.

This report also examines the extent and effectiveness of these changes and identifies electrical safety measures that have been implemented or not yet fully implemented.

Because the issues dealt with in the report are of considerable gravity and public interest, I have decided to present the report to the Speaker for tabling in the Legislative Assembly, as provided for in s.52 of the *Ombudsman Act*.

I would like to thank Assistant Ombudsman Peter Cantwell, who led the project from start to finish, and Senior Investigator Robert McIntyre and former Senior Investigator Max Wise, for their tireless work on this extremely demanding and important project. I also thank Peter and Robert for their efforts in preparing this final report. The professionalism and integrity displayed by these officers and the sensitive way they dealt with the complainants are a credit to the Office.

D J Bevan
Queensland Ombudsman

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Abbreviations and Dictionary

Agencies	Means WH&S and the ESO
Agency	Means, where the context permits, either WH&S or the ESO
Cases	Means, within the context of this Report, the individual Cases 1 to 12 inclusive of the WEP
Commissions of Inquiry Act	Commissions of Inquiry Act 1950 (Qld)
Complainants	Collectively the various persons who made written complaints to my Office about the actions taken by WH&S and the ESO following the notification of a fatal electrical incident relating to their next of kin/relatives as described in Cases 1 to 12 of the WEP.
December 2001 DIR Issues Paper	Means the Issues Paper dated December 2001 prepared by DIR called "Review of the Workplace Health and Safety Act 1995"
Department	Means, where the context permits, either DIR, DME, DETIR or DET
DET	The Department of Employment and Training
DETIR	The former Department of Employment, Training and Industrial Relations or its predecessor
DG of DIR	Mr Peter Henneken, Director-General of DIR
DIR	The Department of Industrial Relations or, where the context permits, DETIR, or its predecessor
DME	The former Department of Mines and Energy or its predecessor
DPP	Director of Public Prosecutions
Electrical legislation	Collectively means the Electricity Act and the Electricity Reg
Electrical Safety Act	Electrical Safety Act 2002 (Qld)
Electrical Safety Regulation	Electrical Safety Regulation 2002 (Qld)

Electrical Safety Taskforce	The joint Ministerial taskforce chaired by Mr Ray Dempsey of Dempsey Consulting that was formed in June 2000 by the Honourable Paul Braddy MP, Minister for DETIR, and the Honourable Tony McGrady MP, Minister for DME
Electrical Safety Taskforce Final Report	The final report of the Electrical Safety Taskforce dated April 2001, being a review of industry compliance with electrical safety standards and the investigation of serious electrical incidents
Electricity Act	Electricity Act 1994 (Qld)
Electricity entity / entities	Means an entity as described in the Electricity Act and the Electrical Safety Act as a participant in the electricity industry.
Electricity Reg	Electricity Regulation 1994 (Qld)
Energex	Energex Ltd, a company GOC under the GOC Act
ESO	The Electrical Safety Office or, where the context permits, the Office of the Electricity Regulator, the Electrical Safety Coordination Unit / Section, or the Electrical Safety Branch
Final report of the Ministerial Review of the ESO	The final report of the Ministerial Review dated July 2001 published by DIR (ISBN 0724282777)
Final report of the Ministerial Review of WH&S and the ESO	The final report of the Ministerial Review dated July 2001 published by DIR (ISBN 0724282769)
Final reports of the Ministerial Review	Means collectively the final report of the Ministerial Review dated July 2001 published by DIR (ISBN 0724282769) and the final report of the Ministerial Review dated July 2001 published by DIR (ISBN 0724282777)
Former Deputy DG of DIR	Mr James McGowan, former Deputy Director-General of DIR
Former Ombudsman / my predecessor	Mr Fred Albietz, LL.B., Solicitor, Queensland Ombudsman from 1 August 1990 to 13 August 2001
GOC Act	Government Owned Corporations Act 1993 (Qld)
GRAVES	The unincorporated association known as the Group Requiring Action for Victims of Electrical Shock
June 2001 DIR Issues Paper	Means the Issues Paper dated June 2001 prepared by DIR called “Ministerial Review of the Division of

	Workplace Health and Safety and the Electrical Safety Office"
June 2004 DIR Issues Paper	Means the Issues Paper dated June 2004 prepared by DIR called "Coroners' Recommendations Project – Safer Electrical Equipment"
Ministerial Review	The Ministerial Review of WH&S and the ESO conducted by Mr John Crittall (assisted by Mr Ray Dempsey in relation to the ESO)
My Office	The Office of the Queensland Ombudsman, formerly known as the Office of the Parliamentary Commissioner for Administrative Investigations
My officers	Mr Peter Cantwell, LL.B. (Hons), Solicitor, Assistant Ombudsman (Major Projects); Mr Max Wise, Dip.Mech.Eng., LL.B., MBA, former Senior Investigator; and Mr Robert McIntyre, Solicitor, Senior Investigator
November 2001 DIR Issues Paper	Means the Issues Paper dated November 2001 prepared by DIR called "Safer Workplaces, Safer Homes – Legislating Electrical Safety in Queensland"
October 2000 Electrical Safety Taskforce Issues Paper	Means the Issues Paper dated October 2000 prepared by the Electrical Safety Taskforce seeking public submissions on a number of broad topic areas
Ombudsman Act	Ombudsman Act 2001 (Qld) that commenced on 3 December 2001
Overhead electric power lines or power lines	Means where the context permits, both high voltage (HV) and low voltage (LV) overhead mains, service lines, live service lines, live overhead conductors, low voltage street mains, overhead mains, exposed overhead LV lines, low voltage energised conductors, low voltage service lines and energised high and low voltage mains
PC Act	The repealed Parliamentary Commissioner Act 1974 (Qld)
Public sector agencies	Means either a department, local government or public authority
QPS	Means the Queensland Police Service
Reviewer to the Minister or Ministerial Reviewer	Mr John Crittall
SEQEB	Means the South East Queensland Electricity Board
WEP	The Workplace Electrocution Project comprising the investigations by my Office into the adequacy of the

	responses of the WH&S and the ESO to nine electrical incidents resulting in 12 fatalities in Queensland between 1995 and 1999
WH&S / WHS/ WHSQ / DWHSQ	The Division of Workplace Health and Safety within the former DETIR and now within DIR
WH&S Act	Workplace Health and Safety Act 1995 (Qld)
WH&S Investigator / Inspector	Means a WH&S investigator
WH&S Reg	Workplace Health and Safety Regulation 1995 (Qld)
Workplace health and safety legislation	Collectively means the WH&S Act and the WH&S Reg.

Executive Summary

Background

Between 1995 and 1999, nine separate incidents occurred in Queensland that resulted in the death by electrocution of 12 people. The relatives of those who died made complaints to the Ombudsman's Office about the way the Division of Workplace Health and Safety (WH&S) and the Electrical Safety Office (ESO) had investigated persons and corporations for alleged breaches of electrical safety standards and/or workplace health and safety obligations that they believed had caused or contributed to the incidents. In most cases, they also complained about the lack of prosecution action arising out of the investigation.

Our investigation of these nine incidents became the Workplace Electrocution Project (WEP). All nine incidents have now been investigated. The last one was finalised in April 2004.

At the time the complaints were made, WH&S was within the Department of Employment, Training and Industrial Relations (DETIR). The ESO was within the Department of Mines and Energy (DME). Both agencies are now within the Department of Industrial Relations (DIR).

Role of Ombudsman

The Ombudsman's role is to investigate administrative actions of officers of public sector agencies and to consider whether those actions are (among other things):

- unlawful, unreasonable or unjust;
- taken on irrelevant grounds or having regard to irrelevant considerations;
- based wholly or partly on a mistake of law or fact; or
- wrong.

The Ombudsman is also empowered under the *Ombudsman Act 2001* (Qld) to make recommendations to the principal officer of the appropriate agency that action be taken to rectify the effect of the maladministration, to improve administrative practice within that agency.

Public report

The *Ombudsman Act* provides that I may report to Parliament, as I consider appropriate, on a matter arising out of the performance of my functions. Understandably, people may ask why we have prepared this Report. After all, we finalised the last investigation over twelve months ago.

There are several compelling reasons for reporting to Parliament on these investigations.

The most important one is that the issues dealt with are so serious that there is a high level of community interest in making public the findings of our nine investigations. Each investigation was the subject of a report under the *Ombudsman Act* to the Director-General of the relevant department and to the relevant complainant.

However, these reports were not made public by tabling them in Parliament because of the large amount of operational and technical detail they contained. Nonetheless, information from some of these reports, but not others, found its way into the media. It is important that an official account of all nine investigations now be given.

Secondly, the role my Office has undertaken in relation to this project has not solely been an investigative one. The former Ombudsman and I have also made extensive recommendations to remedy the administrative deficiencies identified during our investigations and then followed up on progress made by DIR in implementing our recommendations. Two of my senior officers also participated as members of ministerial reference groups established in early 2001 to assist the review process.

Therefore, it is important to report on how the current regulatory system compares with the system that existed at the time the incidents occurred and, in so doing, to acknowledge the action taken by DIR, directly or indirectly in response to our recommendations, to improve the investigation of electrical incidents and the electrical safety system in Queensland.

Finally, it is also in the public interest to place on the public record what further action the department needs to take to fully implement our recommendations and further improve the system.

I am confident that implementation of the recommendations summarised in this report have assisted and will continue to assist in reducing the number of preventable workplace deaths in Queensland and will increase the commitment of all sectors of our community to improving the safety of workers and members of the public who encounter electrical sources in the types of situations discussed in my report.

De-identification

The purposes of this Report are explained in Chapter 1. It is not for the purpose of exposing any individual officer. Therefore, although each of the nine incidents has been the subject of a coronial inquest, wherever practicable in this Report, I have deleted:

- references to the names of officers or former officers and their position titles; and

- other information that could identify any officer or former officer unless the information is critical to a purpose of the Report.

Furthermore, I have not used the names of the persons who were electrocuted in order to protect the privacy of their families.

Principal objects

The two principal objects of the WEP were:

- to determine whether WH&S and the ESO had complied with their legislative responsibilities to investigate the incidents and take regulatory action; and

- to identify how the investigation of such electrical incidents and the electrical safety system in Queensland could be improved.

Investigative process

My officers:

- obtained and examined the files from each agency;
- obtained and examined the transcripts from relevant coronial inquests;
- where appropriate, interviewed the complainants;
- conducted recorded interviews with current and former officers from each agency;
- obtained and examined relevant external and expert reports about the incidents; and
- consulted technical experts and spoke with witnesses.

These inquiries and activities touched almost every aspect of investigative and enforcement activity within the responsibility of the two agencies.

The investigations – Cases 1 to 12

Five of the nine incidents were depressingly similar. They involved young, relatively inexperienced male workers undertaking electrical work or using electrical apparatus:

- NS was a 17 year old apprentice boat builder. He was electrocuted at work while using a faulty vacuum cleaner, apparently while standing barefoot on a metal floor. He had commenced his apprenticeship only four months earlier and had had no previous full time work experience.

- AK was an 18 year old labourer who was electrocuted at a marina while using a heat gun to strip paint from the hull of a boat. The safety guard on the heat gun had been removed. He had commenced work at the marina seven days earlier. His only previous work experience was as a casual packer in a fruit shop.

- TM, who was 17 years old and had just commenced the second year of an electrical apprenticeship, was electrocuted when an elevated work platform (cherry picker) he was maneuvering came too close to live high voltage power lines. At the time, he was removing fluorescent light fittings (light sticks) from inside an overhead advertising sign for maintenance by another worker on the ground. TM died about a month later.

- AM was 24 years old and was employed by SEQEB as an electrical fitter / electrical mechanic. He was electrocuted while operating a ground level metal handle that was connected to a switch mounted on top of a power pole. He was undertaking a switching operation following an incident earlier in the day when a cross-arm supporting the high voltage power lines on another pole had collapsed and fallen onto the low voltage power lines. As a result, the metal handle became live and upon touching it, AM received a fatal shock.

- SG was 28 years old. He was an electrical fitter / electrical mechanic who was employed by a private electrical contractor to carry out maintenance work on service lines, which are the overhead electric power lines that carry low voltage electricity to residences from power poles located on a footpath. He commenced work one day and was electrocuted the next while operating a cherry picker near the live overhead electric power lines. Although he had obtained his qualifications seven years earlier, he had not previously worked on or in close proximity to live or de-energised overhead electric power lines, nor was he experienced in the operation of a cherry picker.

Of the remaining four incidents we investigated, two involved fallen overhead electric power lines, one involved a crane making contact with live overhead electric power lines, and one involved a faulty security light in a caravan park:

- JC was 11 years old. He was fatally electrocuted when he came into contact with a fallen high voltage power line while standing in floodwater after a tropical storm. Although de-energised, the power line had fallen across live low voltage power lines and therefore carried a significant fault current.

- JS was 27 years old. She and ES, her three year old daughter, were electrocuted when they came into contact with a low voltage power line that had fallen to the ground outside their house during a severe storm. The power line had become entangled with tree branch debris. JS made accidental contact with the fallen power line when she went outside to speak with her neighbour and inspect the debris. She was carrying ES at the time. They were fatally electrocuted. KB (a 31 year old neighbour who came to their assistance) was also fatally electrocuted when he accidentally made contact with the fallen power line.

- AB (43 years old) and KC (51 years old) were fatally electrocuted at the same construction workplace within minutes of each other. AB was a crane operator. He had left the cabin of his crane to move a parked vehicle that was impeding his next lift. While he was away from the crane, the boom inexplicably swung around and made contact with live overhead power lines. The crane became charged with electricity and caught fire. AB was electrocuted when he attempted to re-enter the cabin of the crane. KC was a labourer at the site who was handed a fire extinguisher and directed to extinguish the fire. He received an electric shock when he moved too close to the energised crane.

- DD was 16 years old. He was fatally electrocuted when he touched a metal pole that was supporting a security light in a caravan park where he lived. He was coming to the aid of another park resident who had only seconds earlier received a shock from the same pole. The metal pole was a galvanised pipe set in a cement block in the ground. A double insulated light fitting on top of the pole was connected to a wire inside the pole. The active wire had been caught between the edge of the light fitting and the metal pole and the neutral wire was corroded and broken. This resulted in the metal pole becoming energised with low voltage electrical current. When DD touched the live metal pole his feet created an earth and he received a fatal electrical shock.

The Office commenced investigating the first incident in May 1999. Over the following months, the former Ombudsman was contacted by the relatives of some of the other persons who had died in the electrical incidents described above. The allegations made suggested that there were systemic problems with the way electrical incidents in Queensland were investigated.

Maladministration – systemic issues

Regrettably, the evidence presents an overall picture of a lack of investigative and regulatory endeavour. Where investigations were undertaken, they were generally neither thorough nor competent. This situation appears to have resulted largely from inadequacies in training, poor recruiting practices, ineffective investigative procedures, poor and sometimes non-existent record keeping practices and lack of effective supervision by managers. In addition, I found that a significant number of other systemic issues also inhibited performance.

In Chapter 6 I provide details of this systemic maladministration as it existed at the time and highlight the significant improvements that have been made by DIR in relation to these issues.

It is reasonable for the community to expect that Queensland government agencies with regulatory functions will perform their core work to a very high standard, especially where they are investigating potential statutory breaches that may have had fatal consequences. It is not enough that agency officers are committed and well intentioned.

It was clearly in the interests of the general public, as well as electrical and other workers (especially those with limited work experience, skills and competencies), that we vigorously scrutinised these tragic incidents to determine how workplaces and other places where electricity might be encountered could be made safer.

WEP recommendations

The former Ombudsman and I made a total of 92 recommendations in the course of the WEP. Most of these were directed to the Director-General of the Department of Industrial Relations. These recommendations were accepted and have either been implemented or are in the process of being implemented.

In relation to Cases 1 and 2 of the WEP, the former Ombudsman recommended a "comprehensive management and strategic review of WH&S and the ESO be undertaken by a suitably qualified independent reviewer selected in consultation with the Ombudsman".

Mr John Crittall, assisted by Mr Ray Dempsey, was appointed to conduct the review.

The review made a total of 51 recommendations, which were generally consistent with my recommendations and those of the former Ombudsman.

The combined effect of these recommendations was that a new electrical safety legislative framework was established. Significantly:

- The *Electrical Safety Act 2002* and the Electrical Safety Regulation 2002 were enacted;

- The *Workplace Health and Safety Act 1995* was substantially amended; and

- An office of Commissioner for Electrical Safety was created.

Suggestion for legislative amendment

Government Owned Corporations Act 1993

I have made a suggestion for legislative amendment in this Report.

The *Ombudsman Act* excludes certain bodies from my jurisdiction by declaring they are not "agencies" for the purposes of the Act. However, my investigative powers under Part 4 of the *Ombudsman Act* authorise me to obtain information from any such body just as I can from an individual, provided it is relevant to the investigation of an agency within my jurisdiction.

However, the *Government Owned Corporations Act 1993* (GOC Act) provides that the *Ombudsman Act* does not apply to a company government owned corporation (GOC). Energex and Ergon are both company GOCs. This broad exclusion arguably means company GOCs are immune from complying with any notice I issue to obtain information and also allows company GOCs to refuse to cooperate with Ombudsman investigations into the administrative actions of agencies that are clearly subject to the *Ombudsman Act*. This means they can decline to provide relevant information in their sole possession.

I have therefore suggested that the GOC Act and the *Ombudsman Act* be amended to provide that, although GOCs are not within the Ombudsman's jurisdiction, they are not totally immune from the application of the Ombudsman's powers to gather evidence. This immunity is not available to any other citizen or private sector entity.

Further issue for consideration

Dangerous Industrial Conduct

During the WEP, several complainants argued that criminal charges should have been brought against employers in relation to the incidents involving their relatives. They claimed that the imposition of fines was not, in itself, an appropriate penalty or deterrent for employers who may have recklessly breached legislative standards.

In October 2000, the (then) Attorney-General and Minister for Justice and Minister for the Arts, prepared a Discussion Paper called "Dangerous Industrial Conduct", which sought public submissions on a proposal to create a new offence in the Queensland Criminal Code. A final public report was never published and the new offence has not been created.

The Australian Capital Territory recently became the first jurisdiction in Australia to enact legislation creating an offence of industrial manslaughter.

There are a number of arguments for and against the creation of a new criminal offence as discussed. I do not intend to express a view one way or the other. Many of these were debated publicly prior to the enactment of the *Electrical Safety Act 2002* and the recent amendments to the *Workplace Health and Safety Act 1995*, both of which contain custodial penalties (as an alternative to a fine) for a breach of either an electrical safety obligation or a workplace health and safety obligation.

It is not the role of an Ombudsman to advocate to government about what policy position it should take in relation to the creation of a new criminal offence. I have raised the issue in this Report because complainants raised it with me during the WEP and the (then) Attorney-General and Minister for Justice and Minister for the Arts thought the matter of sufficient importance to warrant the preparation of a Discussion Paper.

Chapter 1: Background

1.1 Introduction

Between 1995 and 1999, nine separate incidents occurred in Queensland that resulted in the death by electrocution of 12 people. The relatives of those who died made complaints to the Ombudsman's Office about the way the Division of Workplace Health and Safety (WH&S) and the Electrical Safety Office (ESO) had investigated persons and corporations for alleged breaches of electrical safety standards and/or workplace health and safety obligations that they believed had caused or contributed to the incidents. In most cases, they also complained about the lack of prosecution action arising out of the investigation.

Our investigation of these nine incidents became the Workplace Electrocution Project (WEP). All nine incidents have now been investigated. The last one was finalised in April 2004.

At the time the complaints were made, WH&S was within the Department of Employment, Training and Industrial Relations (DETIR). The ESO was within the Department of Mines and Energy (DME). Both agencies are now within the Department of Industrial Relations (DIR).

Five of the nine incidents were depressingly similar. They involved young, relatively inexperienced male workers undertaking electrical work or using electrical apparatus:

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The Office commenced investigating the first incident in May 1999. Over the following months, the former Ombudsman was contacted by the relatives of some of the other persons who had died in the electrical incidents described above. The allegations made suggested that there were systemic problems with the way electrical incidents in Queensland were investigated. A number of these complaints were selected for investigation and assembled to form the Workplace Electrocution Project (WEP). All nine incidents have now been investigated. The last one was finalised in April 2004.

1.2 The investigation

The two principal objects of the WEP were:

- to determine whether WH&S and the ESO had complied with their legislative responsibilities to investigate the incidents and take regulatory action; and

- to identify how the investigation of such electrical incidents and the electrical safety system in Queensland could be improved.

My officers:

- obtained and examined the files from each agency;
- obtained and examined the transcripts from relevant coronial inquests;
- where appropriate, interviewed the complainants;
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These inquiries and activities touched almost every aspect of investigative and enforcement activity within the responsibility of the two agencies.

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resulted largely from inadequacies in training, poor recruiting practices, ineffective investigative procedures, poor and sometimes non-existent record keeping practices and lack of effective supervision by managers. I also found that a significant number of systemic issues inhibited performance.

It is reasonable for the community to expect that Queensland government agencies with regulatory functions will perform their core work to a very high standard, especially where they are investigating potential statutory breaches that may have had fatal consequences. It is not enough that agency officers are committed and well intentioned.

It was clearly in the interests of the general public, as well as electrical and other workers (especially those with limited work experience, skills and competencies), that we vigorously scrutinised these tragic incidents to determine how workplaces and other places where electricity might be encountered could be made safer.

1.3 Report to Parliament

The *Ombudsman Act* [1] provides that I may report to Parliament, as I consider appropriate, on a matter arising out of the performance of my functions. Understandably, people may ask why we have prepared this Report. After all, we finalised the last investigation over twelve months ago.

There are several compelling reasons for reporting to Parliament on these investigations.

The most important one is that the issues dealt with are so serious that there is a high level of community interest in making public the results of our investigations. Each investigation was the subject of a report under the *Ombudsman Act* [2] to the department[3], in which WH&S and the ESO were located, and to the relevant complainant.

However, these reports were not made public by tabling them in Parliament because of the large amount of operational and technical detail they contained. Nonetheless, information from some of these reports, but not others, found its way into the media. It is important that an official account of all nine investigations now be given.

Secondly, the role my Office has undertaken in relation to this project has not solely been an investigative one. We have also made extensive recommendations[4] to remedy the administrative deficiencies identified during our investigations and then followed up on progress made by DIR in implementing our recommendations. Two of my senior officers also

1 Section 52.

2 Section 50 allows the Ombudsman to provide a report to the principal officer of the Department. Section 57 allows the Ombudsman to "inform the complainant, in the way the ombudsman considers appropriate, of the result of the investigation".

3 DETIR in the case of WH&S and DME in the case of the ESO in Cases 1 and 2.

4 92 principal recommendations.

participated as members of ministerial reference groups[5] established in early 2001 to assist the review process.

Therefore, it is important to report on how the current regulatory system compares with the system that existed at the time the incidents occurred and, in so doing, to acknowledge the action taken by DIR, directly or indirectly in response to our recommendations, to improve the investigation of electrical incidents and the electrical safety system in Queensland.

Finally, it is also in the public interest to place on the public record what further action the department needs to take to fully implement our recommendations and further improve the system.

I am confident that implementation of the recommendations summarised in this report have assisted and will continue to assist in reducing the number of preventable workplace deaths in Queensland and will increase the commitment of all sectors of our community to improving the safety of workers and members of the public who encounter electrical sources in the types of situations discussed in my report.

1.4 Ombudsman's investigative and reporting functions

The Ombudsman's responsibility[6] is to investigate complaints involving the administrative actions of public sector agencies and to recommend remedial action where appropriate.

The Ombudsman also has the functions of considering the administrative practices and procedures:

- of agencies whose actions are being investigated and making recommendations to improve those practices and procedures; or

- of agencies generally and making recommendations or providing other help to the agencies to improve those practices and procedures.

Principally, the Ombudsman's powers are those of investigation and recommendation. I am unable to make determinations or orders as a court is able to do. However, I am required to form opinions and, if necessary, make recommendations to address any maladministration that I identify[7].

Recommendations are made to the principal officer of the relevant agency[8], who is required to notify me of the steps taken or proposed to be taken to give effect to my recommendations[9]. If an agency does not implement my

5 The Workplace Health and Safety Review Reference Group and the Electrical Safety Office Review Reference Group.

6 Section 12 of the *Ombudsman Act*.

7 Part 6 of the *Ombudsman Act.*

8 Section 50 of the *Ombudsman Act*.

9 Section 51(2) of the *Ombudsman Act*.

recommendations, I can report the matter to the Premier or prepare a report for Parliament[10].

Further, section 52 of the *Ombudsman Act* provides that the Ombudsman may at any time, if the Ombudsman considers it appropriate, give the Speaker a report on any matter arising out of the performance of the Ombudsman's functions for tabling in the Legislative Assembly.

The *Ombudsman Act* commenced on 3 December 2001. Investigative work undertaken prior to that date was conducted under the repealed *Parliamentary Commissioner Act 1974* (PC Act). Investigations conducted after 3 December 2001 were conducted under the new Act.

My officers assessed the written complaints made to this office. In all, nine incidents were identified involving 12 fatalities. These fatalities became known as the 12 cases of the WEP and a decision was made on the order in which they would be investigated.

The former Ombudsman[11] advised the Directors-General of DETIR and DME on 27 May and 1 December 1999 respectively of his intention to conduct a formal statutory investigation under the PC Act of the allegations relevant to Case 1 of the WEP.

The former Ombudsman advised the Directors-General of DETIR and DME on 10 January 2000 of his intention to conduct a formal statutory investigation of the allegations relevant to Case 2 of the WEP, which was also conducted under the PC Act.

Once these two investigations commenced, section 19(1) of the PC Act conferred upon the former Ombudsman all of the rights, powers and privileges of a Royal Commission, as contained in the *Commissions of Inquiry Act 1950*.

In particular, under the powers contained in the *Commissions of Inquiry Act*, persons could be required to attend to give information and answer questions, and my officers conducted formal interviews as part of the investigative process. I have similar powers under the *Ombudsman Act*.

The allegations made in Cases 3, 4 and 5 of the WEP were investigated[12] under the PC Act, but the investigation reports were prepared under the *Ombudsman Act*. Allegations relevant to Cases 6 to 12 were investigated under the *Ombudsman Act*.

1.5 Jurisdictional limitations

Certain jurisdictional limitations had an impact on the direction of my investigations, namely:

10 Section 51(3) and (4) of the *Ombudsman Act.*

11 Mr Fred Albietz, LL.B, Solicitor.

12 Although final reports were compiled under the *Ombudsman Act*.

- The combined effect of sections 7(2) and 16(2)(c) and (d) of the *Ombudsman Act* is that I am unable to investigate acts or omissions that relate to what may be described as police operational matters.

- Section 16(2)(b) of the *Ombudsman Act* provides that I am not authorised to investigate any administrative action taken by a person acting as legal adviser to the State or counsel for the State in any legal proceedings.

- My jurisdiction extends only to the administrative action of an "officer[13]" of an "agency[14]". Both words are defined in the *Ombudsman Act,* as is the phrase "administrative action[15]". Accordingly, I have no jurisdiction to form an opinion or make a recommendation in relation to an action or decision of a person who is not an officer of an agency.

- Section 184 of the *Government Owned Corporations Act 1993 (Qld)* provides that the *Ombudsman Act* "does not apply to a company GOC". Relevant electricity entities, such as Energex and Ergon, are company GOCs. Therefore, I was unable to investigate administrative actions taken by these entities. I discuss this particular limitation in Chapter 8 of this Report.

1.6 Procedures for gathering evidence

Section 25 of the *Ombudsman Act* provides as follows:

> 25 Procedure
>
> (1) Unless this Act otherwise provides, the ombudsman may regulate the procedure on an investigation in the way the ombudsman considers appropriate.
>
> (2) The ombudsman, when conducting an investigation:
>
> (a) must conduct the investigation in a way that maintains confidentiality; and
>
> (b) is not bound by the rules of evidence, but must comply with natural justice; and is not required to hold a hearing for the investigation; and
>
> (c) may obtain information from the persons, and in the way, the ombudsman considers appropriate; and
>
> (d) may make the inquiries the ombudsman considers appropriate.

13 Schedule 3 Dictionary of the Ombudsman Act.

14 Section 8 *Ombudsman Act*.

15 Section 7 *Ombudsman Act*.

Section 49(2) outlines the grounds upon which an Ombudsman may make a recommendation. The *Ombudsman Act* is silent as to what standard of proof is required to be met before the Ombudsman can be satisfied that grounds exist for forming an opinion for the purposes of s.49(2). This question is of special importance where an opinion could be considered adverse to an individual.

1.7 Standard of proof and sufficiency of evidence

The question of the sufficiency of evidence requires some assessment of weight and reliability. In making that assessment, the standard of proof, appropriate to the opinions required to be formed, needs to be applied.

Two standards of proof are known to the common law, the criminal standard and the civil standard. The criminal standard requires proof beyond reasonable doubt. The civil standard requires proof on the balance of probabilities. “Balance of probabilities” essentially means that, to prove an allegation, the evidence must establish that it is more probable than not that the allegation is true.

The civil standard of proof applies in investigations conducted by an Ombudsman.

The strength of evidence necessary to establish an allegation on the balance of probabilities may vary according to the seriousness of the issues involved. In the case of *Briginshaw v Briginshaw* (1938) 60 CLR 336, Dixon J remarked that:

> The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved.

1.8 Procedural fairness and natural justice

The terms “procedural fairness” and “natural justice” are often used interchangeably within the context of administrative decision-making.

The rules of procedural fairness have developed to ensure that decision-making is both fair and reasonable.

Several sections of the *Ombudsman Act* either state or reinforce the principle that persons the subject of adverse comment should be provided with an opportunity of being heard in relation to a matter before I form a final opinion.

Section 25(2) of the *Ombudsman Act* provides that when conducting an investigation, I must comply with the “principles of natural justice”.

Section 26(3) of the *Ombudsman Act* provides that, if at any time during the course of an investigation it appears there may be grounds for making a

report that may affect or concern an agency, the principal officer of that agency must be offered an opportunity to comment on the subject matter of the investigation before the report is made.

Section 55 of the *Ombudsman Act* provides that any report under the Act must not make comment adverse to any person unless that person has been given an opportunity of making submissions about the proposed adverse comment. If, after assessing those submissions, I still propose to make adverse comment, I am required to ensure that person's defence is "fairly stated" in the final report.

While the courts have emphasised the need for flexibility in the application of the rules of procedural fairness and natural justice depending on the circumstances of each individual case, procedural fairness or natural justice generally requires an investigator conducting an administrative investigation to:

- inform people against whose interests a decision may be made of the substance of any allegations against them or the grounds for adverse comment in respect of them;
- provide people with a reasonable opportunity to put their case, whether in writing at a hearing or otherwise;
- hear all parties to a matter and consider submissions;
- make reasonable inquiries or investigations before making a decision, forming an opinion or taking any action;
- ensure that no person decides a case in which they have a direct interest; and
- act fairly and without bias and conduct the investigation as expeditiously as possible.

Essentially, the provision of natural justice to an individual helps to ensure that that person's legitimate rights or interests are safeguarded.

Each case in the WEP was completed as a provisional or draft report. These reports were provided in that form to DIR[16] and contained provisional opinions and proposed recommendations. This ensured that my predecessor and I complied fully with the requirement in the *Ombudsman Act* (and previously in the PC Act) to give the relevant Director-General the opportunity to comment on all the matters under investigation.

Similarly, notices under s.55 of the *Ombudsman Act* were provided to persons the subject of adverse comment in any provisional report. Any replies received were considered and, where appropriate, fairly summarised in the final report.

This Report was provided to the Director-General of DIR in provisional form to allow the Director-General an opportunity to comment before my Report was completed. Any issues raised have been addressed in the Report.

16 In Cases 1 and 2 the reports were provided to the Director's-General of DETIR and DME.

1.9 Organisational restructure

DETIR was formally disbanded on 26 February 2001 and restructured into two departments, namely DET and DIR.

DIR was given responsibility for providing industrial relations services, administering the Industrial Court and Industrial Relations Commission, and ensuring the provision of workplace health and safety services including the Workers Compensation Policy Unit.

The ESO, which had previously operated within DME, was integrated into DIR during this restructure.

1.10 Incident causation

I have used the word “incident” throughout this report to describe the events referred to in the cases investigated. I deliberately chose this word instead of the word “accident”, which is defined in the Macquarie dictionary as meaning “anything that happens unexpectedly, without design or by chance”.

The DIR Investigation Skills Training Manual supports the use of the phrase “incident causation” rather than “accident investigation”. The manual points out[17]:

> It would be fair to say that on almost every occasion the reason or cause for these events were as a direct result of either something that some person did or failed to do. This includes the individual worker themselves, supervisors, maintenance workers, management, designers/suppliers/installers of plant.
>
> The continued use of the word “accident” promotes the belief that these events have occurred outside of human influence or control. In fact, they are predictable results of specific actions or non-actions. It is possible to clearly identify their causes and to take the appropriate action to prevent or minimise them. To use the word “accident” allows the idea that the resulting injuries are an unexpected part of life. This totally undermines the goals and aims of the Division as well as the expectations that the community has of us as inspectors. It is encouraged that the use of another appropriate term, such as “incident”, should be used instead.

I endorse the comments made.

17 Page 230.

Chapter 2: Origin of the Workplace Electrocution Project

2.1 Prior investigation

WH&S and its investigative and prosecution functions came to the attention of the former Ombudsman some years ago after he had received a complaint from a worker who had been injured in a workplace incident in North Queensland. The former Ombudsman reported the matter in his 1996-97 Annual Report.

In that case, a worker was exposed at work to various hazardous substances. He became ill, was unable to work, and had to seek specialist medical treatment. He felt that his workplace conditions breached acceptable standards.

The matter was investigated by WH&S and a decision made not to proceed. The complainant was not informed of this until he contacted WH&S to inquire about the progress of the prosecution.

He objected to this decision. WH&S then attempted to re-open the case. Statements were taken and medical reports provided. However, WH&S identified further problems and made the final decision not to proceed on the ground that there was insufficient evidence. The 12 month time limit for commencing a prosecution then expired and no prosecution was ever instigated.

Although WH&S believed its decision was correct, it referred the matter to the former Ombudsman for an independent assessment of the investigation.

The former Ombudsman's investigation identified numerous administrative deficiencies in the handling of the case by WH&S including:

- unexplained periods of delay;
- lack of review by management;
- inadequate bring-up system, particularly having regard to the 12 month time limit for prosecution;
- no case management program existed; and
- confusion about the respective roles of investigators (inspectors) and the prosecutions section so that it was unclear who had responsibility for the prompt gathering of evidence.

In response to these problems, WH&S advised the former Ombudsman that it had put in place new case management (quality assurance) procedures that would prevent a recurrence of the situation. Among other things, those procedures required decisions as to whether or not to institute a prosecution to be made within three months of the receipt of a complaint about an incident.

During our investigation of Case 1 of the WEP, my officers interviewed a former senior WH&S officer about the quality assurance system. He expressed the opinion that compliance with the quality assurance system was never regarded highly by staff and was viewed as something created "at the whim of the Minister and Director-General" of the day to appease the former Ombudsman.

Another senior WH&S officer, when interviewed during the same investigation, was clearly unaware that a quality system even existed.

The failure to meet and monitor quality standards for investigations would prove to be an ongoing theme throughout the WEP.

2.2 The first WEP investigation – Case 1[18]

2.2.1 Background

NS was a 17 year old apprentice boat builder. In March 1998 he was electrocuted at work while using a vacuum cleaner, apparently while standing barefoot on a metal floor. He had commenced his apprenticeship only four months earlier and had had no previous full time work experience.

There were no witnesses to the incident. However, there was evidence that a person or persons had attempted to repair the vacuum cleaner as a result of which live electrical workings had been exposed, rendering inoperative the double insulation status of the appliance, which was its principal safety feature.

Despite the obvious hazards associated with the work, a safety switch was not installed at the workplace.

2.2.2 Response by agencies

NS's death was investigated to varying degrees by both WH&S and the ESO. The vacuum cleaner was sent to Energex for a technical examination.

Initially, neither agency believed the evidence established any breach of legislation. A short time later, WH&S decided not to prosecute and, for all practical purposes, closed the investigation.

NS's parents then spent several months making their own enquiries about how their son had died. They believed that WH&S's investigation had been poorly planned, hastily conducted and prematurely terminated, and that many issues highlighted for further investigation and clarification during an inquest into his death had not been adequately addressed by either agency.

NS's parents presented their findings to the management of both agencies. They considered that they did not receive a meaningful response and

18 Final report completed 12 February 2001.

subsequently made representations to the responsible Minister. They said that it took them months of intense lobbying before their representations bore fruit and WH&S reconsidered its earlier decision.

Shortly prior to the expiration of the 12 month limitation period within which to commence a prosecution, and contrary to the initial decision, WH&S commenced proceedings against NS's employer. The employer was eventually convicted and fined $40,000, the largest fine ever imposed on a company in Queensland for a breach of the legislation at the time.

2.2.3 Complaint

NS's parents complained[19] to us about the way they had been treated. They said they were distressed by the departmental indifference and apathy they had encountered over an extended time.

Furthermore, they informed us that their case was not an isolated one and that the relatives of other electrocution victims, whose deaths had been investigated by WH&S and the ESO, had reported similar experiences.

In the months that followed, we were contacted by some of those relatives. Their allegations suggested to us that there might be systemic problems with the way electrical incidents in Queensland were being investigated. We decided to develop a project to investigate these complaints. We called it the Workplace Electrocution Project (WEP).

2.3 Other reviews

Our decision to undertake the project was reinforced by the findings and recommendations of the Electrical Safety Taskforce[20] in April 2001 and those of the Ministerial Review[21] of WH&S and the ESO in July 2001.

2.3.1 Electrical Safety Taskforce

The Electrical Safety Taskforce was formed in June 2000 by the Honourable Paul Braddy MP, the then Minister for Employment, Training and Industrial Relations and the Honourable Tony McGrady MP, the then Minister for Mines and Energy and Minister assisting the Deputy Premier on Regional Development.

Essentially, the Taskforce was established to "investigate and make recommendations on improving the manner in which electrical incidents can be prevented, investigated and dealt with"[22].

The terms of reference[23] for the Taskforce were to:

19 By written complaint 16 March 1999.

20 Electrical Safety Taskforce – "A Review of Industry Compliance with Electrical Safety Standards and the Investigation of Serious Electrical Incidents".

21 Ministerial Review of the Division of Workplace Health and Safety and the Electrical Safety Office.

22 Page 1 of the Electrical Safety Taskforce Final Report.

23 Page 1 of the Electrical Safety Taskforce Final Report.

- consider strategies to improve compliance with electrical safety standards in industry;
- develop a process to ensure that serious electrical incidents are investigated thoroughly; and
- clarify the investigation and enforcement roles of various regulatory agencies involved with electrical safety.

The Taskforce became the sole responsibility of the Honourable Gordon Nuttall MP, who became Minister for Industrial Relations, following the Queensland state election in February 2001.

The Taskforce examined electrical injury statistics over an extended period. It released an Issues Paper for public comment in October 2000 and an interim report was made available in January 2001. The final report was published in April 2001[24].

The Taskforce confirmed that Queensland's electrical safety performance compared poorly both nationally and internationally. In fact, the Taskforce said that "Queensland consistently rates among the worst performers in the western world"[25]. It found "evidence of non-compliance with electrical safety standards by some involved in the delivery and use of electricity"[26]. It also found "evidence of inadequate past investigative strategies following electrical incidents"[27]. The Taskforce stated that "it became apparent quite early on in its deliberations that standards were quite high, and the problem really related to industry non-compliance…"[28].

The Taskforce identified a number of "structural impediments"[29], namely:

- omnibus electricity legislation, which was essentially operational and not focused exclusively on safety;
- competing legislation (i.e. WH&S Act and Electricity Act), which took a different approach to safety regulation and management;
- ineffective and inefficient investigation of electrical incidents/accidents by the major responsible agencies resulting from overlap of responsibility leading to delay and confusion;
- potential conflict between the statutory investigative function of "authorised persons"[30] and their responsibilities to their employers; and
- lack of enforcement of electrical safety due to inherent weaknesses in the electricity legislation.

The Taskforce made 12 recommendations[31], stating that it had attempted to address its terms of reference by "taking a broad regulatory perspective rather

24 Electrical Safety Taskforce Final Report.

25 Page 5 of the Electrical Safety Taskforce Final Report.

26 Page 12 of the Electrical Safety Taskforce Final Report.

27 Page iii of the Executive Summary of the Electrical Safety Taskforce Final Report.

28 Page 4 of the Electrical Safety Taskforce Final Report.

29 Page iii of the Executive Summary of the Electrical Safety Taskforce Final Report.

30 For a discussion of the role of an "authorised person" see 3.6.1.3 and 6.6 of this Report.

31 See Appendix A.

than one of looking at the adequacy of standards"[32] It asked the Government to be "strong and decisive in its intervention with respect to the recommendations as they were designed to restructure how electrical safety was managed in all sectors of industry"[33].

The recommendations relevant to the issues being considered in the WEP were:

Recommendation 1
That the functions of the electrical safety regulator be clearly outlined in legislation and assigned to an independent body to administer, reporting to the Minister for Industrial Relations.

Recommendation 2
That stand-alone electrical safety legislation be developed as a matter of urgency, based on the *Workplace Health and Safety Act 1995* and complementary to other safety legislation, to apply universally.

Recommendation 3
That a new system of notifications of electrical accidents and incidents together with investigations by the electrical safety regulator be introduced under the new electrical safety legislation funded by a levy on electricity entities.

Recommendation 4
That all workplace electrical incident/accident investigations be conducted by a single body.

…

Recommendation 6
That all domestic premises have at least power circuit safety switches fitted either at point of sale or within a phasing in period determined in consultation with stakeholders, whichever first occurs; and

That workplaces have, as a minimum, electrical safety switches protecting all hand held or portable equipment supplied through electrical power outlets up to 20Amp, with a phasing in period determined in consultation with stakeholders.

Recommendation 7
That Government develop a strategic program of minimising the risk of contact with overhead lines, including undergrounding of existing lines.

Recommendation 8
That a mechanism be developed providing for comprehensive safety management plans for network operators to be monitored and enforced by the regulator.

32 Page iv of the Executive Summary of the Electrical Safety Taskforce Final Report.

33 Page iv of the Executive Summary of the Electrical Safety Taskforce Final Report.

Recommendation 9
That safety management plans include comprehensive asset management programs.

Recommendation 10
That a more strategic role, function and composition of the Electricity Health and Safety Council be subsumed into the corporate governance arrangements for the proposed electrical safety regulator.

Recommendation 11
That the current review of the role of workplace health and safety officers and representatives being undertaken by the Workplace Health and Safety Board take into account the needs of the electrical industry and that the workplace consultative arrangements contained in the *Workplace Health and Safety Act 1995* be enforced more stringently.

Recommendation 12
That the Government ensure adequate resourcing is made available to the proposed new electrical safety regulator. Consideration should be given to the following:

- the introduction of a levy on electrical entities;
- increased fines for breaches of the proposed new electrical safety legislation, including the awarding of investigation costs;
- the introduction of on-the-spot fines for lesser breaches;
- payment for service options (the Victorian model); and
- a review of electrical worker and contractor licence fees, including considering the introduction of application fees and re-inspection fees for errant contractors.

2.3.2 The Ministerial (Crittall) Review

The reports of our investigations of the first two complaints (Cases 1 and 2) comprising the WEP were provided to DIR on 12 February[34] and 10 April 2001[35] respectively. The reports recommended a "comprehensive management and strategic review of WH&S and the ESO be undertaken by a suitably qualified independent reviewer selected in consultation with the Ombudsman"[36].

The former Ombudsman recommended that the Reviewer address the following eight issues:

1. the structure of WH&S and the ESO, including the delegation and allocation of responsibility and the appropriateness of the current classifications of positions;

2. the adequacy of staff and other resources within WH&S and the ESO to enforce the WH&S Act and Regulations and the Electricity Act and Regulation, including whether, specifically, matters developed and

34 Case 1 of the WEP.

35 Case 2 of the WEP.

36 Recommendation 3 of Cases 1 and 2 of the WEP.

earmarked for prosecution have been or are being dropped because of resourcing difficulties;

3. current investigation methodologies and processes, including the giving of warnings in relation to workplace audits;

4. formal and informal staff training and guidance;

5. management systems and processes used by WH&S and the ESO, including internal and external performance indicators to monitor efficiency and effectiveness and internal communication and sharing of information on operations and performance, especially between the audit and investigative teams;

6. the competency of existing staff employed in compliance/enforcement roles within WH&S and the ESO, so as to determine whether all such officers possess the appropriate skills, knowledge and training to undertake investigations, with any identified deficiencies being addressed by specific training and professional development;

7. the lack of awareness of the quality system and the appropriate intervals at which compliance with it should be audited; and

8. any other matters that impact on the economy, efficiency and effectiveness of investigations, prosecutions and audits.

The then Minister for Industrial Relations, the Honourable Gordon Nuttall MP, having considered both of these reports[37], commissioned an independent review of both WH&S and the ESO in order to "consider the framework within which workplace health and safety is administered in Queensland with a view to recommending to Government the most appropriate structures and operational and administrative arrangements to ensure safe and healthy workplaces in Queensland"[38].

Mr John Crittall was appointed to conduct this review[39], assisted by Mr Ray Dempsey in relation to the ESO. This review, and its subsequent reports[40] which were released in July 2001, became generally known as the "Crittall Review" or the "Ministerial Review". Mr Crittall is variously described in appendices to this Report as the Reviewer, the Ministerial Reviewer or the Departmental Reviewer.

The final reports of the Ministerial Review made findings generally consistent with the recommendations contained in the Electrical Safety Taskforce Final Report, which had stated that "Queensland has the highest fatality rate from electrocution in Australia by a factor of at least two"[41] and "rates among the

37 Cases 1 and 2 of the WEP.

38 Page 2 of the Final Report of the Ministerial Review of WH&S and the ESO.

39 The former Ombudsman was consulted in respect of this appointment.

40 Final Report of the Ministerial Review of WH&S and the ESO and the Final Report of the Ministerial Review of the ESO (collectively called the final reports of the Ministerial Review).

41 Page 5 of the Electrical Safety Taskforce Final Report.

worst performers in the Western world"[42]. The Final Report of the Ministerial Review of the ESO stated[43]:

> Queensland has consistently proven to be one of the nation's poorest performers over the last decade in electrical safety. While electrical fatalities have seen dramatic improvements (a drop of 77%) over the last 30 years, Queensland is still lagging behind the national average. Queensland has the second highest electrical fatalities rate per million people in Australia (behind the NT) with an average of 3.57 fatalities per million people compared to the national average of 2.18 fatalities over the last 5 years. This is approximately 60% above the national average.

The Ministerial Review made a total of 51 recommendations, 34 in respect of WH&S[44] and 17 in respect of the ESO[45]. Some of the principal recommendations were:

- the creation of a separate Electrical Safety Act to regulate safety matters in the electricity industry with the legislation to reflect modern enforcement methods and be consistent with the WH&S Act;

- that the WH&S Act be reviewed to reflect changes in the labour market and the modern need associated with the role of regulator;

- the establishment of an independent electrical safety regulator with the status of a statutory officer, under the authority and control of the Minister for Industrial Relations;

- the development of legislative standards that would systematically broaden the scope, application and use of safety switches in workplaces;

- the establishment of an Electrical Safety Board to make recommendations for improved safety performance to the Minister;

- that Authorised Persons[46] cease all investigative functions relating to priority one incidents[47] and these functions be undertaken in future by WH&S;

- that all priority one incidents occurring at a workplace be managed through DIR's Legal Unit;

42 Page 5 of the Electrical Safety Taskforce Final Report.

43 Page 4 of the Final Report of the Ministerial Review of the ESO.

44 See Appendix B.

45 See Appendix C.

46 Section 171(1) of the *Electricity Act 1994* (repealed) required that Authorised Persons (who were employed by relevant electricity entities) investigate an accident involving death or serious personal injury on its works or one of its electrical installations and report to the electricity entity which then reported to the Regulator.

47 An incident involving a death or serious personal injury.

- that a policy be developed and implemented that prevents any newly appointed inspectors from attending fatal incidents in the absence of an experienced investigator within the first 12 months of service;

- that a Director of Prosecutions be recruited at senior officer level to manage DIR's Legal Unit;

- that specialist investigators and other managers be recruited;

- that several key management and reporting structures be realigned to establish clear lines of accountability and reduce ambiguity and overlap; and

- that significant core programs and functions be better resourced.

The Ministerial Review concluded[48] that "all of the parties involved in the review process were unanimous … the current safety performance of the electrical industry needed to be dramatically improved".

2.4 GRAVES

The *Ombudsman Act* provides that, if a person who could have made a complaint has died, the Ombudsman may accept a complaint made by an individual who is, in the Ombudsman's opinion, suitable to represent the deceased.

A significant number of complainants within the WEP were directed to my Office by an organisation known as "GRAVES", the **G**roup **R**equiring **A**ction for **V**ictims of **E**lectric **S**hock. GRAVES has, from time to time, acted as the representative for some of the complainants who initially contacted my Office. Other complainants have chosen to represent themselves.

GRAVES made a submission in response to the interim report of the Electrical Safety Taskforce and has been a consistent and vocal advocate of the need to improve Queensland's electrical safety performance.

2.5 The complainants

Each of the complainants in the WEP submitted written complaints to my Office. Invariably, the complainants were related to the deceased. In seven cases they were the parents of the deceased. In the other cases:

- the former Ombudsman accepted a complaint from the grandfather of a three year old girl who, together with her mother and a neighbour, had been electrocuted by a fallen power line; and

48 Page 7 of the Final Report of the Ministerial Review of the ESO.

- the widows of two workers who had died at a construction site when a crane came into contact with live overhead power lines made the complaint.

I would like to publicly acknowledge the courage and determination of all of these complainants who at a time of extreme personal grief had the fortitude to assemble their complaints as best they could and assist my officers by providing relevant information.

I would also like to acknowledge the assistance given to my investigations by the great majority of former and current officers from WH&S and the ESO, as well as the Director-General and the former Deputy Director-General of DIR and other senior departmental officers.

Chapter 3: Legislative framework

3.1 Workplace Health & Safety – a brief history

The October 2000 Electrical Safety Taskforce Issues Paper summarised the history of regulation, self-regulation and de-regulation of occupational health and safety legislation in Queensland in the following way:

> **History of Change**
>
> Prior to 1989 the workplace health and safety regulatory framework was referred to as "prescriptive", because it sought to prescribe, in minute detail, the legal obligations of employers. The major shortcomings of the prescriptive model could be summarised as:
>
> - the Acts and Regulations were numerous and complex, and were enforced by multiple agencies
> - the laws were slow to change and could not keep pace with new technology
> - there could never be enough laws to cover every situation or workplace
> - there was ineffective enforcement of the myriad of complex prescriptive laws.
>
> After a major review of Workplace Health and Safety legislation in Britain, a general shift away from the prescriptive approach to a model based on "self-regulation" was systemically adopted in each state in Australia during the 1980s. The main components of this new approach include:
>
> - a single Act that introduced broader duties within a comprehensive workplace health and safety framework
> - wider coverage for all people affected by the risks associated with a workplace, and/or workplace activity
> - greater involvement through increased consultation between government, employers, workers and their organisations
> - a new enforcement regime including additional powers for Inspectors.
>
> **Workplace Health and Safety Act 1995**
>
> The Workplace Health and Safety Act was introduced in 1989. In broad terms the Act:
>
> - consolidated many pieces of legislation into one Act
> - created additional subordinate legislation in the form of regulation
> - created a statutory "duty of care" for employers
> - created codes of practice for hazard identification, assessment and control
> - introduced formal tri-partite consultative processes between government, unions and employer associations
> - introduced prohibition and improvement notices as enforcement strategies for inspectors.
>
> The 1989 Act was subsequently replaced by the Workplace Health and Safety Act 1995. The main features of the Act remained relatively unchanged.

However, the duty of care provisions were replaced by "obligations" for employers and all other persons who in some way were involved with a workplace, or workplace activity, namely:

- employers
- self-employed persons
- persons in control of workplaces
- principal contractors
- designers, manufacturers, importers and suppliers of plant
- erectors and installers of plant of specified high risk plant
- manufacturers, importers and suppliers of substances for use at workplaces
- owners of specified high risk plant
- workers and other persons at a workplace.

Workplace health and safety for electrical workers is principally governed by the Workplace Health and Safety Act. However there are additional safety obligations imposed on employers and employees under the terms of the Electricity Act.

3.2 Workplace Health and Safety Act 1995 – basic concepts

All of the incidents in the WEP occurred prior to the 2003 amendments to the WH&S Act. Accordingly, the investigations conducted by my officers made reference to the several reprints of the WH&S Act that were current at the time of each incident[49] between 1995 and 1999. The following basic concepts applied during that period.

The object of the WH&S Act, as defined in section 7 of the Act, is to:

> ensure freedom from disease or injury to persons caused, and risk of disease or injury to persons created, by workplaces, workplace activities or specified high risk plant.

Section 22 describes how workplace health and safety should be ensured, namely by:

- identifying hazards
- assessing risks that may result because of the hazards
- deciding on control measures to prevent, or minimise the level of, the risks
- implementing control measures, and
- monitoring and reviewing the effectiveness of the control measures.

Section 23 sets out the categories of persons who have obligations to ensure workplace health and safety under division 2 of the WH&S Act[50]. They include:

- employers
- persons in control of workplaces

49 Cases 1 to 12 of the WEP.

50 Sections 28 to 35 of the WH&S Act.

- principal contractors
- designers, manufacturers, importers and suppliers of plant.

Section 24 is the offence provision. It provides:

> A person on whom a workplace health and safety obligation is imposed must discharge the obligation.

It imposes a penalty for not discharging the obligation.

Section 28 sets out the obligations imposed upon an employer. It states that an employer has an obligation to:

> ensure the workplace health and safety of each of the employer's workers at work[51]; and
>
> ensure that his or her own workplace health and safety and the workplace health and safety of others is not affected by the way the employer conducts the employer's undertaking[52].

Section 30 sets out the obligations imposed upon a person in control of a workplace. The obligation under subsection (1)(a) is to:

> ensure the risk of disease or injury from a workplace is minimised for persons coming onto the workplace to work.

Sections 26 and 27 set out the various ways in which a person's workplace health and safety obligations can be discharged. Section 26 is applicable if a compliance standard prescribes a way of preventing or minimising exposure to a risk or if an advisory standard states a way or ways of identifying and managing exposure to a risk.

Section 27 is applicable in instances where there is no compliance standard or advisory standard. Section 27(3) is a "catch-all" provision. It states that an obligation, such as those created by s.28, is only discharged if the person who owes it:

> takes reasonable precautions, and exercises proper diligence, to ensure the obligation is discharged.

As previously stated, the employer has an obligation to ensure the workplace health and safety of its workers at work. An employer successfully discharges that obligation if it:

- takes reasonable precautions; and
- exercises due diligence

to ensure that its obligation is discharged[53].

51 Section 28(1) WH&S Act.

52 Section 28(2) WH&S Act.

53 Section 27(1) of the WH&S Act.

3.3 Catalyst for amendments to the WH&S legislation

In September 2001, the Queensland government accepted a recommendation[54] of the Ministerial Review that "the Workplace Health & Safety Act 1995 be reviewed to reflect changes in the labour market and the modern needs associated with the role of regulator".

The December 2001 DIR Issues Paper[55] was prepared for the review of the Workplace Health & Safety legislation. It explained that the submission to the government in support of this recommendation "identified a number of other issues directly related to the updating and review of the Act". The paper went on to say that[56]:

> While minor changes were made to the legislation in 1995 and 1997, the main principles upon which the legislation was based remained largely unaffected. Recent shifts in policy have prompted a review in the legislation to ensure the legislative framework is appropriately meeting the needs of all of the stakeholders. A recent review analysing the impact of 20 years under the Robens self-regulatory model raised a number of potential issues that may impact directly upon the WH&S Act. These include:
>
> - changes in the organisation of labour and the growth of self-employment, contract, part-time and casual labour.
> - growth in the number of small businesses and organisations.
> - decline in union membership and density rates.
> - a realisation that employers do not possess complete health and safety knowledge, expertise, or capacity to develop management systems.
> - a realisation that not all employers possess a willingness to adopt WHS initiatives or effectively self-regulate.
> - work-related death and injury rates are still high. (Institute of Employment Rights, 1999).
>
> Changes in the labour market and, more particularly, the growth of "contingent" workers[57] have dramatically affected the nature of the key relationships at work and have placed considerable pressure on the definitions and responsibilities of obligation holders under the WH&S Act. The anticipated growth in "contingent" workers and the complexity of the legal relationships requires an examination of the current provisions to ensure that the legislative framework reflects an obligation chain that delivers optimal health and safety outcomes. This is an essential feature of the current legislative review.

The Issues Paper went on to point out[58]:

54 Recommendation 7.0 of the Final Report of the Ministerial Review of the WH&S and the ESO.

55 December 2001 DIR Issues Paper.

56 Page 1 of the December 2001 DIR Issues Paper.

57 This term has been used to describe workers who are usually labour only workers paid by the hour or piecework produced and completely contingent upon work being available. It would include homeworkers, casuals, part-time workers, independent contractors and may also include agency-hire workers and self-employed workers.

58 At page 2.

> Another issue for the Government is to ensure that the legislative framework supports and encourages the outcomes expected from the legislation. The issue of compliance has been an important strategic initiative of the Government since the release of the first WH&S Enforcement Framework in 1999. The purpose of this policy framework was to highlight a shift toward more robust enforcement strategies aimed at increasing compliance with the legislation. One of the critical factors in designing a system that delivers optimum compliance is the balance between persuasion and punishment. The 'persuasion' focus concentrates on such things as information products, guidance material and the provision of advice. This is supported by an Inspectorate committed to assisting and supporting obligation holders in meeting their legislative duty. The "punishment" focus utilises a different set of tools and includes the application of various sanctions ranging from improvement notices, prohibition notices, infringement notices (on-the-spot fines) and prosecution.
>
> The exact nature and balance between "persuasion" and "punishment" has proven to be extremely problematic for all health and safety authorities throughout Australia. The role of the authorities has been seen primarily as one of educating and informing obligation holders through the provision of various information products and workplace inspections. While these processes are not mutually exclusive, the WH&S tended to favour the 'persuasion' strategy for the first 10 years of the new legislation.

Importantly, the Issues Paper suggested[59] that "while this emphasis may have been appropriate for the initial introduction of the legislation, the overall effectiveness of this approach has come under increasing scrutiny in terms of delivering optimum health and safety outcomes". The Issues Paper went on to say[60]:

> The shift in emphasis and focus on safety 'blitzes' and the issuing of improvement and prohibition notices for regulatory breaches contrasted significantly from the previous approach. The update and release of the new WH&S Enforcement Framework 2001 and the inclusion of a new Investigation and Prosecution policy further reinforces this shift toward a more robust enforcement strategy. The latest edition of the Enforcement Framework 2001 states that "the appropriate use of a comprehensive range of enforcement strategies will encourage greater workplace health and safety compliance with legislative requirements and enhanced prevention of workplace injury, illness and disease".
>
> While the key focus of consideration must always revolve around 'prevention', enforcement activity has a direct link with the record of incidence and severity of injury and illness at work. The express link between enforcement activity and injury rates is now well established. A study conducted by Gray and Scholtz (1991, cited in Brown, 1992) noted:
>
> > 'The researchers conducting this study estimated that a 10% increase in the number of penalties would reduce the number of injuries by 1.61% and that a similar increase in the average size of penalties would reduce injuries by 0.93%. In other words, both the severity and certainty of punishment strongly influence injury rates, although certainty has a substantially stronger effect than

59 At page 2.

60 At page 2.

> severity. The researchers also found that penalties prevent more injuries by altering the conduct of employers who have not themselves been penalised than by influencing the performance of penalised employers. In other words, general deterrence is a more potent force than specific deterrence in preventing injuries'.

Another major focus of the legislative review is in relation to designing an appropriate penalty regime that secures optimum compliance with the legislative requirements. The main issues under consideration include the penalty regime itself and the tools available to the Inspectorate to adequately perform its role. The suitability, scope and application of the size and nature of current penalties under the Act will be examined as part of this process. The Inspectorate also needs to have a broad range of tools that can be applied in any given context. The role of the legislation is to facilitate and equip the Inspectorate so that it can perform its role as efficiently and effectively as possible. The shift in emphasis toward greater enforcement is designed to provide the right mix of balance between persuasion and punishment while at the same time providing a significant deterrence to willful and aberrant behaviour.

The Issues Paper was "designed to canvass a range of issues[61]" associated with a review of the existing workplace health and safety legislation and to "highlight a number of potential weaknesses in the legislative framework"[62].

As a result of the consultation that followed, significant amendments were proposed to the workplace health and safety legislation. These were contained in the Workplace Health and Safety and Another Act Amendment Bill 2002.

3.4 Workplace Health and Safety and Another Act Amendment Act 2003

The Explanatory Notes to the Workplace Health and Safety and Another Act Amendment Bill 2002 stated[63]:

> **Objectives of the legislation**
>
> The objective of this Bill is to amend the *Workplace Health and Safety Act 1995* (hereinafter referred to as "the Act") to ensure it continues to provide for an effective modern regulatory regime that meets the needs associated with the changing nature of the labour market and ensures appropriate health and safety outcomes are achieved for all stakeholders. The Bill also makes consequential amendments to the *Electrical Safety Act 2002*.
>
> The Bill gives effect to the recommendations of an independent review of the Act conducted in 2001-2002.
>
> **Reason for the Bill**

61 Covering letter from D-G of DIR dated 20 December 2001.

62 Covering letter from D-G of DIR dated 20 December 2001.

63 Pages 1 – 3 of the Workplace Health and Safety and Another Act Amendment Bill 2002.

In March 2001, the Minister for Industrial Relations commissioned an independent review into the Division of Workplace Health and Safety of the Department of Industrial Relations. The review was organised in response to a number of issues and concerns that identified shortcomings in the organisation and delivery of health and safety services in Queensland.

The recommendations of the review were considered and accepted by the Government in September 2001, which further recommended a review of the *Workplace Health and Safety Act 1995* to ensure it reflects changes in the labour market and meets contemporary regulatory needs, and to consider the adequacy of current enforcement mechanisms and penalties.

The proposals to amend the Act have the following three aims:

1. to improve the balance of legal obligations at the workplace

2. to strengthen the consultative arrangements between employers and employees

3. to provide greater consistency with other safety legislation and to streamline reporting requirements for employers.

1. Improving the balance of legal obligations at the workplace

The aim of these provisions is to assign legal responsibility to those that can best control the risk. This is especially important with new work arrangements being introduced on a regular basis. The changes place obligations on persons who conduct work undertakings, persons who design buildings and persons in control of buildings used as workplaces. In addition, the proposals will ensure designers, manufacturers and suppliers of equipment have an obligation to provide safety information with the equipment and to ensure it has been tested or checked. Similarly, manufacturers and suppliers of substances will have an obligation to provide safety information. Finally, the proposals will clarify the specific obligations that employers have to meet to ensure health and safety.

2. Strengthening the consultative arrangements

The changes to the Act will also require workplace health and safety officers to conduct an annual inspection at the workplace and will provide for accredited training for workplace health and safety representatives. The Queensland Industrial Relations Commission will be available to resolve any disputes over issues related to the training of representatives.

3. Providing greater consistency with other safety legislation and streamlining reporting requirements for employers

The changes will bring the *Workplace Health and Safety Act 1995* in line with the recent *Electrical Safety Act 2002* with the introduction of enforceable undertakings as an alternative to prosecution and will align penalties with that Act and the *Dangerous Goods Safety Management Act 2000*. In addition, investigation powers are being clarified.

The proposed amendments also seek to align reporting requirements with WorkCover Queensland provisions so that employers will not have to report

the same accident twice. For the building and construction industry, reporting and fee provisions are being aligned with the *Building and Construction Industry (Portable Long Service Leave) Act 1991*.

The *Workplace Health and Safety and Another Act Amendment Act 2003* was enacted on 9 May 2003 with effect from 1 June 2003.

3.5 Background and history of electrical safety regulation in Queensland

The Electrical Safety Taskforce Final Report published in April 2001 contains a comprehensive summary[64] of the background and history of electrical safety regulation in Queensland. The following is an extract[65] from the summary:

> Electrical energy is of vital importance to industries and households in Queensland.
>
> Government intervention to ensure safety in its use has long been recognised as essential. In more recent times there has been a tendency towards partial or some forms of self regulation as the suppliers are now corporatised and the industry is subject to competition that it did not have to contend with in the past. **There is another view that industry in itself is unable to guarantee satisfactory electrical safety performance levels for workers in the electrical industry (as the primary focus is now profit driven), users of electricity and the general public exposed to electricity supply and installations and therefore the need for Government intervention has been a strong and significant feature to date**. [emphasis added]
>
> Electrical safety regulation is concerned with the works of the electricity supply industry (i.e. the generators, transmitters and distributors of electricity), consumers' electrical installations, equipment and appliances used by electricity consumers and work in general industry (i.e. any other workplace, excluding mines). Hence, such regulation deals with all aspects of electrical energy from its ***generation to final use***. The need for effective regulation arises primarily from the adoption of supply and use systems which potentially constitute a danger to people. It is also a source of accidental fires and a source of damage to other facilities through electrolytic corrosion.
>
> Commercial interest in public electricity supply was accelerated by the development of the electric light in 1880. Historically, electrical safety regulation has had three distinct phases.

The Electrical Safety Taskforce Final Report then describes the three phases of electricity regulation in Queensland, namely:

- from the enactment of *The Electric Light and Power Act 1896* to the establishment of the State Electricity Commission of Queensland (SECQ) in 1938. A Royal Commission on Electricity was instituted in

64 Electrical Safety Taskforce Final Report contained the following acknowledgment: "A great deal of the information contained in the Issues Paper with respect to the history and development of the electricity supply industry had been supplied to the Taskforce by [an ESO officer – name and position description deleted]".

65 Page 7 of the Electrical Safety Taskforce Final Report.

December 1935. The Royal Commission recommended the establishment of the SECQ, which commenced operation in January 1938.

- from the establishment of the SECQ in 1938 to the enactment of the *Electricity Act 1994*. The SECQ was replaced by the QEC in 1984. It also merged with the Queensland Electricity Generating Board. The QEC acted, in effect, as an integrated electrical safety regulator, particularly after it assumed chairmanship of the Electrical Workers Contractors Board in 1964, a role it continued under the *Electricity Act 1976*, which gave legislative confirmation to the arrangement.

- from the time the QEC's electrical safety coordination unit transferred to the Department of Minerals and Energy in 1995 to the enactment of the *Electrical Safety Act 2002*. The Department of Minerals and Energy became the Department of Mines and Energy in 1996. The (former) DME acted for six years as technical regulator of the electrical industry. Since 1995, corporatisation resulted in further significant change.

The Taskforce concluded by stating[66]:

> The electricity supply industry in Queensland has undergone significant structural changes since 1976. The industry structure has been subject to significant change on no fewer than four occasions, the most recent two being primarily concerned with adapting the structure of the industry to meet the demands of establishing a competitive market for the supply and sale of electricity. **It is understandable then that technical regulation and particularly electrical safety regulation of the industry may not have been given its due priority in the past decade**. [emphasis added]
>
> Under the Electricity Act, the regulator was the chief executive, or the Director-General, of the (former) DME. In practice, however, most of the electrical safety regulatory functions were delegated to the ESO, the organisational branch of the Department's Safety and Health Division established to specialise in this regulatory role.

In a similar vein, a former Director-General of DME advised my predecessor[67], when responding to Case 2 of the WEP, that:

> Since coming into my current position I have spent considerable time reviewing the legislation and in particular the *Electricity Act 1994*. This legislation resulted in the break-up of the previous Queensland Electricity Commission (QEC) into smaller entities and set the Chief Executive Officer of the Department of Mines and Energy as the Regulator of the industry. My review of the legislation convinces me that the safety function of the QEC was simply moved to the Department of Mines and Energy Electrical Safety Office (ESO) without any clear thought as to the future role of the ESO.
>
> **The further reform of the industry into Government Owned Corporations (GOCs) with separate boards and in a competitive environment has**

66 Page 9 of the Electrical Safety Taskforce Final Report.

67 By letter dated 20 December 2000.

> **exacerbated the problems in electrical safety. The GOCs have a strong focus on profit which was much less evident in the QEC**. [emphasis added]

3.6 Electricity Act 1994 and Electricity Regulation 1994 – basic concepts

The October 2000 Electrical Safety Taskforce Issues Paper described[68] the *Electricity Act 1994* as:

> an all encompassing piece of legislation that deals with the operation and regulatory aspects of the delivery of electricity, licensing of electrical workers and has the safety function … insofar as the public and workers are concerned.

The Ministerial Review of the ESO pointed out that the primary purpose of the Electricity Act was to regulate the electricity generators, transmitters and distributors.

3.6.1 Regulation – both industry and use

One of the objects of the Electricity Act, as described in section 3, is to "regulate the electricity industry and electricity use".

3.6.1.1 Regulator

One way this was achieved was through the creation of an electricity "regulator", which section 62 identified as being the Chief Executive of the DME.

The functions of the regulator follow on from the objects of the Electricity Act and are discussed in section 63. They include:

- ensuring the safety requirements under the Act are complied with; and
- monitoring compliance with the Act, including compliance with conditions of authorities, approvals and licences.

3.6.1.2 Licensing

Another way that regulation was achieved was through the licensing[69] of electrical workers. The purpose of licensing was to ensure the electrical safety of electrical and other workers, consumers and the general public through regulatory arrangements that ensured the competency of the licence holder[70].

Under the Electricity Reg, "a person who holds a licence must not perform electrical work of a kind to which the licence does not relate" unless an

68 Page 10 of the October 2000 Electrical Safety Taskforce Issues Paper.

69 The licensing of electrical workers has been in place since 1914.

70 Page 12 of the November 2001 DIR Issues Paper.

exemption applied[71]. The Electricity Act defined[72] "electrical work" as the work of installing or repairing an electrical line or electric article used for generating, transmitting, supplying or using electricity. In certain circumstances[73], electrical work was defined to include work "incidental to electrical work".

The November 2001 DIR Issues Paper summarised[74] the licensing requirement in the following way:

> The Electricity Regulation 1994 further requires that a person must not connect, disconnect, interfere with or remove a fixed part of an electrical installation unless the person acts under the authority of a licence or permit. This means that a person other than a licence holder cannot legally undertake any activities such as repairing a mechanical component of an electrical machine (e.g. refrigeration, hydraulics) even if the work is not of an electrical nature. This includes work regularly carried out by unlicensed persons such as changing belts or repairing mechanical parts of washing machines and repairing equipment such as computers where extra-low voltage circuitry is involved.

There were six main classes[75] of electrical licences that could be issued under the Electricity Regulation[76], namely:

- electrical fitter
- electrical mechanic
- engineering tradesperson (electrical)
- electrical jointer
- electrical linesperson
- electrical contractor.

3.6.1.3 Authorised persons

Another regulatory feature was the appointment and use of "authorised persons" who were required to carry out a number of compliance activities. The November 2001 DIR Issues Paper noted:

> The work undertaken by authorised persons is considered to be a community service obligation by the generators, transmitters and distributors that engage them. Historically, the functions of authorised persons were undertaken by persons employed by the various Electricity Boards.
>
> The powers and functions of authorised persons are similar to inspectors appointed under the *Workplace Health and Safety Act 1995.* The functions of authorised persons are:
>
> 1. investigate electrical incidents;
> 2. audits to ensure electrical contracting standards;

71 Section 27(1) of the Electricity Regulation did not apply to a registered apprentice.

72 Section 16(1) of the Electricity Act.

73 Section 16(3) of the Electricity Act.

74 Page 7 of the November 2001 DIR Issues Paper.

75 There were also two additional classes of licences – training permit and restricted licences.

76 Section 36 of the Electricity Regulation.

3. inspections of hazardous and high voltage installations;
4. free check inspections of consumers' homes and appliances;
5. respond to consumer concerns relating to the safety of fixed wiring or appliances;
6. investigate alleged breaches of the *Electricity Act 1994* and Electricity Regulation 1994;
7. provide rulings regarding compliance with electrical safety standards;
8. audits to determine safety and compliance; and
9. ensure compliance with standards prior to supply.

3.6.2 Policy issues

The November 2001 DIR Issues Paper identified a number of policy issues arising from the basic concepts outlined above.

Firstly, the Issues Paper pointed out[77] that the review of the ESO had recommended that an independent safety regulator be established with the status of a statutory officer.

Secondly, it was apparent that the definition of "electrical work" had "not kept abreast of technical changes and current work practices"[78]. The Issues Paper conceded[79] it was "common practice for unlicensed persons to carry out work such as mechanical repairs on washing machines, hydraulic and refrigeration equipment and extra low voltage circuitry of electronic equipment such as computers".

Thirdly, the appointment and use of authorised persons created a potential for "a conflict of interest" that was "inconsistent with modern enforcement practices"[80].

These policy issues were taken into consideration in the development of a new electrical safety framework.

3.7 Electrical Safety Act 2002 and the Electrical Safety Regulation 2002 – basic concepts

The fourth phase of electrical safety regulation in Queensland commenced in October 2002 with the enactment of the *Electrical Safety Act* and the Electrical Safety Regulation and significant amendments to the WH&S Act and the *Electricity Act*.

The June 2004 DIR Issues Paper[81] summarises the current regulation of electrical safety in Queensland as follows:

77 Page 5 of the November 2001 DIR Issues Paper.

78 Page 7 of the November 2001 DIR Issues Paper.

79 Page 7 of the November 2001 DIR Issues Paper.

80 Page 17 of the November 2001 DIR Issues Paper.

81 Page 4 of the June 2004 DIR Issues Paper.

The *Electrical Safety Act 2002* (The Act) and the Electrical Safety Regulation 2002 (the Regulation) form the legislative framework for electrical safety in Queensland, and are directed towards eliminating the human cost to individuals, families and the community of death, injury and destruction that can be caused by electricity.

The framework:

- imposes obligations on persons who may affect the electrical safety of others by their acts or omissions
- establishes benchmarks for industry and the community through regulations, ministerial notices and codes of practice for electrical safety and by introducing safety management systems for electricity entities
- licenses electrical workers and provides for hearings with respect to non-compliant electrical work
- protects consumers against incomplete and shoddy electrical work
- provides for the appointment of a Commissioner of Electrical Safety to advise the Minister on electrical safety matters and to manage the activities of the Electrical Safety Board and its committees
- allows industry and public involvement in developing electrical safety
- promotes electrical safety.

Electrical safety obligations

The Act in section 26 imposes an obligation for electrical safety on the following persons:

- electricity entities
- employers
- self-employed persons
- designers of electrical equipment and electrical installations
- manufacturers of electrical equipment
- importers of electrical equipment
- suppliers of electrical equipment
- installers of electrical equipment and electrical installations
- repairers of electrical equipment and electrical installations
- persons in control of electrical equipment
- workers at places where electrical equipment is located
- other persons at places where electrical equipment is located.

Discharging electrical safety obligations

The Act in section 27 states that:

> A person on whom an electrical obligation is imposed must discharge the obligation

and provides guidance in ways in which the obligation for electrical safety may be discharged in the form of regulations, ministerial notices and codes of practice. Further, section 28 provides that:

> A person may be the subject of electrical safety obligations in more than 1 capacity.

Obligation holders with more than one obligation are required to discharge them all.

Under Division 2 - Electrical Safety Obligations, section 29 provides:

Obligation of electricity entity

(1) An electricity entity has an obligation to ensure that its works -

(a) are electrically safe; and
(b) are operated in a way that is electrically safe.

(2) Without limiting subsection (1), the obligation includes the requirement that the electricity entity inspect, test and maintain the works.

Relevant terms in that section are defined in section 10:

Meanings of *electrical risk*, *electrically safe* and *electrical safety*

(1) ***Electrical risk*** means -

(a) in relation to a person, the risk to the person of death, shock or injury caused directly by electricity or originating from electricity; or

(b) in relation to property, the risk to the property of -

(i) damage caused by a cathodic protection system; or
(ii) loss or damage caused directly by electricity or originating from electricity.

(2) ***Electrically safe*** means -

(a) for a person or property, that the person or property is free from electrical risk; and

(b) for electrical equipment or an electrical installation, that all persons and property are free from electrical risk from the equipment or installation; and

(c) for the way electrical equipment, an electrical installation or the works of an electricity entity are operated or used, that all persons and property are free from electrical risk from the operation or use of the equipment, installation or works; and

(d) for the way electrical work is performed, that all persons are free from electrical risk from the performance of the work; and

(e) for the way a business or undertaking is conducted, that all persons are free from electrical risk from the conduct of the business or undertaking; and

(f) for the way electrical equipment or an electrical installation is installed or repaired, that all persons are free from electrical risk from the installing or repairing of the equipment or installation.

(3) ***Electrical safety***, for a person or property, means the person or property is electrically safe.

(4) In this section -
free from electrical risk, for a person or property, means that the electrical risk to the person or property is as low as reasonably achievable, having regard to -

(a) likelihood of harm; and
(b) likely severity of harm.

An "electricity entity" is a supplier[82] of electricity.

Relevant to considerations under s.29 of the Act is the definition contained in s.25, which provides:

Meaning of *works* of an electricity entity

Works, of an electricity entity, means the electrical equipment, and electric line associated equipment, controlled or operated by the entity to generate, transform, transmit or supply electricity.

Section 4 describes the Act's purpose in the following terms:

Purpose

(1) This Act is directed at eliminating the human cost to individuals, families and the community of death, injury and destruction that can be caused by electricity.

(2) Accordingly, the purpose of this Act is to establish a legislative framework for -

(a) preventing persons from being killed or injured by electricity; and
(b) preventing property from being destroyed or damaged by electricity.

Section 5 describes how the purpose of the *Electrical Safety Act* is to be achieved:

How purpose of Act is to be achieved

The purpose of this Act is to be achieved in the following ways -

(a) imposing obligations on persons who may affect the electrical safety of others by their acts or omissions;

(b) establishing benchmarks for industry and the community generally through -

82 For example Energex and Ergon.

(i) making regulations, ministerial notices and codes of practice about achieving electrical safety; and
(ii) introducing safety management systems for particular electricity entities;

(c) providing for the safety of all persons through licensing and discipline of persons who perform electrical work;

(d) providing for protection for consumers against failures of persons who perform electrical work to properly perform and complete the work;
…

Part 5 of the *Electrical Safety Act* sets up Safety Management Systems for electricity entities. Section 66 provides that a Safety Management System may be put in place for a "prescribed electricity entity". The system should document the hazards and risks associated with the design, construction, operation and maintenance of the entity's works.

It was envisaged that the document would detail how the electricity entity is required to manage the hazards and risks in order to ensure that its electrical safety obligation is properly discharged. Furthermore, the document should contain some quite detailed protocols for generally ensuring that the purposes of the Act for the protection of all persons in respect of electricity are carried out.

3.8 Codes of practice

Codes of Practice[83] are documents made under section 44 of the *Electrical Safety Act*. Codes provide ways of meeting electrical safety obligations under the *Electrical Safety Act*. Presently there are three[84] such codes:

- Code of Practice for Working near exposed live parts
- Code of Practice for Electrical Work
- Code of Practice for Works.

The June 2004 DIR Issues Paper[85] described these codes of practice as follows:

> With respect to codes of practice, guidance to obligation holders is based on risk management principles. The obligation holder is required to do something that is equal to or better than the code of practice to discharge an electrical safety obligation. This approach is consistent with the Coroners' recommendations and a code of practice is considered to be one way of improving the safety outcomes in relation to electrical equipment and fixed wiring.

83 Codes of Practice do not apply to the works of electricity entities, which are required to manage electrical safety issues by having in place Safety Management Systems that are audited independently.

84 A confidential draft of a fourth Code dealing with electrical equipment was provided to me in May 2005.

85 Page 5 of the June 2004 DIR Issues Paper.

These codes are designed to assist obligation holders and give practical advice on ways to discharge electrical safety obligations. Included in a code are ways to identify and manage exposure to risks of injury and property damage caused indirectly or directly by electricity.

Risk (including electrical risk) can be defined as the chance of something happening that will have an impact on objectives, and in relation to electricity, the risk of injury is strongly related to where and how electricity is used.

Risk can be managed by a hierarchy of control measures appropriate for ascertaining and managing electrical risk, which can be applied in any situation:

1. eliminate the hazard
2. substitute a less hazardous material, process or equipment
3. redesign equipment or work process
4. isolate the hazard
5. introduce administrative controls
6. use appropriate personal protective equipment.

3.9 Coroners Act 1958

The *Coroners Act 1958* has been repealed and replaced by the *Coroners Act 2003*. Each of the incidents in the WEP was the subject of an inquest conducted under the *Coroners Act 1958*[86].

The purpose of an inquest under the 1958 Act[87] is to establish, as far as practicable:

- the fact that a person has died;
- the identity of the deceased person;
- when, where and how the death occurred; and
- whether any person should be charged with any of the offences[88] referred to in s.24 of the *Coroners Act 1958*.

The nature and extent of an inquest are under the control of the coroner. An inquest is a fact-finding exercise and is not a method of apportioning guilt. The procedure and rules of evidence suitable for a criminal trial are not suitable for an inquest.

Theoretically, there are no parties, charge, prosecution, defence or trial in an inquest. An inquest is simply an attempt to establish facts in a non-adversarial environment. An inquest should be conducted as an inquisitorial process, in other words, a process of investigation.

86 Under the transitional provisions of the 2003 Act, inquests into deaths occurring before the commencement of the 2003 Act are held under the 1958 Act.

87 Section 24.

88 Includes murder, manslaughter, dangerous driving of a motor vehicle causing death, or any other offence contained in the *Criminal Code (Qld).*

Given that an inquest is an investigation by inquisition, no person has an absolute right to be heard. The rules of natural justice and procedural fairness are applicable and the application of these rules will depend upon the particular circumstances of the case in question[89].

In making findings under the *Coroners Act 1958*, a coroner is not permitted to express any opinion on any matter which is outside the scope[90] of the inquest, except in the form of a "rider"[91].

A coroner may admit any evidence that the coroner thinks fit, whether or not the evidence is admissible in any other court[92]. However, a coroner is unable to admit any evidence for the purposes of the inquest unless in the coroner's opinion the evidence is necessary for the purpose of establishing or assisting to establish any of the matters within the scope of the inquest[93].

Section 33 of the *Coroners Act 1958* provides that:

> **Protection of witnesses and counsel**
>
> (1) Subject to the provisions of this Act, every witness attending and giving evidence at any inquest and every counsel or solicitor appearing before a coroner holding any inquest shall have the same protection and immunities as witnesses and counsel or solicitor appearing before justices in any proceeding under the Justices Act.
>
> (2) Without limiting the generality of subsection (1) and except upon an inquiry under section 10, nothing contained in this Act shall render any person compellable to answer any question tending to incriminate himself or herself or, upon an inquest into a death, render a husband or wife competent or compellable to answer any question tending to incriminate his or her spouse.

Therefore, under s.33, any witness attending and giving evidence at an inquest could not be compelled to answer any question that might incriminate them. Such witnesses could be persons allegedly owing workplace health and safety obligations to others, for example, an employer or a co-worker. In some cases, they may have been eyewitnesses to an incident.

The fact that witnesses could claim privilege in the manner described was a fact not universally understood by the majority of the complainants in the WEP. Several of the complainants advised my officers when interviewed that from their perspective, the inquest was unable to ascertain the full facts of an incident because eyewitnesses, such as co-workers at the incident site, claimed privilege at the inquest by refusing to answer any questions that could tend to incriminate them.

89 See Chapter 1 of Selby, Hugh, (1998) *"The Inquest Handbook"*, Federation Press, Armidale, New South Wales.

90 Section 43(5) of the *Coroners Act 1958.*

91 Sections 43(5) and (5A) of the *Coroners Act 1958*.

92 Sections 7(3) and 34(1) of the *Coroners Act 1958*.

93 Section 34(1) of the *Coroners Act 1958.*

The role of the coroner in this context was specifically addressed in Cases 1 and 2 of the WEP where the former Ombudsman strongly stressed that, for the very reason described by the complainants, an inquest should not be considered by regulatory agencies to be a substitute or catchall for their own investigation. My predecessor stated[94]:

> In conducting an inquest, a Coroner is capable of calling on a wide range of witnesses to assist him or her. Where those witnesses are public officials, the process will be flawed, and even derailed, if those witnesses have failed to undertake their statutory duties or appreciate the significance of the evidence they are asked to give.

The October 2000 Electrical Safety Taskforce Issues Paper commented[95], in relation to s.33 of the *Coroners Act 1958*, that:

> The problem with this provision is that it has a tendency to prevent an adequate inquiry.

The former Ombudsman agreed[96] with that comment and pointed out that:

> this is all the more reason for public officials to perform their legislative responsibilities competently.

3.10 Coroners Act 2003

The *Coroners Act 2003* commenced on 1 December 2003 and provides the legislative framework for the modernisation and coordination of the Queensland coronial system.

Coroners are now able to compel a witness to give self-incriminating answers at an inquest, subject to appropriate safeguards[97].

Section 39 of the *Coroners Act 2003* now allows a coroner to require a person at an inquest to give oral evidence that would tend to incriminate the person if the coroner is satisfied that it is in the public benefit for the person to give the evidence.

The explanatory notes to the Coroners Bill 2002 stated[98] the reason for including this provision as follows:

> The insertion of this power is to help a coroner at inquest find out what actually happened to cause the death. This in turn will help the coroner to make appropriate comments or recommendations to prevent similar deaths happening in the future.
>
> The clause contains appropriate safeguards in that the evidence is not admissible in any other proceeding against the person other than a

94 Page 43 of Case 1 of the WEP.

95 At page 25.

96 Page 43 of Case 1 of the WEP.

97 Section 4(3)(f) of the *Legislative Standards Act 1992* provides that legislation is to provide appropriate protection against self-incrimination.

98 Page 4 of the Explanatory Notes to the *Coroners Bill 2002*.

> proceeding for perjury. Any information, document or other evidence obtained as a direct or indirect result of the evidence given at the inquest is not admissible against the person in a criminal proceeding.

The extent to which coroners will invoke[99] s.39 of the *Coroners Act 2003* is not yet apparent.

3.11 Amendment to Ombudsman Act

Section 57A was recently included in the *Ombudsman Act*. This amendment authorises the Ombudsman to provide a copy of a report prepared by the Ombudsman to the State Coroner for use by a coroner "to help in an investigation under the *Coroners Act 2003* or an inquiry under the *Coroners Act 1958*".

99 In respect of deaths that have occurred since 1 December 2003.

Chapter 4: The Investigations

4.1 Case 1[100] – investigation completed 12 February 2001

4.1.1 Background

NS was a 17 year old apprentice boat builder. He was fatally electrocuted at work while using a vacuum cleaner, apparently while standing barefoot on a metal floor. He had only commenced his apprenticeship four months earlier and had no other full time work experience.

There were no witnesses to the incident. However, there was evidence that a person or persons had previously tampered with the vacuum cleaner in an attempt to repair it, to such an extent that live electrical workings had been exposed. As a result, the double insulation status of the vacuum cleaner, which was its principal safety feature, had become inoperative.

Despite the potentially hazardous nature of the work, a safety switch was not installed at the workplace.

NS's death was investigated to varying degrees by both WH&S and the ESO. The vacuum cleaner was sent to Energex for a technical examination.

Initially, neither agency believed the evidence gathered established any breach of legislation. A short time after NS's death, WH&S decided not to prosecute and, for all practical purposes, closed the investigation at that point.

A coronial inquest was held over two days. The coroner found that there was insufficient evidence to commit any person for trial for any criminal offence.

4.1.2 The complaint

For some months after their son's death, NS's parents made their own enquiries about how he died. They felt that the investigations undertaken by both agencies had been poorly planned, hastily conducted and prematurely terminated, and that many issues highlighted for further investigation and clarification during a coronial inquest had not been adequately addressed by either agency.

NS's parents presented their findings to the management of both agencies. When they claimed to have received no meaningful response at that level, they subsequently made Ministerial representations.

NS's parents said that it took them months of intense lobbying before their representations bore fruit. Shortly prior to the expiration of the 12 month limitation period within which to bring proceedings, and contrary to the initial decision not to prosecute, WH&S commenced proceedings against NS's

100 The background to and details of this case appear in Chapter 2 but are repeated here so that similar information about all cases in the WEP are contained in the same chapter.

employer. The employer, a company, was eventually convicted and fined $40,000, the largest fine ever imposed on a company in Queensland for a breach of the legislation at the time[101].

Distressed by what they alleged was the department's indifference and apathy over an extended period of time, NS's parents complained to this Office about the way they had been treated.

4.1.3 Investigation

The complainants provided a large amount of documentation in support of their allegations.

For the purposes of our investigation, we:

- interviewed the complainants;
- interviewed and obtained statutory declarations from witnesses identified by the complainants;
- obtained and reviewed relevant files and other documentation held by WH&S, the ESO and the Queensland Police Service (QPS);
- reconstructed and then assessed the adequacy of the investigations undertaken by WH&S and the ESO;
- inspected records held by the employer; and
- conducted formal tape recorded interviews with relevant witnesses who included former and current officers.

In all, nearly a hundred hours of interviews were conducted.

4.1.4 Maladministration identified

The former Ombudsman found that the standard of investigation of NS's death by both agencies was severely inadequate in that:

- the investigative processes adopted by both agencies were fragmented and uncoordinated;
- many obvious avenues of inquiry had not been explored such as the interviewing of relevant witnesses;
- WH&S had formed an opinion that the workplace health and safety legislation had not been breached, prior to receiving the technical report from Energex in relation to the vacuum cleaner. This report, received some months after the opinion had been formed, clearly

101 See 4.1.7.1 – Further developments for discussion on company's capacity to pay the fine.

showed that the vacuum cleaner had been tampered with and was unsafe; and

- although WH&S had a quality assurance system in place for investigations, for all relevant purposes it had been ignored by officers concerned, including WH&S management at the time.

Other opinions were:

- the coroner who conducted the inquest into NS's death was not provided with all the relevant evidence because of the inadequacy of the WH&S investigation and because the results of the workplace audit at NS's employer were not made available to him;

- duplication of responsibility existed between WH&S and the ESO in relation to the investigation of electrical accidents in the workplace;

- there was a lack of co-ordination between WH&S and the ESO in relation to the investigation;

- a WH&S audit was not conducted of the employer's workplace until five months after NS's death and the employer was inappropriately given advance notice of that audit; and

- there was a lack of competent supervision throughout the investigation.

4.1.5 Recommendations

The former Ombudsman prepared a report on the investigation and forwarded it to the Directors-General of DETIR and DME on 12 February 2001. The central recommendation made was that a comprehensive management and strategic review of WH&S and the ESO be established and undertaken by a suitably qualified independent reviewer, selected in consultation with the former Ombudsman, to further examine the range of issues identified in the report, including[102]:

- the structure of WH&S and the ESO;

- the adequacy of staff and other resources within the agencies to enforce the relevant safety legislation;

- current investigation methodologies and processes, including, in the case of WH&S, the giving of warnings in relation to workplace audits;

- formal and informal staff training and guidance;

- management systems and processes used by the agencies;

102 See Paragraph 2.3.2 of this Report for particulars of the Terms of Reference.

- the competency of existing staff employed in compliance/enforcement roles within the agencies; and

- in the case of WH&S, lack of awareness of its quality assurance system.

Other important recommendations were that:

- a tripartite memorandum of understanding be developed between the ESO, WH&S and the QPS concerning the conduct of investigations into electrical fatalities in the workplace, to address the investigative duplication identified in my report;

- the concept of a single agency responsible for the investigation of electrical accidents in Queensland be considered;

- the giving of advance warnings of workplace audits by WH&S officers cease immediately unless unavoidable;

- specialised training be provided for investigative staff within WH&S in relation to dealing with the grieving family, friends and associates of persons who have died or been seriously injured in the workplace; and

- both agencies apologise to the complainants for the poor standard of their investigations.

A complete list of the opinions formed and recommendations made in the former Ombudsman's report on Case 1 is contained in Appendix D.

4.1.6 Response of agencies

Initially there was significant resistance in the two agencies to the former Ombudsman's recommendations. However, shortly after our investigation was completed, WH&S (which was formerly a division within DETIR) and the ESO (which was formerly an office within DME) were placed within the newly created DIR under the control of one Minister.

The new Minister readily accepted all of the recommendations. Of special significance was his decision to establish a Ministerial Review[103] in response to the former Ombudsman's recommendation for a comprehensive management and strategic review of WH&S and the ESO. The Ministerial Review considered all of the issues raised in the former Ombudsman's report and made further recommendations for improving electrical safety in Queensland, complementary to those contained in his report.

Two of my investigators were members of the reference group for the Ministerial Review and made regular contributions based upon the information

103 The Ministerial Review of WH&S and the ESO conducted by Mr John Crittall and assisted by Mr Ray Dempsey in relation to the ESO.

they had obtained during the course of this and other investigations in the WEP.

Placing both agencies within the one department helped overcome the problems highlighted in my report regarding lack of communication and coordination between the agencies.

DIR apologised to NS's parents for the way in which the investigations were originally handled.

4.1.7 Further developments

4.1.7.1 Prosecution of company directors

The company that employed NS was placed under administration some months before the conviction was recorded and the $40,000.00 fine imposed. The directors of the company were never prosecuted personally. NS's parents complained to our Office that the eventual WH&S prosecution was a "pointless political stunt" as there was little or no likelihood that the fine would ever be paid. In his report, my predecessor discussed[104] the issue in the following way:

> Section 167 of the WH&S Act makes the executive officers of a corporation jointly liable for any offence that the company commits. In this matter, [the employer] was fined for breaching section 28 of the WH&S Act and section 76 of the WH&S Reg. The Queensland provision is stronger than in any other State as an executive officer's ignorance of an offence is not a defence[105]. The only defences open are that the executive officer exercised reasonable diligence or was not in a position to influence the conduct of the corporation[106].
>
> Therefore, as both [named directors] were directors of [the employer] at the time NS was electrocuted, they were jointly liable unless they exercised reasonable diligence to prevent the company committing the offence or were otherwise not in a position to influence the company.
>
> The Director-General of DETIR suggested in a letter to me of 18 January 2000 that no evidence existed for the [named directors] to also be charged. The APO[107] echoed this opinion when interviewed[108].
>
> However, I have had substantial difficulty with these opinions. These views cannot be reconciled with the evidence contained on the WH&S file or the explanation of [the employer]'s operations given by the [named directors] themselves when interviewed by my officers[109].
>
> In my opinion, the more likely explanation for why the [named directors] were not prosecuted, and one which was volunteered by other WH&S officers

104 Page 31 of Case 1 of the WEP.

105 Page 18 of the October 2000 Electrical Safety Taskforce Issues Paper.

106 Section 167(4)(a) and (b) of the WH&S Act.

107 WH&S Area Prosecution Officer.

108 Line 555 of transcript 01/06/00.

109 Lines 22-35, 83-104, 110-128 and 147-172 of transcript 09/06/00.

> when interviewed, is that there was simply no policy or practice in place at the time in relation to prosecuting executive officers of a corporation. That position may have now changed.
>
> I can only conclude that, while the former Director of WH&S claimed in the media at the time that the $40,000 fine imposed on [the employer] represented the largest in the history of the legislation, this outcome was never going to be anything more than a "paper judgment" that would never be recovered.
>
> I accept that there could be a possible deterrent element in obtaining a result against a company even though it was already under administration. However, as no similar action was taken against the directors personally, I can fully appreciate why [NS's parents] would view the process as nothing more than a belated and pointless exercise by WH&S brought about by the political pressure that they [NS's parents] had instigated.

4.1.7.2 Update

Since this investigation was completed, DIR has advised[110] me that:

> Prosecutions undertaken by the department now include, where appropriate, prosecutions of directors of companies as well as the company entity. A protocol has been developed and disseminated regarding the prosecution of executive officers.

Details of recent s.167 prosecutions are contained in Appendix M.

110 In response to Issues Matrix – WEP 2004.

4.2 Case 2 – investigation completed 10 April 2001

4.2.1 Background

AK was an 18 year old labourer who was fatally electrocuted at a marina while using a heat gun to strip paint from the hull of a boat. It was alleged that he had been working bare foot in water at the time of the incident. The safety guard on the heat gun had been removed.

AK's only previous work experience was as a casual packer in a fruit shop. At the time of the incident, he was working alongside another person who was using a separate heat gun. The work was being undertaken for a shipwright[111].

WH&S and the ESO investigated AK's death. Neither agency identified any potential breaches of legislation, essentially because of the way they interpreted the contractual relationship between AK and the shipwright. The shipwright alleged that AK was not a worker but an independent contractor. This assertion was initially accepted by WH&S. If AK was an independent contractor, the workplace safety obligations owed to him were substantially less onerous than those owed to workers. A WH&S officer sought Crown Law advice about this issue.

A coroner found no evidence to suggest that any person should be committed for trial for any criminal offence.

Neither WH&S nor the ESO commenced any prosecution proceedings prior to the expiry of the statutory limitation period. When the matter was eventually reviewed internally by WH&S, some two years after AK's death, an opinion was formed[112] that "aspects of the original investigation were deficient in that more comprehensive inquiries in relation to the employment relationship between AK and the shipwright could have resulted in a finding that AK was an employee".

4.2.2 The complaint

AK's parents queried the decisions of the agencies. They alleged that, because of the inadequacy of the WH&S and ESO investigations, relevant evidence had not been placed before the Coroner and a number of contradictory and improbable statements by witnesses were not able to be tested.

They were concerned that vital evidence at the scene had been removed before police arrived[113]. They also alleged that the shipwright's claim that their son was an independent contractor rather than an employee or a worker was not adequately investigated, including the issue of who owned the equipment AK had been using immediately prior to his death.

111 A shipwright is a shipbuilder or ship's carpenter.

112 "Review of Investigation into the death of [AK]" by WH&S Director (24/03/99).

113 Section 17 of the WH&S Reg creates an offence if a person suffers a serious injury and relevant aspects of the workplace are interfered with without consent.

They requested the Ombudsman's Office to review the adequacy of the investigations undertaken by both WH&S and the ESO.

4.2.3 Investigation

This investigation required a significant commitment of investigative resources over several months.

The same methodology was adopted as in Case 1 of the WEP. Officers obtained all of the relevant files from each of the agencies and conducted recorded interviews with over a dozen witnesses. The investigations undertaken by both WH&S and the ESO were reconstructed and assessed.

4.2.4 Maladministration identified

The former Ombudsman found that the standard of the investigation of AK's death by both agencies was clearly inadequate in that:

- the investigative process lacked direction;
- only a superficial effort was made to investigate the circumstances of AK's death;
- many obvious avenues of inquiry were not explored; and
- available witnesses were not questioned adequately, or at all, and interviews were not conducted with potential defendants with the result that the investigation was concluded before all possible offences had been identified and considered.

Other opinions were:

- the internal review of the investigation was inadequate in that a competent assessment by management should have recognised the shortcomings in the investigation at the time; and
- the coroner who conducted the inquest was not provided with all relevant evidence because of the inadequacy of the WH&S investigation.

4.2.5 Recommendations

The final report for Case 2 of the WEP was delivered to the Director-General of DIR on 10 April 2001, some two months after the delivery of the final report for Case 1. Accordingly, the recommendations made in Case 2 complemented those made in Case 1.

Cases 1 and 2 of the WEP recommended a comprehensive management and strategic review of WH&S and the ESO. A complete list of the opinions formed

and recommendations made in the former Ombudsman's report on Case 2 is contained in Appendix E.

4.2.6 Response of agencies

As was the situation in Case 1 of the WEP, DIR accepted the recommendations made and referred the report to the Ministerial Reviewer for assessment and implementation.

4.2.7 Further developments

4.2.7.1 Superficiality of investigation

Determining whether AK was a worker or an independent contractor was pivotal to WH&S's investigation and involvement in this matter. Essentially, if AK was an independent contractor, the scope of safety obligations owed to him under the WH&S Act was much narrower and, therefore, the possible offences relating to the circumstances of his death were also more limited.

When contacted by the WH&S inspector after the incident, the shipwright asserted that AK was performing work under a "contract for services" and, therefore, he was not a "worker" within the meaning of the WH&S Act[114]. The shipwright made the same assertion at the inquest into AK's death and when interviewed by my officers[115].

The shipwright provided WH&S with a single page document that he alleged evidenced this contractual relationship between AK and himself.

Among other things, the contract required AK to provide:

- plant;
- equipment (including a compressor); and
- materials.

In addition, AK was required to agree that:

- he was established in his own business and therefore liable to pay his own tax;
- he was not covered by workers compensation;
- he would take out his own personal accident insurance; and
- the shipwright was in no way liable for his actions.

However, AK's father told my officers that given AK was only 18 years of age, and that his only prior work experience was as a casual packer in a fruit shop, it was ridiculous to suggest that AK was "established in his own business". In fact, AK's father claimed that AK would not have been able to afford the plant

114 Section 11 of the WH&S Act defines "workers". The definition excludes persons who perform work under a "contract for services".

115 Transcript of inquest 09/02/98, transcript of interview 14/11/00.

and equipment detailed in the contract and no reasonable person would have expected him to have done so, having regard to his youth and inexperience.

When interviewed by my officers, the WH&S inspector indicated that he had not seen a contract of that type before in the eight years he had worked for WH&S[116]. In order to clarify the effect of the contract, he referred the matter to the WH&S APO[117] for an opinion as to whether AK was a worker or an independent contractor.

The APO conceded when interviewed by my officers that he was initially concerned by the document because "it looked like a sham"[118]. He also acknowledged that there would be significant financial benefits for the shipwright if it were binding upon AK[119]. Despite these initial reservations, the APO said that he still felt a valid contractual arrangement could have existed, especially as AK was 18 years old and therefore capable of entering into a contract[120]. To be certain, the APO said that he faxed the contract to Crown Law on 14 March 1997 “for confirmation” of his view[121].

The APO stated that in a subsequent telephone discussion with the Crown Law officer, he received verbal confirmation that the contract was in fact binding on AK, therefore making him a self-employed contractor and not a worker[122].

This advice was then conveyed, again verbally, by the APO to the WH&S inspector who, based on the advice, determined that the shipwright could not have owed AK an obligation of safety as an employer under the WH&S Act.

The WH&S investigator agreed at interview that the receipt of this advice was effectively where the WH&S investigation ended[123]. He expressed[124] the effect of the advice as follows:

> Once I had established that the deceased was a self-employed person, I then could no longer look at the person overseeing the project, if you like in control, as being an employer, because the self-employed person has obligations to provide Workplace Health & Safety for themselves. So that took that potential employer type of person out of the loop and brought it simply back to this deceased person and that was very pivotal. The fact that this person was self-employed, who else could we look at? From Crown Law advice, we didn't have anybody else to look at.

These views were consistent with those in a report produced by the WH&S inspector the same date the contract was faxed to Crown Law for advice. The WH&S inspector stated that AK was "a self-employed person" and "all work

116 Line 226 of transcript 30/05/00.

117 WH&S Area Prosecution Officer.

118 Line 67 of transcript 01/06/00.

119 Lines 87-90 of transcript 01/06/00.

120 Line 67 of transcript 01/06/00.

121 Lines 67-69 of transcript 01/06/00.

122 Lines 67-69 of transcript 01/06/00.

123 Lines 288-289 of transcript 30/05/00.

124 Line 281 of transcript 30/05/00.

on the vessel was carried out under a contract for service arrangements"[125]. He concluded that the incident "was beyond circumstances over which neither the contractor or the marina had any control (sic)"[126].

The former Ombudsman was concerned that no inquiries appeared to have been made as to whether AK was capable of complying with the contract. These concerns were heightened once my officers obtained a copy of the WH&S file, which contained additional (written) Crown Law advice, dated 22 February 1999, that contradicted the verbal advice the APO said he had been given by the Crown Law legal officer.

This written advice had been sought following a number of representations by AK's father to WH&S management and the then Minister, the Honourable Paul Braddy MP, about the quality of the WH&S investigation.

In the advice, the Crown Solicitor stated:

> Despite the terms of the "contract" between [AK] and [the shipwright], it is my opinion that [AK] was more likely to have been a "worker" (as per the definition of same in the WH&S Act) than a "sub-contractor" as alleged by [the shipwright][127].

The basis for this opinion included the fact that AK lacked the work and business experience required by the contract. The fact that he worked subject to the direction of the shipwright and that virtually all tools, equipment and materials were provided by the shipwright[128] were both factors relied upon in forming that opinion.

By the time this further advice was obtained, the statutory limitation period for the initiation of prosecution action under the WH&S Act had expired[129].

Because of the inconsistency between the verbal and the written Crown Law advices, my predecessor contacted the Crown Solicitor and asked what advice had been initially sought and provided to WH&S.

The former Ombudsman received a response from the Deputy Crown Solicitor on 31 October 2000. The Deputy Crown Solicitor advised that he did not believe the written advice of 22 February 1999 was inconsistent but, rather, clarified the preliminary advice given to the APO over the telephone following the receipt of his fax on 14 March 1997.

He stated that:

> Having considered the wording of the document, a telephone conversation occurred between my Principal Legal Officer and [the APO]. The conversation at no time made any determination of the employment status of

125 Pages 1-2 of Memorandum of No Further Action prepared by WH&S investigator on 14/03/97.

126 Pages 1-2 of Memorandum of No Further Action prepared by WH&S investigator on 14/03/97.

127 Page 5 of Crown Law advice to WH&S, dated 22/02/99.

128 Page 5 of Crown Law advice to WH&S, dated 22/02/99.

129 s.165 WH&S Act.

> [AK]. My Principal Legal Officer outlined that the document purported to define [AK] as a sub-contractor and not an employee or worker of [the shipwright]. It sought to do this by referring to a number of issues, which would be taken into account by a court in determining the employment relationship. Such items were: the provision of plant, equipment and materials; sole trade or partnership; pays own tax; no PPS or PAYE to be deducted; and the provision of self-insurance for accident or injury or illness.
>
> My Principal Legal Officer advised [the APO] that the document itself did not determine the relationship that existed between [AK] and [the shipwright]. There were other factors to be considered and **the investigation into the incident should provide more factual information to enable a final decision to be made. Such other factors included who in fact controlled the work being performed, as discussed as the "control test" set out in a number of High Court authorities on this issue**. [emphasis added]
>
> There was no further discussion in relation to this matter. My Principal Legal Officer was not required to provide any further advice and was provided with no other material.

On 12 May 1997 the AM[130] sent a memorandum to the Inspector commending him on his efforts. He stated, "Congratulations on the speed and thoroughness of your investigation into this matter" and went on to discuss the importance of timely investigations[131].

The former Ombudsman said[132] in his report:

> In summary, WH&S's failure to adequately determine [AK's] employment status was of enormous significance to the investigation. In my view, this action had the effect of completely derailing the investigation at an entirely premature stage. I believe that a number of further inquiries were clearly necessary to determine whether [AK] was capable of complying with the contract and therefore whether any offences had been committed by [the shipwright] under the WH&S Act as a consequence of this relationship.

130 WH&S Area Manager.

131 Memorandum from WH&S AM to WH&S inspector dated 12/05/97.

132 Page 13 of Case 2 of the WEP.

4.3 Case 3 – investigation completed 22 February 2002

4.3.1 Background

TM had just commenced the second year of an electrical apprenticeship when he was injured in a workplace incident involving live overhead power lines. TM received severe injuries and passed away approximately one month after the incident. He was 17 years old.

TM's work entailed maneuvering an elevated work platform (cherry picker) from ground level to a spot adjacent to an overhead advertising sign. The evidence suggests he removed several fluorescent light fittings (light sticks) from inside the sign and returned the cherry picker to ground level for another worker to carry out maintenance to them. The other worker was a recently qualified electrician.

TM had removed nine light sticks[133] from inside the sign and had placed them in the bucket of the cherry picker. When TM reached a position below the overhead power lines, one of the light sticks either made contact with or struck an arc with the overhead 22kV main at a point 185 mm from the top of the fitting. This caused a short circuit through the fitting to the frame of the cherry picker and then to earth via the four stabilising outriggers of the trailer. A 12,700-volt short circuit was maintained for a period of 11.859 seconds.

Officers from the QPS, WH&S and the electricity entity attended the scene of the incident and commenced an investigation.

The initial investigation conducted by the WH&S investigator consisted of him interviewing and taking statements from various witnesses and one of the directors of the employer. The WH&S investigator also took photographs and made certain measurements. However, within 2 to 3 weeks of the incident, the WH&S investigator came to a view that there was insufficient evidence to warrant a prosecution against TM's employer. The WH&S investigator concluded that the accident had occurred due to **operator error**[134].

This view was also expressed publicly in two newspaper articles some 6 – 8 weeks after the incident. A story in the *Sunday Mail* carried the caption "Death Probe Clears Firm". The second article appeared in a regional newspaper and was captioned "Death No Fault Of Firm". The newspaper articles reported the WH&S decision that **no further action** would be taken against TM's employer on the basis that TM had been adequately trained and was properly supervised.

The ESO did not conduct an independent investigation into the incident. The ESO stated that it relied upon the investigations conducted by the electricity entity and WH&S. Senior officers of the ESO formed a view that TM was not

133 Each of the light sticks consisted of 25 sq.mm aluminium RHS (rectangular hollow section) tube 2.2 metres long supporting 2x36 watt fluorescent tubes, ballasts, lamp holders and starters connected to supply via a short three core flex and plug top.

134 Joint Ministerial Briefing of WH&S and ESO of 21 March 2001.

undertaking “electrical work” at the time of the incident and therefore the electrical legislation did not apply to the incident. Unfortunately, this view was not documented by anyone at the ESO.

Several months after the incident the ESO appointed an independent consultant to investigate the performance of the sensitive earth fault (SEF) protection system at the incident site. The consultant’s Investigation Report revealed that the “SEF was not connected to trip the feeder at the time, as it was not fully commissioned”. The Report made a recommendation that “SEF be in service on all overhead distribution feeders that transverse populated areas”. However, the report also advised that protection systems on 22kv mains (such as SEF) were not designed to prevent electrocution of persons who come in contact with high voltage overhead power lines and that they were merely designed to render an area safe.

4.3.2 The complaint

The first indication that TM’s parents had that the investigation had been discontinued was when they read about this decision in the newspapers.

Not satisfied with that outcome, they made contact with the ESO and WH&S and lodged a complaint with us shortly afterwards. They were distressed by the decision not to pursue the matter and by the insensitivity of WH&S in failing to advise them that the case was closed before they learned of it in the media.

As a result of TM’s parents contacting WH&S, an experienced WH&S officer was directed to re-investigate the matter. Within two days the initial finding was overturned. The employer was subsequently prosecuted. The employer pleaded guilty and was fined a total of $45,000.

Their complainants alleged that:

- the initial phase of the WH&S investigation was inadequate;
- there was a systemic culture or desire within WH&S and the ESO to close files prematurely and/or to not diligently pursue prosecutions; and
- the incident involving TM would not have been properly investigated had they not made their complaint.

4.3.3 Investigation

For the purposes of our investigation, we:

- interviewed the complainants;
- obtained and reviewed the WH&S and ESO files;
- reconstructed and then assessed the adequacy of the investigations undertaken by WH&S and the ESO;
- conducted formal interviews with several WH&S and ESO officers;

- researched relevant legislation and industry guidelines; and
- reviewed the transcript of the evidence given at the Coronial Inquest.

Our investigation revealed a breakdown of work processes within WH&S, which resulted in the initial investigation being grossly inadequate.

4.3.4 Maladministration identified

I identified serious instances of maladministration by WH&S relating to:

- inadequate (and in some areas, non-existent) procedures for investigating and reporting on potential breaches of the WH&S Act;
- the failure of investigators to follow policies and procedures;
- its auditing procedures;
- its media policy; and
- the method by which relatives of victims were informed of the progress and outcomes of investigations.

Instances of the failure of WH&S officers to follow correct investigative procedures included the following:

- the investigator did not adequately document his investigation, thereby making it impossible for his managers to review his investigative strategies; and

- the investigator did not comply with WH&S Event and Case Management Procedure[135] which required the investigator to carry out a number of tasks in accordance with an action strategy within defined time periods[136].

I also found that under WH&S's auditing procedures, an inappropriately low number of files marked as "no further action" were reviewed by senior officers. Therefore, it is unlikely that this case would ever have been reviewed if not for the persistence of TM's parents.

In relation to the media strategy followed by WH&S in this instance, I formed the opinion that:

135 At interview, the WH&S investigator conceded that he had not previously seen the flow chart attached to WH&S Event and Case Management Procedure WHS P56.

136 The procedure required significant events in an investigation by WH&S officers to be documented and entered at specified times on the Department's IAS (integrated automation and document management system). The significant events included:

- The entry of initial data onto IAS (immediate);
- The determination of the relevant priority and action strategy by the District Manager (immediate);
- The carrying out of an initial investigation by an Inspector (5 days);
- The preparation of an Incident Report (Report) by the Inspector (20 days);
- The forwarding of the Report to the District Manager for review (5 days);
- The review of the Report by the District Manager (5 days);
- The review of the Report by the Area Manager (5 days);
- The review of the Report by the Area Prosecutions Officer (14 days); and
- The preparation of a Breach Report for commencement of legal proceedings and approval by Area Manager (within 10 weeks of the date of the accident).

- the media policy allowed an inappropriate level of autonomy in disseminating media releases and gave an inappropriate level of access to non-delegated decision-makers for the purpose of preparing media briefings;

- the policy failed to acknowledge the interests of the worker's relatives in that it allowed for findings to be released to the media before informing the relatives;

- the release of information to the media was mismanaged; and

- an incorrect WH&S media report resulted in the employer being given tacit approval to continue using unsafe work practices.

WH&S and the ESO did not respond to a request from TM's parents for answers to questions regarding the circumstances of their son's death.

In relation to the ESO's involvement in the investigation, its officers failed to document the decision that TM was not undertaking "electrical work" at the time of the incident. As previously stated, the ESO did not conduct an investigation into the incident.

4.3.5 Recommendations

I made several recommendations to address the maladministration evident in WH&S's investigation. They included:

- advice should be sought from senior counsel on the definition of the term "electrical work" with a view to developing new electrical safety legislation in Queensland;

- WH&S should apologise to TM's parents for the inadequacy of the initial stage of the investigation and the premature and inappropriate release to the media of unsustainable conclusions concerning their son's death;

- senior WH&S officers should be the only persons with the authority to mark a file as "no further action" for Priority One[137] matters;

- an audit should be conducted of WH&S Priority One and Priority Two[138] files marked "no further action";

- DIR should consider taking disciplinary action against certain WH&S officers for the way in which they handled the initial investigation;

- a separate Electrical Safety Act should be enacted to regulate safety measures pertaining to the electrical industry[139];

137 An incident involving a death or serious personal injury.

138 A less serious workplace incident.

- an independent Safety Regulator should be established; and
- WH&S's media policy should be rewritten.

A complete list of the opinions formed and recommendations made in my report is contained in Appendix F.

4.3.6 Response of agency

All of my recommendations were accepted by the DG of DIR.

DIR sought advice from senior counsel on whether the definition of the term "electrical work" should be expanded to address the deficiencies identified on my report. The issue is discussed in greater detail in 4.3.7.1.

An audit of the WH&S Priority One and Priority Two files that had been marked "no further action" was subsequently undertaken by a senior WH&S officer. The outcome of the audit was that 120 files were inspected and a determination made that 17 of those files warranted further intervention by WH&S. The action taken included:

- 3 files were re-opened in order to make further enquiry;
- 3 files required verification of claims;
- 8 files required workplace audits to be conducted; and
- 3 files required both a general workplace audit and verification of claims.

DIR initiated disciplinary action against two WH&S officers in relation to their handling of the initial stage of the investigation.

DIR implemented a new Media Policy, which rectified the shortcomings we had identified in the previous policy. DIR also prepared a publication *"Response to a Death in the Workplace"*.

DIR apologised to TM's parents for the way in which the initial investigation was handled.

A coronial inquest was held over two days. The coroner committed TM's co-worker to appear before the criminal sittings of the Supreme Court in Brisbane at a date to be fixed on a charge that he unlawfully killed TM. The DPP[140] subsequently decided the matter should not proceed.

139 This had also been a recommendation of the Ministerial Reviewer in his report in July 2001.

140 The Director of Public Prosecutions.

4.3.7 Further developments

4.3.7.1 Definition of "electrical work"

A significant outcome of this case was that the definition of the term "electrical work" was expanded in the new *Electrical Safety Act* to include maintenance carried out to an electric line or electric article.

As previously stated, the ESO did not regard the work that TM was undertaking immediately before the incident as falling within the definition of "electrical work" as defined in (the then) s.16(1) of the *Electricity Act 1994*. In the report, I discussed both the broad and the narrow meaning of the definition. I stated[141]:

> The broad meaning of the phrase "electrical work" would encompass the whole of the cleaning, servicing and maintenance works carried out as part of the "full signage service" conducted by [co-worker] and [TM] to the … sign. It would include all of the steps associated with the work, namely, the isolation of the power supply, the removal of the cover of the sign, the removal of the light sticks from inside the sign, the replacement of the fluorescent tubes and starters on the ground, the replacement of the light sticks inside the sign, the replacement of the cover of the sign, the re-connection of the power source and final testing.
>
> The narrow meaning of the phrase "electrical work" would be to restrict the work to purely "installing or repairing" an electric line or electric article. It would segregate the various stages of the work into "electrical work" and "non-electrical work". For example, the isolation of the power source, the removal of the cover of the sign, and the removal of the light sticks from inside the sign would be "non-electrical work". The replacement of the fluorescent tubes and starters would be "electrical work". Having done that, the replacement of the light sticks inside the sign, the replacement of the cover of the sign, the re-connection of the power source and the final testing would be "non-electrical work", unless that activity was classified as "installing an electrical article".
>
> As I stated previously, I would be surprised if Parliament intended such a narrow interpretation of the phrase "electrical work" in the *Electricity Act*.

For this reason, I recommended to DIR that it obtain senior counsel's opinion in relation to the definition of "electrical work" with a view to including a clearer, more consistent definition in the proposed new electrical safety legislation.

4.3.7.2 Update

The expanded definition of "electrical work", contained in s.18 of the *Electrical Safety Act,* accords with the advice of senior counsel.

141 Page 28 of Case 3 of the WEP.

4.4 Case 4 – investigation completed 21 February 2003

4.4.1 Background

AM was employed by SEQEB as an electrical fitter / electrical mechanic. He was fatally electrocuted while operating the ground level metal handle of a pole-top mounted switch. He was undertaking this switching operation in order to energise a section of the 11kV supply circuit. This action was necessary because earlier in the day a cross-arm supporting the 33kV power lines on another pole had collapsed and fallen onto the 11kV supply.

While the immediate problem with the 33kV cross-arm and lines had been addressed, a fault was still being recorded on the 11kV supply. Therefore, the exercise of isolating and sectioning the 11kV supply was aimed at both detecting the location of the fault and rerouting the electricity supply.

The fault was later discovered to have been a short circuited surge diverter. Surge diverters are designed, chiefly, to divert lightning strikes away from the supply system to prevent the damage that they may otherwise cause to electrical installations and works. In this case, the surge diverter detected the fault current caused by the fallen 33kV lines and sent it, along with the normal 11kV supply, to earth via a cable running down the side of the pole, namely a HV Arrester Downlead.

The relevant protection devices “tripped” within seconds of this occurring, cutting the 33kV and 11kV supply. Even though this occurred, the surge diverter appears to have sustained damage and remained in the fault position, which effectively created a short circuit to earth down the HV Arrester Downlead.

While SEQEB were evidently aware of these faults, what they did not initially know was the precise location of the fallen cross-arm or where the fault current was earthed.

The design of the earthing system involved a steel cable running from the surge diverter down the outside of the pole and into the ground at the base of the pole. As an intended safety measure, the ground level metal handle for the switch was also earthed, by connecting it to the metal cable running down the pole from the surge diverter. However, this design meant that the handle was, effectively, part of the 11kV fault circuit and upon operating it, AM received a severe electric shock, calculated by SEQEB to be 6.6kV over 1.3 seconds. AM died instantly. He was 24 years old.

WH&S responded to the incident. The WH&S inspector attended the scene on the day and an investigation was commenced. He subsequently recommended that SEQEB be prosecuted.

The WH&S inspector prepared a prosecution report, which was sent to Crown Law for advice. Crown Law sought expert technical assistance from the

WH&S Senior Policy Adviser Technology. On the basis of that officer's advice, Crown Law recommended that prosecution not be initiated.

The WH&S Area Manager then sought further expert technical assistance from the ESO. The ESO concluded that SEQEB could not be held accountable for the incident.

WH&S never proceeded with the matter. No prosecution was ever brought against any person or entity as a result of this incident.

A senior ESO officer attended the scene. However, no independent investigation was conducted by the ESO. Rather, the ESO, as was the practice at the time, relied upon an investigation of the incident conducted by authorised persons employed by SEQEB. SEQEB controlled or operated the infrastructure that was the subject of the investigation.

A coronial inquest into AM's death was held over two days. On the basis of the evidence presented, the coroner found that no person could be committed for trial.

4.4.2 The complaint

AM's parents made the following complaints to us:

- the WH&S investigation was incompetent and prosecution action should have been pursued;
- the ESO did nothing when a number of offences against the electrical legislation appeared evident; and
- the coroner was not presented with relevant information.

Their concerns about the ESO were heightened after the first day of the coronial inquest, when it became apparent from the SEQEB investigator's own admissions that he did not possess the requisite expertise to investigate many important aspects of the incident.

They were dismayed with the outcome of the WH&S and the ESO investigations (and the subsequent inquest) but were uncertain where to direct their concerns until they became involved with GRAVES.

GRAVES raised serious concerns about the incident on their behalf, firstly, with the then Premier, and then with the Minister for Employment, Training and Industrial Relations.

AM's parents remained dissatisfied with the result of these representations and wrote to us at the suggestion of GRAVES.

4.4.3 Investigation

Our investigations included:

- obtaining and reviewing the WH&S and the ESO investigation files;
- reconstructing and then assessing the scope and quality of the WH&S and the ESO investigations;
- reviewing and analysing the transcript of the evidence given at the Coronial Inquest; and
- conducting formal interviews with several officers from WH&S, the ESO and Energex (formerly SEQEB).

4.4.4 Maladministration identified

The maladministration I identified was that:

- the Senior Policy Adviser Technology was not adequately briefed by WH&S about all facets of the investigation;
- the technical advice provided by the ESO did not address the earthing system in place at the site and was significantly and materially incomplete;
- the ESO did not conduct an independent investigation or consider possible breaches of the electrical legislation; and
- the ESO's decision to rely on investigations undertaken by SEQEB ignored the fact that SEQEB controlled or operated the infrastructure that was the subject of the investigation.

4.4.5 Recommendations

I made several recommendations to address the maladministration that was identified, namely that DIR should:

- maintain a central register of all internal persons who have a level of technical knowledge sufficient to qualify them to provide expert evidence in a court;
- provide its inspectors with appropriate training in good investigative practice and presentation of evidence at coronial inquiries;
- establish an effective internal complaints handling process in consultation with us; and
- formally apologise to AM's parents for the ESO's failure to conduct an investigation and consider possible breaches of the electrical legislation.

A complete list of the opinions formed and recommendations made in my report is contained in Appendix G.

4.4.6 Response of agency

DIR accepted and implemented all of the recommendations.

The changes it has implemented include:

- establishing an in-house Legal and Prosecution Services Unit to provide legal input to investigations and properly prepare cases for prosecution;

- implementing an extensive (two week) investigations training course for its officers that includes modules devoted to the standardisation and structuring of investigation reports, the referencing of provisions and strict reporting and recording protocols. It also covers the compilation and presentation of evidence in court; and

- taking part in my Office's project designed to help agencies implement best practice systems for the management of complaints from members of the public[142].

142 See 6.12.2.

4.5 Case 5 – investigation completed 13 August 2002

4.5.1 Background

DD was fatally electrocuted when he touched a metal pole that was supporting a security light in a caravan park where he resided. He was 16 years old. At the time DD touched the pole, he was coming to the aid of his 14 year old friend who, seconds earlier, had received a non-fatal electric shock and been knocked unconscious. While DD and his friend were lying on the ground, an 11 year old girl also touched the pole, but her father was able to pull her away from the force of the current. This adult male and his daughter received non-fatal electric shocks.

The metal pole was a galvanised pipe set in a cement block in the ground. On top of the pole was a double insulated light fitting connected to a wire inside the pole. An inspection later revealed that the active wire had been caught between the edge of the light fitting and the metal pole and the neutral wire was corroded and broken. This resulted in the metal pole becoming energised with low voltage (240 volts) electrical current. When DD leaned against the energised pole his feet created an earth and he received a fatal electric shock.

One issue for assessment was whether the electrical work that had been undertaken at the caravan park was required to have been undertaken by a person holding an electrical mechanic's licence. Any competent investigation of the incident therefore needed to establish who had carried out the work and when, whether that person or persons held the appropriate licence and what work had been done.

The former caravan park owner was a qualified electrical fitter[143]. However, at the time of the incident, the caravan park had changed hands and the former caravan park owner was no longer involved with the operation of the park.

WH&S investigated the incident. There was evidence that non-compliance with the Wiring Rules[144] in relation to earthing was the fundamental cause of the fatality. However, no prosecution was ever commenced although a prosecution brief was prepared.

The ESO did not independently investigate the incident. However, the ESO did commence a "show cause" action against the former caravan park owner. The show cause action related to a licensing issue[145], but was later discontinued.

The relevant electricity entity identified several potential contraventions of the electrical legislation. These were not actioned by the ESO.

143 The classification of electrical licences is discussed at paragraph 3.6.1.2 of this Report.

144 The Wiring Rules were an Australian electrical safety standard referred to in the *Electricity Act*. A person performing the electrical installation work of extending a lighting column was required to comply with the requirements of the Wiring Rules current at that time.

145 An allegation concerning the performance of electrical work in a negligent, unsatisfactory or incompetent way.

The QPS also investigated the incident. As a result of that investigation, the former caravan park owner was charged with a number of criminal offences. A committal hearing was held. At the conclusion of the hearing, counsel for the former caravan park owner submitted that there was "no case to answer" because it could not be ruled out that the light pole had been interfered with since the former caravan park owner had left the park.

The magistrate hearing the matter found[146] there was insufficient evidence for a properly instructed jury to convict the former caravan park owner and the charges were dismissed.

The DPP took no further action in relation to the incident.

4.5.2 The complaint

DD's father made a complaint to us. He alleged that:

- the investigation of the incident by WH&S should have resulted in a prosecution under the WH&S legislation;
- the ESO did not investigate the incident despite the fact that the electricity entity identified possible offences under the electrical legislation;
- the ESO should have taken prosecution action for breaches of the electrical legislation;
- the ESO's decision to cease disciplinary action against the former caravan park owner was wrong; and
- the ESO provided false and misleading information to the (then) Criminal Justice Commission and other entities alleging that he was the source of certain information about who had allegedly performed the electrical installation work.

4.5.3 Investigation

In the course of our investigation, we:

- obtained and reviewed the agency's files;
- perused the transcript of the evidence given at the committal hearing; and
- interviewed DD's father.

We decided not to directly interview agency officers on this occasion because a Coronial Inquest was pending. Rather, we completed a detailed list of issues that, in our view, needed further investigation and recommended to DIR that it conduct the necessary inquiries and provide a report on its investigation to the coroner.

WH&S gave two reasons for its decision not to prosecute, namely:

146 16 January 1998.

- the QPS was conducting contemporaneous inquiries and later charged the former caravan park owner, who had allegedly performed the electrical installation works, with a number of criminal offences; and

- it was unreasonable to expect the current caravan park owner to have had knowledge that the wiring in the pole did not comply with the applicable Australian Standard.

As stated previously, the QPS prosecution did not proceed beyond the committal stage and WH&S gave no further consideration to the commencement of prosecution action for breach of the workplace health and safety legislation.

4.5.4 Maladministration identified

I identified the following instances of maladministration by the agencies:

- the WH&S investigation was poorly planned;
- there were significant record-keeping and communication failures;
- WH&S did not follow its documented internal processes for conducting an investigation;
- WH&S failed to monitor the progress of the prosecution brief prior to the matter becoming statute barred;
- the decision by WH&S to defer the commencement of prosecution action until the QPS had finalised its investigations was wrong; and
- the ESO failed to investigate possible breaches of the electrical legislation.

4.5.5 Recommendations

I made the following recommendations to address the maladministration identified, namely, that DIR should:

- develop a Memorandum of Understanding with the QPS regarding their respective investigative responsibilities for incidents involving potential breaches of the workplace health and safety legislation and potential offences under the criminal law;
- conduct further investigations of the incident with a view to providing relevant evidence to the coroner; and
- apologise to DD's father for wrongly attributing to him certain comments made about who had undertaken the relevant electrical work at the caravan park.

A complete list of the opinions formed and recommendations made in my report is contained in Appendix H.

4.5.6 Response of agency

The DG of DIR accepted and implemented all of our recommendations.

DIR conducted the further investigations we recommended and provided a report[147] to me regarding the quality of the investigations undertaken at the time.

The DIR report concluded that there was sufficient evidence to establish a prima facie case against both the previous owner of the caravan park and the owner of the caravan park at the time of the incident for offences under the workplace health and safety and/or electrical legislation.

DIR also conceded that the investigation carried out by both WH&S and the ESO was sub-standard because of a number of contributing factors, namely:

1. At the time of this incident there was no investigation training in place for officers of either Division. The officers involved in the investigation were, in the main, recruited for their technical expertise and not investigative experience. While they were competent in locating and identifying workplace and/or electrical deficiencies, there was at best minimal experience or expertise in the practical requirement of investigating an incident with a view to prosecution. This was so at all levels of responsibility.

   It should be noted that at around this time the Division of Workplace Health and Safety in particular was in the process of changing the focus of the Division from a predominantly proactive strategy to a balance of proactive and reactive strategy. It would appear that insufficient training was in place to ensure competent and comprehensive investigations occurred in all cases.

2. Similarly, at the time there was a policy within the Division of Workplace Health and Safety of decentralisation of the investigative process with each region responsible for decisions affecting the investigation process and decisions to prosecute. It is clear that during this investigation this decision-making process broke down. There was no proper procedure in place that spelt out the areas of responsibility of each of the officers involved in the investigation/prosecution. Consequently, decisions were made without adequate communication between those involved.

3. There was no proper procedure in place for those involved in the investigation to obtain clear and authoritive legal advice when and as required. The system of asking advice from an agency outside the Division proved to be inefficient with sometime inordinate delays before advice was received. Further there was no adequate process where a person investigating the incident could discuss or question the advice provided.

4. In this investigation there was clearly a breakdown of communication on an individual level, both verbally and in documentation. Of most concern in this regard was the failure of the persons involved in the investigation to keep documented accounts of conversations had, reasons for decisions and even those decisions. This led to one part of the investigation acting on information either unknown to the others in the investigation or different to information had by others.

147 Under cover of letter dated 5 March 2003.

5. The lack of an adequate investigation by the ESO in this matter is best understood in the context of their policy at the time to not investigate with a view to prosecution but with a view to education and awareness in an attempt to ensure the incident would not happen again as per the ESO strategic plan as it then was.

6. As a consequence of this and other matters arising from the involvement of the Ombudsman's office, the Division of Workplace Health and Safety and the Electrical Safety Office have established a number of business processes (e.g. protocols, comprehensive training, organisational restructuring, etc) which would ensure a comprehensive investigation and prosecution if this incident were to occur today.

4.5.7 Further developments

4.5.7.1 DIR Report for coroner

DIR also prepared a technical report[148] for use at the coronial inquest. The report specifically dealt with the application of relevant legislative requirements and the Wiring Rules.

The report stated that there were a number of matters to consider in "preventing recurrence" of the incident. They were:

6.1 Limitations

While non-compliance with the Wiring Rules in relation to earthing is considered to be the fundamental cause of the fatality, the ability to ensure electrical safety by applying these principles depends on maintaining the integrity of the earthing system and the protective device operating as per its design in the event of an insulation breakdown.

In addition, while a double insulated cable is allowed in an unearthed metal enclosure, damage to the cable causing contact with the enclosure is possible. For example, if a double insulated cable or light fitting is damaged by a fixing screw used to attach something to the column, the protection device will not operate unless there is sufficient current flow to operate the protective device.

6.2 Safety Switch Protection

A residual current device or safety switch has the ability to provide enhanced protection against electric shock because the device detects any electrical leakage to earth and isolates supply before this leakage becomes dangerous. The latest edition of the Wiring Rules recognises the benefits of these devices, requiring that electrical circuits and equipment in high risk locations be provided with protection by these devices. Legislation has also been introduced in Queensland requiring these devices be fitted in all domestic installations regardless of age when they are sold.

6.3 Recommendations to prevent Recurrence

The author believes that the following would prevent recurrence:

148 "Technical Issues – Fatality", a report to clarify technical aspects of electrical safety issues relevant to the fatality, prepared by DIR Director – Electrical Safety Policy, dated August 2003.

- ensuring electrical work complies with relevant standards when carried out;
- fitting a safety switch to external lighting circuits such as the one involved in this fatality; and
- a regular maintenance regime of an electrical installation and equipment by a competent person.

These recommendations reflect initiatives incorporated into the *Electrical Safety Act 2002.* As an example, a business that carries out electrical work is required to ensure the work is tested to ensure [the work is] electrically safe. An employer or self employed person has an obligation to ensure all electrical equipment used in the conduct of their business is electrically safe. In practice this could be achieved by ensuring electrical equipment complies with relevant standards when installed and a competent person carries out periodic checks to ensure the standards are maintained.

4.5.7.2 Coronial inquest

A coronial inquest into the cause and circumstances surrounding the death of DD was held over three days and concluded in September 2003. The coroner found[149] that the electrocution had occurred because "a damaged active supply conductor contacting the unearthed metal pole" resulted in the pole "being energised". The coroner also found[150] that there was insufficient evidence "to commit any person for trial".

The coroner did, however, make[151] seven riders (recommendations) namely:

1. That the Department of Industrial Relations progress the current Queensland Government initiative to adopt safety switches and that the fitting of such safety switches be not only in domestic dwellings as is currently the case but in all places which provide accommodation to the public, both to be constructed and already existing. That such switches meet Australian Standards based on degree of risk considering both equipment and fixed wiring.

2. That the Department of Industrial Relations continue to develop regulatory initiatives to ensure electrical contractors carry out electrical work appropriately. That is, that there be assurances to ensure that licences are current, that electrical contractors have access to and knowledge of relevant standards and that there be continuing education to ensure such continued access and knowledge and that there be steps taken to ensure compliance with relevant regulations and standards.

3. That the Department of Industrial Relations promote electrical safety awareness for the public so that the dangers of substandard electrical work and the benefits of safety switches are understood. This might best be done by television advertising campaigns and written campaigns and by the further developments of programs for school children to educate them with respect to the dangers of exposure to electricity.

149 Page 7 Transcript of proceedings 23/09/2003.

150 Page 7 Transcript of proceedings 23/09/2003.

151 Page 8 Transcript of proceedings 23/09/2003.

4. That there be a review of current requirements for safety switches and electrical maintenance requirements in workplaces.

5. That there be supervision of electrical installations and maintenance in all places which provide accommodation to the public and that this be by way of regular and close inspections or audits by Department of Industrial Relations so as to detect non-compliance.

6. That there be compulsory conduct of electrical inspections by purchasers of any such accommodation places.

7. That there be implementation of compulsory follow-up inspections by Far North Queensland Electricity Board officers in relation to any reported electrical safety risks or after the issue of any statutory notices in relation to such risks.

4.5.7.3 Coroner's Recommendations Project

DIR initiated the Coroner's Recommendations Project in June 2004 to explore a number of coronial recommendations that had been made in relation to workplace electrical fatalities. An Issues Paper[152] was published concerning the project stating[153]:

> Recent inquests into a workplace electrical fatality and the electrocution of a child at a caravan park have resulted in coronial recommendations for wider use of safety switches and amended regulations for the use of electrical equipment used outside the home. Specifically, the coroners recommended:
>
> - amending the Electrical Safety Regulation 2002 to require regular inspection and maintenance of all electrical equipment used outside the home including the means of delivery of power to equipment;
> - expanding the safety switch initiative to include public accommodation such as caravan parks, hostels, boarding houses and public housing;
> - introducing compulsory electrical inspection of these types of accommodation when sold and mandating regular supervision of electrical installations and maintenance regimes in them; and
> - legislating for the mandatory installation of safety switches in workplaces.

A number of issues were identified in the Issues Paper as a basis for initial consultation with key industry stakeholders. Comments were sought[154] regarding:

- the capacity of the current "class of work" system to adequately address the risks associated with types of work that do not fall strictly within the classification system.

152 Department of Industrial Relations, June 2004, Issues Paper – Coroner's Recommendations Project – Safer electrical equipment, Queensland Government, Brisbane, Queensland.

153 Page 4.

154 Pages 13 – 22.

- the adequacy of the current "class of work" system to address the broad range of electrical risk that can be present in any one workplace.

- a change in the definition of "specified electrical equipment" to one that would address inherent risk rather than classes of work.

- the effectiveness of the current requirement (that safety switches be fitted to dwellings built before 1992 at the point of sale) to enhance the electrical safety of Queenslanders.

- extending safety switch installation requirement to rental properties at the point where there is a new rental agreement signed.

- the best way to improve electrical safety in caravan parks with respect to those circuits not already covered by safety switch protection.

- the best way to improve electrical safety in areas that provide accommodation to the public with respect to those circuits not already covered by safety switch protection.

- awareness of electrical safety obligations among persons who provide accommodation to the public.

- the introduction of a set of guidelines, for example a code of practice, for discharging electrical safety obligations in relation to the maintenance and repair of electrical equipment.

Our recent inquiries of DIR elicited the following response[155] in relation to this project:

> The outcome of the project has resulted in the development of a Code of Practice for Electrical Equipment. The Code is in the final rounds of consultation and is dependent on the introduction of some legislative changes. These are programmed to be completed on 1 August 2005. Following will be an intensive communication campaign that will precede the implementation of the Regulations programmed for February 2006.

4.5.7.4 Proposed Code of Practice for Electrical Equipment

DIR provided me with a confidential draft copy of the proposed Code of Practice for Electrical Equipment. The draft Code:

- is to apply to plug in and fixed wired electrical equipment including wiring systems whether inside or outside a building;

- does not apply to construction or demolition workplaces or to the works of electrical entities;

- addresses the issue of increased electrical risk; and

155 Email from DIR dated 18 May 2005.

- provides for risk assessment and control measures where there is no safety switch.

The draft Code, if implemented in the form submitted, should address a number of the more significant issues raised in my report.

We will continue to monitor developments as they arise.

4.6 Cases 6 and 7 – investigation completed 14 February 2003

4.6.1 Background

AB and KC were fatally electrocuted at the same construction workplace within minutes of each other in two separate but related incidents. There were live overhead power lines located on the footpath adjacent to the construction site.

AB was a crane operator. He left the cabin of his crane to move a parked vehicle that was impeding his next lift. While he was in the process of moving the vehicle, the boom of the crane moved unexpectedly[156] and rotated in excess of 90 degrees. The coroner found[157] that the evidence did "not establish what caused the boom to rotate". A length of chain was hanging from the end of the boom and, as the boom rotated, the chain made contact with the live high voltage overhead power lines. This resulted in the crane becoming energised with electricity. An arcing noise was heard and a small fire ignited under the cabin of the crane. AB then attempted to climb back onto the crane and was electrocuted.

KC was a labourer at the same construction site. He was handed a fire extinguisher and directed to extinguish the flames under the cabin of the crane as best he could. While doing so, he moved too close to the energised crane and, due to a phenomenon called "step potential"[158], was electrocuted.

Officers from QPS, WH&S and Energex attended the incident site and commenced an investigation. WH&S closed their file after nine months. The WH&S inspector made a recommendation of "no further action" despite identifying breaches of the workplace health and safety legislation. His recommendation was accepted and endorsed by WH&S senior officers.

The ESO did not investigate the incident. It was of the view that it was not required to do so because neither worker was undertaking "electrical work" at the time of the incident.

A coronial inquest was held 16 months after the incident over two days. The coroner found, based on the evidence presented, that no person should be committed for trial.

4.6.2 The complaint

The widows of AB and KC both made similar complaints to us. They claimed that WH&S and the ESO did not adequately investigate the incident that resulted in the death of their husbands.

156 A mechanical failure was not discounted.

157 Transcript of Findings made 17 December 1999.

158 Step potential can exist on work sites where the ground may inadvertently become energised. Step potential is the possibility of ground gradient electricity passing through the body from the difference in potential between the two feet.

4.6.3 Investigation

Our investigation found that the overhead power lines located adjacent to the construction site could have been de-energised. As I stated[159] in my report:

> The tragic reality of this case is that the deaths of the two men were avoidable. The HV power lines in front of the construction site could have been de-energised. In fact, they were de-energised immediately following the incident, at a cost of $1,702.00. Had that been the case on the day of the incident, the crane would not have become energised and neither of the men would have been fatally electrocuted.

The legislation in place at the time of the incident required the builder to "consult" with the electricity entity and to comply with any safety precautions imposed by it. However, there was no requirement under the legislation for the electricity entity to impose safety precautions or give written notification to the customer of what those precautions were.

Our investigation ascertained that the builder had consulted with Energex and, following consultation, "tiger tails"[160] had been installed on the low voltage mains. An Energex officer stated at interview that he informed the builder that the high voltage power lines could have been de-energised, but at a cost. However, the builder denied that the issue of de-energising was ever discussed.

4.6.4 Maladministration identified

The maladministration I identified in relation to WH&S was that, in the course of its investigation, it had failed to:

- assess whether it was the dogger's role to secure (or back-hook) the chains hanging from the boom of the crane at the completion of the lifting procedure;

- adequately explore with Energex the consultation that took place between it and the builder with respect to the de-energising of the power lines; and

- adequately undertake relevant inquiries concerning potential breaches of the workplace health and safety legislation.

I also formed the opinion that the fact that the ESO did not undertake an independent investigation of the incident or consider whether relevant electrical legislation had been breached when it had a responsibility to do so constituted maladministration in itself. I expressed a view that, even if no breaches of electrical legislation were apparent, the ESO, on behalf of the Regulator, should have fully investigated the incident or at least assisted WH&S to do so.

159 Page vi of the Executive Summary of Cases 6 and 7 of the WEP.

160 "Tiger tails" is the common name for toropoly covers that are installed on LV power lines as a visual device.

4.6.5 Recommendations and legislative amendment

4.6.5.1 Provisional report

My provisional report of this investigation was delivered to the DG of DIR on 17 September 2002. It contained one recommendation, namely:

> that the reviewers of the WH&S legislation and/or the taskforce preparing the new Electrical Safety legislation assess the WH&S issues raised in … this report with a view to addressing those issues, where appropriate, in the legislation.

I addressed the issue of "consultation" with the electricity entity in the provisional report. One of the provisional opinions I formed was that:

> WH&S [had] failed to carry out relevant inquiries in relation to whether or not the respective employers of the deceased had complied with s.80 of the WH&S (Miscellaneous) Regulation 1995 and, therefore, its administrative actions were wrong within the terms of s.49(2)(g) of the *Ombudsman Act*.

Section 80 of the WH&S (Miscellaneous) Regulation 1995, which was current at the time of the incident, required an employer to consult with the electricity entity in the event equipment being used by a worker (for example, a crane) was likely to come within two metres of an aerial conductor.

I addressed this issue in my provisional report[161] as follows:

> The WH&S inspector concluded that there was "consultation" and that Energex's requirements were met by the principal contractor. He was satisfied that s.80 had not been breached.
>
> However, the evidence I have gathered suggests that crucial evidence regarding the consultation with the electricity entity, Energex, was not obtained. The Energex employee who met the principal contractor's representative on site and who provided the quotation for the tiger tails was not interviewed by the WH&S inspector, nor was the principal contractor's representative. Both of these persons have since been separately interviewed by my officers and each provided conflicting accounts regarding the initial consultation.
>
> The Energex employee stated that he informed the principal contractor's representative that it was possible to de-energise the HV power lines (for a price). The principal contractor's representative has denied receiving such advice. It is not my role to form an opinion as to where the truth of the matter lies.

I was not satisfied that the legislation as it then stood provided adequate protection to workers working near live overhead power lines. For that reason, I made a provisional recommendation that the taskforce preparing the new electrical safety legislation take the following issues into consideration[162]:

161 At page 53.

162 Pages 77 – 78 of my provisional report.

> As I have stated previously, s.149 of the current WH&S Regulation 1997 is in similar terms to s.80 of the repealed WH&S (Miscellaneous) Regulation. In my opinion, s.149 does not provide adequate protection to workers who are working in the vicinity of live overhead power lines. All that is required by the current legislation is for an employer or self-employed person to "**consult with the relevant authority and ensure the safety precautions required by the authority are complied with**". Employers may ignore the section if they form the view that it is unlikely the crane will come within the prescribed distance of an aerial conductor.
>
> In my view, that is not sufficient. Accordingly, I intend recommending to the Review Team that the current s.149 of the WH&S Regulation 1997 be amended so that it provides better protection for workers and others and imposes stronger obligations upon employers and power supply entities.
>
> Once consulted by an employer, the electricity entity should have the duty to provide the directions necessary to ensure the work can be undertaken safely. Those directions should be in writing and work should not commence until the directions have been complied with. In appropriate cases, the power supply entity should inspect the site in the presence of the applicant. The focus should be on the elimination of the risk.

4.6.5.2 Electrical Safety Act 2002

The *Electrical Safety Act* and the Electrical Safety Regulation 2002 commenced on 1 October 2002. Due to the short period of time between the delivery of my provisional report and the enactment of the new legislation, the new legislation had the effect of making my provisional recommendation impracticable. However, my concerns were speedily considered by DIR, which initiated steps to amend the new legislation shortly after it commenced.

4.6.5.3 Legislative amendment

The Electrical Safety Regulation 2002 was amended on 8 November 2002. One of the amendments included the insertion of a new s.64A addressing the issue I had raised. The new section requires an employer (or self-employed person) to give written notice to the person in control of overhead electric lines of the intention to perform work near the lines. The person in control of the lines is then required to give written "safety advice" to the employer (or self-employed person) within seven days. No work can be commenced until the safety advice has been received.

4.6.5.4 DIR's response to provisional report

In response to my Provisional Report the Director-General of DIR stated[163], in relation to this issue, that:

> The Department has recognised the insufficiency of the current consultation requirements detailed in the previous s.149 of the WH&S Regulation. The (new) Regulation clarifies the consultation requirements for employers and

163 Page 2 of letter dated 21 November 2002.

> persons in control of electric lines (e.g. electricity entities). Before commencing work that has a reasonable likelihood of directly contacting or coming within the exclusion zone of an electric line an employer must notify the person in control of the line[164].
>
> The person in control must provide written safety advice in 7 days advising how the employer can best ensure the electrical safety of persons and property. The employer cannot, without reasonable excuse, start work until they have received the written safety advice from the person. The employer's overriding obligation would necessitate that they implement the most appropriate and safe measure.

4.6.5.5 Final report

My final report of the investigation was delivered to the DG of DIR on 14 February 2003. It contained one recommendation directed to the newly appointed Commissioner for Electrical Safety. I recommended that the Commissioner take into consideration the relevant electrical safety issues contained in the report and, as part of the Commissioner's function, report to the Minister on those issues.

The main safety issues identified were:

- ensuring appropriate consultation occurs between an employer and the relevant electricity entity and clarification of their respective obligations where the employer is carrying on business in proximity to overhead power lines;
- de-energising, re-gridding or undergrounding overhead HV power lines;
- earthing of mobile cranes used in proximity to overhead power lines;
- use of a safety observer when work is being carried out in close proximity to or on overhead power lines;
- action to restrict movement of mobile cranes working under power lines; and
- use of insulated swivels on cranes.

In relation to the issue of consultation with the electricity entity, my final report stated[165]:

> Even though the section [s.64A of the Electrical Safety Regulation 2002] does not require the employer or self-employed person to comply with the advice given by the person in control of the electric line, a new overarching obligation has been imposed on employers and self-employed persons.

164 Section 64A of the Electrical Safety Regulation 2002.

165 Page 79 of final report dated 14 February 2003.

> In particular, section 30(3)(c) of the *Electrical Safety Act 2002* places an obligation upon an employer or self-employed person who is undertaking work involving contact with, or being near to exposed live parts, to ensure that persons performing the work are "electrically safe". Section 10(2) of the Act states that a person is “electrically safe” if that person is “free from electrical risk”. Section 10(4) states that a person is “free from electrical risk” when the electrical risk is as low as reasonably achievable, having regard to the likelihood of harm and the likely severity of harm.
>
> Under s.41(3) of the *Electrical Safety Act 2002*, if a regulation is identified as prescribing a way of discharging a person’s electrical safety obligation and the person contravenes the regulation, the person fails to discharge the electrical safety obligation[166].
>
> Therefore, in order to discharge this obligation, an employer or self-employed person has to meet requirements for performing risk assessments (Part 4 of the Code of Practice - Working Near Exposed Live Parts) and ensure they have consulted the electricity entity (s.64A) and complied with the exclusion zones in the regulation (s.62).

A complete list of the opinions formed and recommendations made in my report is contained in Appendix I.

4.6.6 Response of agency

The DG of DIR advised[167] as follows:

> This Department fully accepts your opinions, including your acknowledgment of the improvements which have been made in addressing these concerns.
>
> Your recommendation is also fully accepted. I have discussed the matter with the Commissioner for Electrical Safety who will be pleased to consider the issues raised in … your report and provide appropriate recommendations to the Minister.

The Commissioner for Electrical Safety advised[168] me that:

> Your recommendation has been placed on the agenda of the Electrical Safety Board for discussion at the next meeting.
>
> My suggestion to the Board would be to form a working party to examine all the safety issues raised in [your report] and report back to the Electrical Safety Board.
>
> The Board would then consider the report from the working party and advise the Minister of any appropriate changes to the Act or Codes that may be required to ensure the electrical safety of persons working near exposed live conductors.

166 See Part 4 of the Electrical Safety Regulation 2002, particularly s.58.

167 By letter dated 20 February 2003.

168 By letter dated 11 March 2003.

4.7 Case 8 – investigation completed 28 February 2003

4.7.1 Background

During a cyclone in North Queensland, a high voltage power line that crossed a river broke mid-span and fell into trees on a riverbank. A crew from the electricity entity attended the site and isolated the damaged section of the high voltage supply. They then left the scene.

However, some time later, the broken high voltage power line fell from the trees and came to rest across live low voltage power lines located below before trailing onto the ground. JC made contact with the broken high voltage power line while he was standing in floodwaters. Although the power line had been de-energised, its contact with the live low voltage power lines meant that it carried a significant fault current. JC was fatally electrocuted. He was 11 years old.

Section 9.1 of the WH&S Act defined a "workplace" as "any place where work is, is to be, or is likely to be, performed by a worker".

WH&S did not attend the incident site or conduct an investigation. WH&S claimed that an assessment was made at the time that the incident did not occur at a "workplace" and therefore was outside its jurisdiction.

Another interpretation, and one suggested by my investigation, was that the incident did occur at a "workplace" because, by the time the broken power line had fallen, the site was a place where work was likely to be performed by a worker by virtue of the necessity of repair. This alternative interpretation was subsequently supported by legal advice[169] obtained by DIR following delivery of my report. That legal advice stated[170]:

> … there is no case in Queensland of which I am aware that addresses the nature or ambit of "workplace".
> …
>
> I am however of the view, to take the example of a fallen power line, that once a power line has fallen to the ground, then the area or place where the power line has fallen at the time of falling becomes for the purposes of the WH&S Act a "workplace".

A coronial inquest was conducted shortly after the incident. The coroner found that there was sufficient evidence for charges to be preferred for criminal negligence pursuant to s.289 of the Criminal Code, but he exercised his discretion not to commit any person for trial due to the "emergency of the cyclone and the unusual situation at the time".

169 Senior Counsel dated 22 April 2003.

170 At page 11.

Some 18 months after the incident, JC's parents sought a review of WH&S's decision not to prosecute for breaches of the WH&S legislation. A WH&S officer informed the Minister that WH&S had "conducted a thorough investigation into the circumstances surrounding the death of [JC]" and that "no clear breach of the WH&S Act could be found".

This briefing clearly gave the impression that an investigation had been conducted when this was not the case. In fact, no investigation had been conducted because WH&S had considered the incident was outside its jurisdiction. However, the Minister subsequently wrote to GRAVES and, based upon the briefing he had received from WH&S, advised that "this investigation showed there was no breach of the WH&S Act". This statement suggested that something more than a jurisdictional assessment had been made.

The ESO did not conduct an independent investigation into the incident. It merely relied on information provided to it by the electricity entity, which controlled or operated the infrastructure involved in the incident.

4.7.2 The complaint

JC's mother alleged that the workers from the electricity entity had failed to adequately secure the broken high voltage power line in such a way that it was no longer a danger to the public. She also alleged that WH&S and the ESO did not investigate the incident, when both entities had a clear statutory obligation to do so.

4.7.3 Investigation

During our investigation we:

- obtained and reviewed the agency's files;
- sought submissions from JC's mother;
- analysed the transcript of the evidence given at the coronial inquest;
- interviewed several officers from WH&S and the ESO; and
- obtained written statements from other agency officers.

4.7.4 Maladministration identified

The maladministration I identified was that:

- WH&S failed to obtain legal advice as to whether the incident occurred at a "workplace";

- the information provided by the WH&S officer to the Minister was false. It misled the Minister who in turn passed the false information through GRAVES to JC's parents; and

- the ESO failed to undertake an independent investigation of the incident. Instead, it relied on information provided to it by the electricity entity. As JC was electrocuted by infrastructure controlled or operated by the electricity entity, the ESO should have conducted an independent investigation.

4.7.5 Recommendations

Two of the principal recommendations I made to address the maladministration identified were that DIR:

- undertake relevant independent research into the various types of splice joins used by electricity entities with a view to determining whether any of those joins are unsuitable to bear the static and dynamic loadings likely to be encountered in the geographic region in which any such entity operates; and

- apologise to JC's parents and the coordinator of GRAVES for the deficiencies in the investigative processes of the WH&S and the ESO and for providing misleading information.

A complete list of the opinions formed and recommendations made in my report is contained in Appendix J.

4.7.6 Response of agency

DIR accepted all of my recommendations. DIR advised that a number of the recommendations were already receiving attention and that my report had reinforced their priority as important parts of an ongoing work program.

4.7.7 Further developments

4.7.7.1 Splice joins

In relation to my recommendation that DIR undertake research into splice joins, DIR responded[171] as follows:

> The department has approached this subject by assembling data on the experience of the entities with splice failures through their periodic incident reports. In collecting that information ESO has been made aware of entities' preference for other joining methods – avoiding splice wherever there is an alternative.

171 By letter dated 10 February 2004.

> It has also researched manufacturers' specifications for both splice joins and cables and noted the industry's assessment that the cause of failures in these joins lies in their installation rather than in the specifications of performance.
>
> In spite of the shortcomings in this aspect of overhead wire assembly and their occurrence in networks generally, there has been no research undertaken by a national body. For that reason ESO has taken the initiative of raising this issue with the National Electricity Network Safety Steering Committee with a view to it being incorporated in that body's work program.

The Commissioner for Electrical Safety's response in relation to this issue is contained[172] in Chapter 7 of this Report.

172 See 7.1.6.2.

4.8 Cases 9, 10 and 11 – investigation completed 28 February 2003

4.8.1 Background

JS (a 27 year old mother), ES (her 3 year old daughter) and KB (their 31 year old neighbour) were all fatally electrocuted when they came into contact with a fallen low voltage power line on or near the footpath outside KB's residence.

The power lines were brought down by a large tree branch that had apparently separated from a nearby eucalyptus tree during a severe storm. After the storm had ended, JS went outside to speak with KB's wife and inspect the damage. JS was nursing ES. They made contact with the fallen live power lines. KB saw that JS and ES were in difficulty and attempted to assist them, but was fatally electrocuted while trying to do so, when he also made contact with one of the power lines.

WH&S did not conduct an investigation because it formed the view that the incident did not occur at a "workplace" and was therefore outside of its jurisdiction.

The former Director-General explained WH&S's position as follows[173]:

> No investigation file is held by the Department … The incident was not investigated by the Division of Workplace Health and Safety.
>
> By way of explanation, this incident was a result of storm damage on a domestic property, and not a workplace. Because there was not a workplace activity taking place, nor specified high risk plant involved, the Department believes that the incident is outside the application of the Workplace Health and Safety Act 1995 and its jurisdiction.

When asked by the former Ombudsman to provide a more detailed explanation about the investigative inaction of WH&S, the former Director-General restated WH&S's position as follows[174]:

> I confirm that this department did not conduct an investigation. This incident was not reported to the Division of Workplace Health and Safety. The incident occurred at a place not within the jurisdiction of the Workplace Health and Safety Act 1995 and therefore was not investigated. Workplace Health and Safety inspectors at the regional office knew of the incident, however, only through what the media reported.

I formed a view that both of these explanations were unsustainable for two reasons:

173 By letter dated 7 April 2000.

174 By letter dated 6 July 2000.

- the WH&S Act did not state that domestic premises were incapable of being a workplace. In any event, the evidence was that the power lines fell onto the footpath and roadway, not onto private property; and

- there was evidence that within 45 minutes of the incident, Energex officers had attended at the scene and undertaken repair work. Therefore, there was a persuasive argument that at the time of the incident, repair work was likely to be performed given that power lines had fallen. This argument was subsequently supported by legal opinion[175] obtained by DIR.

An ESO officer attended the incident site. He later prepared[176] a Ministerial briefing in which he concluded:

> A wind-borne branch (or branches) of a eucalypt some distance from the span fouled the conductors causing burning of the strands and mechanical failure.
>
> My inspection of the site showed the eucalypt debris on the section of the footpath involved originated from a tree or trees quite remote from the fallen span. I concluded there is no evidence that there were trees in contact with the overhead conductors prior to the storm or in other words, ***there is no evidence of culpability on the part of the distribution entity through failure to maintain the overhead lines concerned in an acceptable manner***.

The Ministerial briefing also contained the following comment under the heading “Further action”:

> I advised [name] to prepare a diagrammatic representation of the most likely origin of the eucalypt debris in relation to the conductors to assist us and the Coroner and he undertook to revisit the scene immediately before the debris was removed by the local authority to carry out a more detailed examination.
>
> The copper cable which formed the span will be secured by [name] Depot as evidence for the likely Coroner’s inquiry.
>
> We will consider the desirability of a timely reminder to all eight Queensland distributors of the necessity of **maintaining tree clearing programs which has been a perennial source of concern**. [emphasis added]

Neither WH&S nor the ESO commenced any prosecution action against any person or entity for a breach of the workplace health and safety legislation or the electrical legislation.

A coronial inquest was held over two days. The coroner found that there had not been any evidence produced which would justify any person being committed for trial.

175 Previously referred to in 4.7.1 of this Report.

176 Briefing dated 11 April 1998.

The coroner made eight riders that covered a number of topics including vegetation management, storm safety education and undergrounding of power lines, namely:

1. The system of auditing tree trimming contracts needs to be reconsidered and all tree trimming should be viewed and assessed by Energex.

2. The system of relying upon the public and other similarly haphazard means of identifying problem areas should be discontinued and Energex should ensure that all areas serviced by overhead power lines should be subjected to a regular maintenance program, including a regular tree-trimming program.

3. A system of tagging those trees that may cause potential problems to overhead power lines should be immediately implemented. These tags should be attached to trees sold or made available to the public with warnings about the potential problems created by such trees to power lines when they achieve full development.

4. A more vigorous public awareness campaign of not venturing outside after storms should be instituted forthwith.

5. It has been suggested by the Electrical Safety Office and I endorse same wholeheartedly that the technical limitation of fallen low voltage lines not causing a power interruption, such as is the case with high voltage lines, should be addressed as a matter of urgency to determine whether in Australia or overseas there is a feasible solution available or capable of being implemented.

6. It also seems that there also needs to be an education of environment groups about the dangers of large trees in the vicinity of overhead power lines.

7. Despite the cost electrical suppliers have to look at undertaking a program of putting lines underground and thereby reducing the risk of fatalities from storm damage. It seems that this is the only reasonably safe way of reducing fatalities from this type storm damage. The means by which this can be achieved has to be the province of government and other interested stakeholders. Because it is so expensive should not cause it to be shelved. It is a challenge but at the end of the day and as I observed earlier what price can be put on a human life.

8. The alternative would be to implement the breakaway system referred to during the hearing. There are some flaws with this system such as the risk to health and public safety, including traffic control and that upon re-energising unless all areas had been thoroughly checked there was the potential for the public to deal with downed lines in the false belief that they had been rendered safe. However again I am sure that with the level of expertise available both nationally and internationally a suitable solution to these problems could be achieved.

4.8.2 The complaint

JS's father-in-law (ES's grandfather) complained to us that:

- insufficient investigations were undertaken by WH&S and the ESO;
- the coroner was not presented with all relevant evidence; and
- no action was taken regarding the electricity entity's failure to follow its written procedures to trim tree branches that overhang power lines.

4.8.3 Investigation

During our investigation we:

- obtained and reviewed the agency's files;
- conducted records of interview with WH&S and ESO officers;
- reviewed and analysed the transcript of the evidence given at the coronial inquest;
- reconstructed and then assessed the actual investigations undertaken by the agencies; and
- sought submissions from JS's father-in-law.

4.8.4 Maladministration identified

I identified the following instances of maladministration:

- WH&S failed to undertake an investigation of the incident in circumstances where it had a statutory responsibility to do so;
- WH&S failed to obtain formal written legal advice about the application of the WH&S Act to the incident; and
- The ESO failed to consider whether or not the electricity entity had complied with its obligations under s.173 of the *Electricity Act* to "take all reasonable steps to ensure" its low voltage power lines were "not unsafe" after they fell to the ground.

4.8.5 Recommendations

The principal recommendations I made were that DIR should:

- undertake relevant independent research into the vegetation management policies and practices of electricity supply entities and determine whether they were appropriate;

- consider whether electricity entities should be required as a matter of law to immediately de-energise supply upon receiving notification of a fallen power line so that a specific safety procedure is followed before the electricity supply can be re-energised to ensure the risk to health and safety has been completely removed;

- undertake independent research into the regulatory approaches of other State and (relevant) international jurisdictions to LV fault protection and consult widely with relevant academic and industry bodies on any existing, new or emerging technology that would enable the risks presented by fallen LV power lines to be removed or minimised;

- review any action taken by the ESO with respect to the coroner's riders and address those not implemented; and

- apologise to JS's father-in-law for the deficiencies in the WH&S and the ESO investigative processes.

A complete list of the opinions formed and recommendations made in my report is contained in Appendix K.

4.8.6 Response of agency

DIR accepted all of the recommendations and stated[177] that it would implement them and forward details to my office upon completion.

4.8.7 Further developments

Eleven months after the delivery of my final report, I sought an update from DIR in relation to its implementation of several of the recommendations. DIR responded shortly afterwards, and provided further information about the outstanding issues that I had raised.

4.8.7.1 Vegetation management

In relation to my recommendation about vegetation management, DIR initially advised[178] that it proposed to research and monitor industry best practice in vegetation management. DIR subsequently provided[179] additional information about the steps it had taken in relation to my recommendation. It stated that:

> Work on this recommendation has occurred at three levels.

177 By letter dated 7 March 2003.

178 By letter dated 21 December 2002.

179 By letter dated 10 February 2004.

> The coincidence of vegetation and power lines is a national issue both from the point of view of electrical safety but also as a contributing factor to bushfires. DIR has been extensively involved in researching and reviewing best practice in vegetation management through its active participation in the development of *National Guidelines for Safe Vegetation Management Work near Overhead Power Lines.*
>
> Within the state, DIR has undertaken a lead role in the development of *Guidelines for use in Developing an Agreement on Vegetation Management under Power lines between an Electricity Entity and a Local Government.* That work involved extensive consultation with the entities, other government departments, and the Local Government Association of Queensland.
>
> Concurrent with these initiatives DIR has been working with the major entities to assist them in meeting the legislative requirement to have a Safety Management System in place by October 2004. An important component of any such system will be effective vegetation management controls and the weather conditions of recent times have served as a most timely reminder of their vital importance.
>
> DIR will continue to monitor the performance of the entities in this area and one of the topics of the external research will be a comparison of measures in place in this jurisdiction compared with those applying internationally.

More recently, the Detailed Report of the Independent Panel[180] (commonly referred to as the Somerville Report) made a number of comments about vegetation management. In particular, it said that:

> Energex has not spent sufficient amounts in recent years on maintaining its system and, in particular, has not had an adequate focus on preventative maintenance, such as on vegetation management and cross arm inspections. This has significantly contributed to the number and duration of outages across Energex's system. The Panel recommends that Energex ensure that sufficient amounts are spent to deliver an effective maintenance programme. In particular, attention needs to be given to its overhead network.

The Commissioner for Electrical Safety's response in relation to this issue is contained[181] in Chapter 7 of this Report.

4.8.7.2 De-energising supply

DIR interpreted my recommendation about de-energising supply to fallen power lines as requiring it to:

- inquire into the feasibility of strengthening the obligations placed upon electricity entities to de-energise supply upon receiving notification of a fallen power line;
- obtain a legal opinion about these obligations; and,
- address the implications of that advice with the entities.

180 Page 29 of Office of Energy, Department of Natural Resources Mines and Energy, July 2004, *Detailed report of the independent panel – electricity distribution and service delivery for the 21st century*, Queensland Government, Brisbane, Queensland.

181 See 7.1.6.2.

DIR responded[182] stating that it had obtained legal advice, the effect of which was as follows:

> [Senior Counsel] concluded that as a matter of law there is no obligation on power authorities to immediately de-energise supply on receipt of notification of a fallen power line. [Senior Counsel] also acknowledged that any such automatic response could bring with it the introduction of other hazards (such as the disabling of traffic lights) which in certain circumstances could add to the dangers in the affected area rather than mitigating them.
>
> Under s.29 of the *Electrical Safety Act 2002* (the Act) electricity entities have an obligation to ensure that their works are electrically safe. The philosophy of the legislation is an outcomes one and for that reason emphasises the obligations of those concerned with the electricity industry to ensure safety rather than defining in a prescriptive manner how they should go about doing so. In the case of fallen power lines, de-energising is one way of satisfying that obligation, and safe re-energising is an essential part of that process. In that regard, the ESO has monitored the performance of entities, become aware of some instances in which practices have not met the safety requirement and issued notices in those instances. Follow-up monitoring has revealed that the organisations concerned have addressed those issues and behaviours have changed.
>
> **[Senior Counsel] found the obligation on an entity to be sufficiently wide to cover fallen power lines and all of the things necessary to deal with and repair those lines and return them to service in a safe condition. The advice highlighted that DIR is not responsible and does not have the authority under the Act to direct the manner in which entities discharge their obligations in that regard.**
>
> **On the basis of that advice it is considered that the obligations of entities are clear and do not require amendment.** [emphasis added]

4.8.7.3 Low voltage protection systems

In relation to my recommendation that DIR undertake research into LV fault protection and minimising risks from fallen LV power lines, DIR initially advised[183] that it intended to monitor existing, new and emerging technologies in the area of low voltage protection systems. DIR subsequently advised[184] as follows:

> Low voltage protection systems are a matter of significant interest throughout the industry. Under the auspices of the Energy Supply Association of Australia, the National Electricity Network Safety Steering Committee has produced a draft *National Low Voltage Electricity Network Electrical Protection Guideline* published in December 2003. That document was produced through cooperative research among the regulators of which DIR was an active participant.
>
> The objective of the guideline has been to establish a standard across the

182 By letter dated 10 February 2004.

183 By letter dated 21 December 2002.

184 By letter dated 10 February 2004.

> country at least equal to international best practice in an environment such as the Australian one. The guideline also explicitly recognises the dynamic nature of the technologies involved, and envisages that amendments will be required both in the light of those developments and of experience. It also adopts the outcomes approach of the Act.

4.8.7.4 Coronial riders

In relation to my recommendation about the eight coronial riders, DIR advised[185] as follows:

> In pursuit of this recommendation DIR wrote to Energex on 13 March 2003 requesting information about their responses to the eight riders. That letter elicited a response received on 3 April 2003 which identified each of the riders and that organisation's practices in respect of them.
>
> ESO considered that material in detail and concluded that it represented appropriate action by Energex in each case.

Coroner's Riders 1, 2 and 3 dealt with issues of vegetation management.

The Detailed Report of the Independent Panel (commonly known as the Somerville Report), which was published more than 12 months after Energex's response to DIR, concluded[186] that Energex:

- had not spent sufficient amounts in recent years on maintaining its system; and
- had not had an adequate focus on preventative maintenance such as on vegetation management and cross arm inspections.

Accordingly, the Independent Panel concluded that Energex needed to give attention to its overhead network.

The Commissioner for Electrical Safety's response in relation to this issue is contained[187] in Chapter 7 of this Report.

Coronial Rider 4 related to a public awareness campaign about the dangers of venturing outside following storms. This campaign, based on the "Snake" theme, has been running for several years and on any assessment has been a highly visible campaign.

185 By letter dated 10 February 2004.

186 Page 29 of Office of Energy, Department of Natural Resources Mines and Energy, July 2004, *Detailed report of the independent panel – electricity distribution and service delivery for the 21st century*, Queensland Government, Brisbane, Queensland.

187 See 7.1.6.2.

4.9 Case 12 – investigation completed 8 April 2004

4.9.1 Background

SG was a qualified electrical fitter / electrical mechanic. He was 28 years old. He was employed by an electrical contractor to carry out maintenance work on service lines, which are the overhead electric lines that carry low voltage electricity to residences from power poles usually located on footpaths.

SG was carrying out maintenance work at the pole end of a particular service line. There was also a co-worker at the site, who, at the same time, was carrying out work at the house end of the service line. SG was working from the basket of an Elevated Work Platform[188] (EWP).

While SG was maneuvering the basket of the EWP, his shoulders came into contact with the live low voltage (415 volts) overhead electric lines. He was fatally electrocuted. The co-worker at the site did not see the incident and there were no other witnesses, nor was there any person on the ground within physical reach of, or in close proximity to, the base controls of the EWP. No one at the site was performing the role of an observer at the time of the incident.

The suitability of the EWP that SG was using at the workplace became an issue for investigation of the incident. There was evidence[189] about the potential for possible inadvertent movements that could cause an unsafe situation to arise. The ESO issued a Safety Alert in August 1998 warning about certain control features of the EWP.

SG had obtained his qualifications seven years prior to the incident. However, the evidence was that he had not previously worked on overhead power lines, live or otherwise, or used an EWP. SG had undertaken a training course at a recognised training organisation over a period of three days during the week prior to the commencement of his employment with the electrical contractor. Part of his training involved the use of an EWP. His training did not include precision maneuvres among live overhead power lines, nor was he trained in the requirements and safety obligations contained in the Queensland Government's Guidelines for the use of EWPs. Therefore, it is highly unlikely that he was aware that, according to the Guidelines, it was his responsibility to utilise the services of a ground observer while he was aloft in the basket of the EWP.

The Queensland Government Guidelines for the use of EWPs and the Energex Guidelines make it a requirement for a ground observer to be utilised at all times while the basket of the EWP is raised from its cradle. However, it is the basket operator's role to seek the services of a ground observer. It is then the ground observer's role to assist or guide the basket operator in

188 Commonly called a "cherry picker".

189 Page 99 of Case 12.

maneuvering the EWP and to warn the basket operator of any dangerous situation including moving too close to live power lines.

Officers from the QPS, WH&S, the ESO and the electricity entity attended the incident site and commenced separate investigations.

The ESO's involvement in the investigation included one of its officers:

- inspecting the EWP at a workshop
- attending a re-enactment of the incident
- consulting with and obtaining information from Energex
- consulting with and providing information to WH&S officers
- attending a field audit at the employer's premises.

The ESO officer who managed the investigation was on secondment from Energex at the time. About 3 1/2 months after the incident, the ESO officer provided written information to the WH&S investigator.

The WH&S investigator:

- inspected the EWP at a workshop
- interviewed an officer from the employer
- consulted with and obtained information from Energex
- attended a re-enactment of the incident
- consulted with and obtained information from ESO officers
- attended a field audit at the employer's premises.

Some four months after the incident, following receipt of information from the ESO and Energex, the WH&S investigator made a written recommendation to his supervisor that no further action be taken, because a specific cause of the incident was not able to be established.

The WH&S Incident Report concluded that "the investigation did not reveal any contravention of the WH&S Act".

This recommendation was accepted by WH&S and the investigation was concluded. No proceedings were ever instigated against any person or entity for a breach of any legislation, and the time for commencement of any prosecution under the WH&S Act expired.

Seven months after the incident, the ESO officer prepared an Electrical Accident Investigation Report. The report did not analyse or consider the obligations placed upon persons by the electrical legislation or whether any such obligations had been breached.

4.9.2 The complaint

SG's father complained to us that:

- SG did not have sufficient practical experience to undertake the type of work he was required to do;

- SG was not adequately trained to operate an EWP, particularly in precision movements among live overhead electric lines;

- SG's electrical mechanic / electrical fitter licence did not qualify him to work on overhead electric lines;

- There was no on-site supervision by SG's employer when there should have been. A competent assistant and a ground observer should have been provided but no one adequately performed those functions;

- The insulating mats that SG was required to use at the workplace were unable to be accessed by him because they were locked in a box on the vehicle upon which the EWP was mounted;

- SG's employer did not fully comply with the contractual obligations it owed to Energex in that it failed to ensure that all work was performed in accordance with relevant statutory obligations and industry standards;

- SG's employer failed to provide a safe system of work for SG and contravened the legislative requirements of the WH&S Act and the Electricity Act;

- WH&S and the ESO failed to identify any breach of legislation and, because of a prevailing culture within both entities that discouraged prosecution, lost the opportunity to commence prosecution action against the employer and its directors, by allowing the time within which prosecution action could be commenced to expire;

- The ESO officer who managed the investigation had a clear conflict of interest in that he:

    - was on secondment from Energex at the time
    - sought and relied on advice received from Energex, even though the incident involved infrastructure controlled or operated by Energex
    - then provided advice to WH&S, which WH&S relied upon in deciding to take "no further action".

- The conduct of several officers employed by WH&S and the ESO needed to be investigated to determine whether those officers had:

    - breached their statutory duties
    - committed acts of "official misconduct"

- deliberately and/or recklessly provided incorrect and/or misleading advice to the relevant Ministers, Directors-General and the coroner; and

- Overall, the several investigations undertaken were severely deficient because they were:

  - fragmented and unco-ordinated
  - characterised by a lack of independent analysis
  - concluded before all available lines of inquiry were exhausted
  - not supported by written legal opinion
  - not subject to adequate internal review
  - characterised by a "blame the victim" approach
  - influenced by a desire not to institute any prosecution and based upon interpretations of legislation and guidelines that led to that result
  - not conducted in a way that considered the elements of any possible offences and what evidence was required
  - generally, not conducted in accordance with accepted investigative practice.

4.9.3 Investigation

During our investigation we:

- perused and analysed the copies of the files that had been provided to us by WH&S and the ESO;

- perused and analysed the transcript of the ten days of evidence given at the coronial inquest; and

- inspected the agencies' files at their premises.

During an inspection of the agencies' files, we located two legal opinions prepared by Crown Law. Copies of these legal opinions had not previously been provided to me. Both opinions specifically dealt with the issue of whether SG's electrical fitter / electrical mechanic licence authorised him to perform electrical work on overhead electric power lines.

I discussed this issue in my report[190] in the following way:

> Crown Law provided an opinion[191] on 29 November 1999. It stated[192]:
>
> > The issues raise competing interpretations of the relevant legislation. However, based on the information presently before me, there is a real risk that a court could come to the view that:

190 Pages 51 – 52 of Case 12.

191 The first Crown Law opinion.

192 Page 2 of Crown Law opinion dated 29 November 1999.

- [SG] was not authorised, under his electrical fitter and electrical mechanic licences, to perform the relevant type of work he was engaged in immediately before his accident occurred; and

- A linesperson licence is required to lawfully perform electrical work on overhead electric lines.

The opinion also stated that:

> If an electrical mechanic licence authorised the holder to perform electrical work on overhead electric lines there would be no need for an electric linesperson licence. Furthermore, the special mandatory qualifications required to hold an electrical linesperson licence, could be readily circumvented, to the detriment of one of the main purposes of the *Regulation*, namely, ensuring the electrical safety of electrical workers.

The first Crown Law opinion essentially supported the interpretation that had been suggested by the complainant.

My report then stated[193]:

> Upon receiving the first Crown Law opinion, several senior ESO officers met with Crown Law officers on two separate occasions during the following days and provided Crown Law with additional information and documentation. The ESO officers requested the Crown Solicitor to review the Crown Law opinion.
>
> The (then) Acting Crown Solicitor provided his advice[194] to DME on 8 February 2000.
>
> In his opinion, the Acting Crown Solicitor set out his understanding of the ESO's interpretation of the legislation as follows[195]:
>
> > I am instructed that the interpretation which has long been held by the Department and the electricity industry to be the correct interpretation of the *Act* and *Regulation* is that:
> >
> > (i) the holder of an electrical mechanic's licence may perform work on overhead electric lines depending upon their experience and competence to do the work in question, and that whether a person is experienced and competent to perform such work is a matter for their employer under s.126 of the Regulation; and
> >
> > (ii) an electrical linesperson's licence is a "lesser" type of licence to that of an electrical mechanic licence.
>
> The Acting Crown Solicitor then advised[196]:
>
> > I have perused the additional material provided to me, and although the view contended for by the Department is certainly arguable, I remain of the view, for the reasons set out in my previous advice and for the reasons that follow, there is a real risk that a court would hold that an electrical mechanic's licence does not authorise its holder to work on an overhead electric line.

193 Page 52 of Case 12.

194 The second Crown Law opinion.

195 Page 5 of the opinion of the Acting Crown Solicitor dated 8 February 2000.

196 Pages 5 - 6 of opinion of the Acting Crown Solicitor dated 8 February 2000.

The Acting Crown Solicitor reached the conclusion[197]:

> I consider that the view expressed in the earlier Crown Law advice remains valid, namely, that there is a risk that a court might take a view of the legislation which is contrary to the view held by the Department. In saying that, I am not saying that the Department is not entitled to continue to hold the view which it currently has. The Department's view is arguable, and might ultimately prevail if the issue is ever argued in court.

The Acting Crown Solicitor made the following recommendation[198]:

> **I strongly recommend that consideration should be given to clarifying the relationship between the various categories of licence-holder so that the interpretation for which the Department contends is expressed in unequivocal language**. [emphasis added]

When interviewed by my officers, ESO officers confirmed that, despite this strong recommendation, the ESO took no immediate action to clarify the meaning of the language used in the legislation.

The catalyst for legislative clarification was the recommendation of the Ministerial Review that new stand-alone electrical safety legislation be enacted, rather than any action by DIR in response to the recommendation made by the Acting Crown Solicitor.

4.9.4 Maladministration identified

Overall, I formed the view that the investigations conducted by WH&S and the ESO were inadequate.

My principal opinions were that:

4.9.4.1 Electrical Safety Office

- The ESO did not properly investigate whether the employer had an obligation to ensure that the work SG was undertaking just before the incident could be performed safely and, if so, whether the employer discharged that obligation.

- The ESO did not properly investigate whether the employer had an obligation to provide a competent assistant and, if so, whether the co-worker discharged the obligations of the competent assistant.

- The ESO did not properly investigate whether the employer had an obligation to provide a safety observer and, if so, whether the co-worker discharged the obligations of the safety observer.

197 Page 8 of the opinion of the Acting Crown Solicitor dated 8 February 2000.

198 Page 8 of the opinion of the Acting Crown Solicitor dated 8 February 2000.

- The ESO investigation placed too much emphasis on whether [SG] had met his responsibilities for his own safety and insufficient emphasis on the employer's responsibilities for SG's safety.

- The ESO should not have involved the ESO senior officer in the investigation because his association with Energex could reasonably have given rise to the perception that the ESO investigation was not conducted impartially.

- The investigation by the ESO was not coordinated with the investigation by WH&S.

- The ESO took no immediate steps, despite a strong recommendation by the Acting Crown Solicitor to do so, to initiate action to amend the legislation to clarify the relationship between the various categories of licence-holders so that the interpretation favoured by the ESO was expressed in unequivocal language.

4.9.4.2 Division of Workplace Health and Safety

- WH&S was the lead investigating agency in relation to possible breaches of the WH&S Act.

- WH&S did not properly investigate whether the employer discharged its workplace health and safety obligation.

- The recommendation to take no further action, and the decision to accept the recommendation, were inappropriate because relevant lines of inquiry had not been pursued.

- An investigative plan should have been prepared but was not.

- The WH&S investigation uncritically adopted the "findings" of other entities and failed to adequately consider potential offences from a workplace health and safety perspective.

- The WH&S investigation placed too much emphasis on whether SG had met his responsibilities for his own safety and insufficient emphasis on the employer's responsibilities for SG's safety.

- Legal advice in relation to possible prosecution action regarding the incident was not obtained when it should have been.

4.9.5 Recommendations

The principal recommendations I made were that DIR should:

- investigate why the Crown Law legal opinions were not disclosed to my office, the coroner and the complainant and advise me of the results of its investigation;

- review the investigations of the incident conducted by WH&S and the ESO and form an opinion as to whether the findings made were correct and advise me of the outcome of the review;

- establish procedures to ensure officers involved in investigations do not have potential or actual conflicts of interest in matters being investigated;

- request the Commissioner for Electrical Safety to review:

    - whether the issues of concern expressed in the Electrical Safety Alert relating to the design and operation of EWPs and their suitability for undertaking work in proximity to overhead electric lines are still valid and, if so, what action should be taken to ensure the health and safety of electrical workers using EWPs for overhead line work

    - the adequacy of current training programs for electrical workers in the operation of EWPs

    - any inconsistencies, ambiguities and duplication in the various Guidelines and Manuals discussed in my report

    - whether the *Electrical Safety Act*, the Electrical Safety Regulation or any of the Codes of Practice issued under the legislation require amendment in light of the opinions I expressed and the issues for investigation I identified in the Report; and

- Seek legal advice from the Solicitor-General about the non-disclosure of the two Crown Law opinions to the coroner.

A complete list of the opinions formed and recommendations made in my report is contained in Appendix L.

4.9.6 Response of agency

DIR accepted all of the recommendations. It agreed to appoint an experienced officer who had no prior involvement in the matter to reinvestigate the incident and ascertain why the Crown Law opinions were not provided to us. DIR also agreed to refer the various issues raised in my Report to the Commissioner for Electrical Safety.

4.9.7 Further developments

4.9.7.1 Reinvestigation of incident

In January 2005, DIR provided my office and the coroner with a report of its re-investigation of the incident. DIR's report stated:

> The department has concluded from the review that the original findings were not soundly based and the recommendation not to prosecute contained in the investigation report was clearly flawed.
> …
> If a proper comprehensive investigation had been conducted, it may well have concluded that there was sufficient evidence of a breach by the employer of Section 28 of the Workplace Health and Safety Act 1995.

4.9.7.2 Non-disclosure of Crown Law advices

In relation to my request for an investigation of the non-disclosure of the Crown Law opinions, DIR provided the following response[199]:

> All Crown Law advice was held on a central file at the DME at 61 Mary Street, Brisbane.
>
> All parties who had access to this legal advice were interviewed. No person could be identified who purposely withheld such documentation from the Ombudsman or the Coroner.
>
> The investigation revealed a poor document tracking system then in use by the ESO.

4.9.7.3 Referral of issues to Commissioner for Electrical Safety

In relation to my recommendation that DIR refer the various electrical safety issues[200] identified in my report to the Commissioner for Electrical Safety, DIR advised that the matters would be referred to the Commissioner.

The Commissioner for Electrical Safety's response in relation to these issues is contained[201] in Chapter 7 of this Report.

4.9.7.4 Solicitor-General's legal opinion

One of my recommendations was for DIR to obtain a legal opinion from the Solicitor-General about a number of issues I raised in my report. One of those issues was whether a public agency, with significant regulatory responsibilities like the ESO, had a special responsibility to assist a coronial inquest - in other words, whether the ESO had an obligation to ensure that the

199 Attachment to letter from DIR dated 8 February 2005.

200 See 4.9.5.

201 See 7.1.4.

coroner in this case was made aware of any information in the ESO's possession concerning any matter or thing relevant to the inquest.

As support for such a proposition, I referred in my report to the notion that public sector agencies should be model litigants in any proceedings and to the following opinion of the New South Wales Ombudsman contained in guidelines issued for State and local government agencies in that State[202]:

> Public sector agencies should be model citizens in the same way that government policy states that such agencies should be model litigants. These agencies exist to serve the public. The public are entitled to rely on them to do the right thing. This includes performing their functions in a responsible and transparent way.
>
> All public sector agencies and officials should perform their official functions and duties, and exercise any discretionary powers, in ways that promote or preserve the public interest.
>
> They must determine the public interest as it applies to them by reference to the purposes for which the agency has been established or the functions it is required or permitted to perform as expressed through enabling legislation or any objectives set out in government policy. Public sector agencies and officials must act in the public interest as so determined.

I also pointed out in my report that during the course of the WEP, I had seen documents in which DIR officers had requested that:

- counsel be briefed "to protect" the interests of both an officer and the department at a Coronial inquest;
- Crown Law be asked "to provide representation to protect the government's and the department's interests because of … unexpected hostile evidence" at a Coronial inquest; and
- "a way be found, with the assistance of legal advice, to avoid providing a coroner with any written material". This request was purportedly based on the belief that such material, if provided to the coroner, could potentially be used as evidence in possible civil proceedings and that the agency could therefore be perceived as "attempting to influence the justice process".

In my view, these examples suggested an inappropriate emphasis on protecting the agency's reputation and interests rather than ensuring that a coroner was in possession of all relevant information.

DIR accepted my recommendation and obtained a written legal opinion from the Solicitor-General[203], which was subsequently provided to me. The legal opinion rejected the proposition I had advanced – at least in so far as it

202 Good Conduct and Administrative Practice – Guidelines for State and Local Government – August 2003, NSW Ombudsman, Sydney.

203 Joint opinion dated 10 September 2004.

applied to DIR in the coronial inquest into SG's death. DIR summarised the advice[204] as follows:

> The Solicitor-General has identified two key issues. The first is whether a State agency has a special responsibility to assist a Coronial inquest that may extend to raising for consideration by the Coroner legal opinions, tentative or otherwise, which may be adverse to the State agency in question. Secondly, whether such special responsibility extends to waiving an otherwise valid claim for legal professional privilege to which the State agency is entitled.
>
> The legal opinion received does not support the proposition that the position of State agencies gives rise to any special responsibility of the kind contemplated by you. The Solicitor-General has indicated that this is simply because a model litigant can consistently discharge its obligations to act as an exemplar while retaining the right to rely on legitimate forensic, evidential, legal and juridical advantages it may enjoy as a party to litigation. Additionally, advice received is that the *Coroners Act 2003* does not contain any express provision having effect to abrogate the common law right of legal professional privilege.

The Solicitor-General stated[205]:

> In summary, then, the right to legal professional privilege is itself a legal expression of principle founded on the public interest in the due administration of the law. It is also a matter of public interest that the privilege be available to, and exercisable by, public bodies unless the legislature says otherwise.

DIR also advised[206] me that:

> This department seeks to be open and transparent in its dealings. It recognises its obligation to place before an enquiring body relevant facts and evidence to assist the purposes of that enquiry. However, there may be some circumstances where special issues apply. In those circumstances, discretion will be exercised based upon the legal opinion of the Solicitor-General and with appropriate reference to the authority of the enquiring body.

The overall purpose[207] of the *Electrical Safety Act* is directed at eliminating the human cost to individuals, families and the community of death, injury and destruction that can be caused by electricity.

While I agree with the Director-General's comment that there may be some circumstances where "special issues" apply, any entitlement to claim legal professional privilege should always be assessed by an agency having regard to the overall purpose of the legislation that is administered by it.

Legal professional privilege is just that - a privilege that can be waived. The fact that a public regulatory agency has an entitlement to claim privilege does

204 By letter dated 28 October 2004.

205 Page 18 of legal opinion dated 10 September 2004.

206 By letter dated 28 October 2004.

207 Section 4(1).

not of course mean, in the context of good administrative decision-making, that it should do so as a matter of course without considering where the public interest lies in any particular case.

4.9.7.5 Conflict of interest

The officer who managed the ESO investigation of the incident was on secondment from Energex. Energex controlled or operated the infrastructure. I formed an opinion that the ESO should not have involved this officer in the investigation because his association with Energex could reasonably have given rise to the perception that the ESO investigation was not conducted impartially.

I recommended that DIR establish procedures to ensure that officers involved in investigations did not have potential or actual conflicts of interest in matters being investigated.

DIR accepted this recommendation and have since adopted a policy that addresses this issue.

Chapter 5: Response of officers

5.1 Adverse comment

Section 55(2) of the *Ombudsman Act* provides that I must not make adverse comment about a person in a report unless I give that person an opportunity to make submissions about the proposed adverse comment.

Section 55(3) of the *Ombudsman Act* requires me to ensure that a "person's defence is fairly stated" in any report that I prepare if, after providing a person with an opportunity, I propose to include the adverse comment in my report.

Adverse comment is not defined in the *Ombudsman Act*. However, the phrase has been the subject of judicial interpretation and is generally interpreted to mean any comment that is critical or fault finding of a person or entity.

Section 55(3) does not oblige me to include a response in its entirety but to fairly state the person's response to the adverse comment. Nor am I obliged to include those parts of a person's submission containing material that is not relevant to the subject matter of any proposed adverse comment.

Throughout the WEP, the former Ombudsman and I prepared numerous notices of proposed adverse comment and provided these to a range of former and current DIR officers. The responses received were carefully considered. In some cases they were included in full in the reports I provided[208] to the Director-General of DIR. In other cases, where they were lengthy, a fair summary was included.

5.2 De-identification

The purposes of this Report are explained[209] in Chapter 1. It is not for the purpose of exposing any individual officer. Therefore, although each of the nine incidents has been the subject of a coronial inquest, wherever practicable in this Report, I have deleted:

- references to the names of officers or former officers and their position titles; and

- other information that could identify any officer or former officer unless the information is critical to a purpose of the Report.

Furthermore, I have not used the names of the persons who were electrocuted in order to protect the privacy of their families.

208 The reports for Cases 1 and 2 were provided to the respective D-Gs of DETIR and DME.

209 See 1.3.

5.3 The responses

A number of former and current WH&S and ESO officers responded to notices of proposed adverse comment in the nine investigation reports. All of these comments have been de-identified in this Report. Nonetheless, I have set out below a general summary of the defences contained in the submissions received and have, where appropriate, provided references to my comments on the issues raised in the defences. These comments appear in Chapters 4 and 6 of this Report.

The submissions stated that:

- officers followed normal agency practice and interpretations which, in some cases, had been in place for many years[210];
- officers did not have the requisite experience or qualifications to undertake some of the work they were allocated and they undertook the work they were directed to perform to the best of their ability[211];
- training was inadequate[212];
- there were no appropriate agency policies in place to deal with the circumstances the officers had encountered and, where policies were in place, they were inadequate[213];
- the WH&S Event and Case Management Procedure was not accorded a high priority and non-compliance with the procedure was common[214];
- officers relied upon the advice of others who they considered had expertise in certain fields[215];
- they were not readily able to access legal opinion[216];
- officers was inadequate supervision, especially in relation to investigations and whatever recommendations officers made, were just that, recommendations, and should have been reviewed by their supervisors[217];
- record keeping was not accorded a high priority[218];
- WH&S's computerised information system in place had a number of inadequacies and was not user-friendly[219];

210 See 4.9 (Case 12) and 6.2 for a discussion on investigative planning.

211 See 4.9 (Case 12) and 6.3 for a discussion on training.

212 See 4.9 (Case 12) and 6.3 for a discussion training.

213 See 4.3 (Case 3) and 6.2 for a discussion on investigative planning.

214 See 4.1 (Case 1) and 4.3 (Case 3) and 6.1 for a discussion on case management procedures.

215 See 4.4 (Case 4) and 6.4 for a discussion on access to experts.

216 See 4.4 (Case 4) and 6.4.1 for a discussion on the use of legal advice.

217 See 4.1 (Case 1) and 4.4 (Case 4) and 6.5 for a discussion on supervision.

218 See 4.1 (Case 1) and 4.2 (Case 2) and 6.7 for a discussion on record keeping.

- there was a "closure emphasis" in respect of investigations and officers' administrative conduct was affected by that emphasis[220];
- the organisational structure of WH&S impeded efficiencies[221];
- reporting relationships within regions and between regions and State office of WH&S were ill-defined and not observed[222];
- there was inconsistency of approach to WH&S regulatory functions among the regions[223];
- there was a lack of resourcing for WH&S regulatory functions[224];
- the workplace health and safety legislation was inadequate for a regulatory compliance role[225]; and
- officers from other agencies did not cooperate with WH&S officers in relation to the provision of information[226].

The following general criticisms were made of my opinions in the investigation reports on Cases 4 and 5:

- in the course of my investigation, despite the seriousness of the opinions formed, I did not seek advice from competent and informed persons by way of interview or otherwise;
- the ESO and its predecessors, never at any time had a primary accident investigation role but only a coordinating and oversight role; electricity entities were primarily responsible for electrical incident investigation[227];
- the ESO and its predecessors never had the staffing resources required for an electrical incident investigation role[228];
- Queensland's prescriptive electrical safety legislation was unworkable; illegal electrical work in Queensland was commonplace and tolerated and there was a need for comprehensive regulatory reform to permit equitable enforcement[229]; and

219 See 4.3 (Case 3) and 6.1 for a discussion on case management procedures..

220 See 4.1 (Case 1) and 4.2 (Case 2) and 4.3 (Case 3) and 4.9 (Case 12) and 6.5 for a discussion on supervision.

221 See 4.3 (Case 3) and 6.10 for a discussion on the regional model.

222 See 4.3 (Case 3) and 6.10 for a discussion on the regional model.

223 See 4.3 (Case 3) and 6.5 for a discussion on supervision.

224 See 4.1 to 4.5 (Cases 1 to 5) and 6.15 for a discussion on resourcing.

225. See 4.6 (Cases 6 and 7) and 6.8 for a discussion on the regulatory framework.

226 See 4.6 (Cases 6 and 7).

227 See 4.1 (Case 1) and 4.2 (Case 2) and 6.3 for a discussion on the role of authorised persons.

228 See 4.1 (Case 1) and 4.2 (Case 2) and 6.15 for a discussion on resourcing.

229 See 4.4 (Case 4) and 4.5 (Case 5) and 6.8 for a discussion on legislative framework.

- my opinion that regulatory inaction was indicative of a culture within the ESO of not investigating or prosecuting possible offences, related more to a result than a cause of the problem and grossly misrepresented the true situation, and it was untenable to criticise individual officers for a lack of enforcement action when the legislation itself was so defective[230].

5.4 Comment

In addition to the above, I also received a number of very positive and encouraging responses from officers in WH&S and the ESO who had received notices of proposed adverse comment. These officers were supportive of the reforms that were taking place as a consequence of the WEP and the Ministerial Review.

DIR did not dispute any of my or the former Ombudsman's opinions stated in the reports and supported the recommendations made.

230 See 6.11 for a discussion on regulatory capture.

Chapter 6: Systemic maladministration and DIR's response

In this chapter, I summarise the main instances of systemic maladministration I identified in my investigations and the action taken by DIR and the government to address that maladministration[231]. In so doing, I provide, in effect, a before and after comparison of the electrical safety system in Queensland.

As a theoretical basis for making this comparison, I have used a model developed in a project called the Better Decisions Project, which I have recently undertaken in partnership with the Department of Tourism, Fair Trading and Wine Industry Development and the Department of the Premier and Cabinet. The purpose of the project is to develop a framework that incorporates the key features of an effective administrative decision-making system – in other words, a system that promotes and supports good decision-making. The framework is intended to be of particular application to the decision-making of an agency with regulatory functions.

The components of the framework and my assessment of the decision-making framework that existed in WH&S and the ESO before my investigations are shown in the following table.

Table 1: Decision-making framework

	DIR's system
Legislation	Inadequate (multiple and overlapping) legislation
Policies and procedures	Inadequate case management procedures and failure by officers to observe those procedures
Management	Lack of effective supervision by managers of investigations and recommendations of investigators
Training and professional development	Lack of relevant investigative skills and inadequate training
Record keeping	Poor case management record keeping practices
Complaints management	Ineffective system for handling complaints from members of the public

My comparison does not deal with DIR's system in the order of the components in the table but in the order of the seriousness of the deficiencies I found in the system. The most serious deficiencies related to investigative practice issues, namely:

231 The term "maladministration" is not used in the *Ombudsman Act 2001* but is a term used commonly by Ombudsmen to describe unlawful, unreasonable, unfair or wrong decisions by a public agency.

- the standard of written policies and procedures for investigations;
- the procedures actually followed by officers;
- lack of investigative skills and expertise caused by poor recruitment practices and inadequate training; and
- inadequate supervision.

DIR has acknowledged the systemic maladministration that was identified. DIR's response is contained in Appendix M.

6.1 Case management procedures

An essential ingredient of a good regulatory framework is a quality set of procedures for the guidance of investigators. These procedures should be documented and readily available to all relevant officers, and supervisors need to be made responsible for monitoring and enforcing compliance with the procedures.

A senior officer or quality manager should be responsible for the maintenance of the procedures.

6.1.1 What we found

6.1.1.1 Workplace Health & Safety

At the relevant time, WH&S had in place investigative procedures for event and case management[232]. However, a significant recurring theme throughout the WEP was the apparent non-compliance by WH&S officers with those procedures. Our investigations also showed there had been little or no auditing or enforcement of compliance with the procedures by WH&S management. When interviewed, WH&S officers said that they were generally unaware of any consequences of non-compliance with the procedures and that there had been little information, training or promotion of them throughout WH&S.

During our investigation of Case 1, my officers interviewed a former senior WH&S manager about the procedures. He expressed the opinion that compliance with the procedures was never regarded as a priority by staff and was viewed as something created "at the whim of the Minister and Director-General" of the day to appease the Ombudsman.

Another senior WH&S manager, when interviewed during the same investigation, was clearly unaware that a quality system even existed.

232 QAIAS-PROC-1 007 and WHS P56.

The former Ombudsman discussed one of the consequences of this non-compliance in his report on Case 1:

> Perhaps the most disturbing admission made to my officers was that investigations that had been completed and earmarked for prosecution never reached that stage simply because work pressures were such that prosecution officers were unable to physically read files or act upon recommendations before the statutory twelve month time limitation for bringing action expired. When this occurred, the prosecutions were simply aborted, effectively wasting the extensive resources that had already been expended in bringing such matters up to a high evidentiary standard and ready for the institution of proceedings.

In Case 3, I formed the opinion that the WH&S investigator did not comply with the WH&S procedures, which required the WH&S investigator to carry out a number of tasks in accordance with an action strategy within defined time periods[233].

In Cases 6 and 7, I also formed the opinion that the WH&S procedures were inadequate because they did not require workplace incident reports in relation to critical incidents to be referred to an Area Prosecutions Officer for review.

6.1.1.2 Electrical Safety Office

The ESO did not have investigative procedures[234] for event and case management in place until an adequate Compliance Policy[235] was developed in November 2000. All of the cases in the WEP concerned incidents that occurred before that date. None of the ESO officers interviewed suggested that they had ever investigated an incident in the WEP in accordance with any defined investigative procedures. In fact, in responding to a Notice of Proposed Adverse Comment that had been issued in relation to Case 12, an ESO investigator conceded that there were no criteria within the ESO for the design and outcome of investigation reports.

6.1.2 What has changed

There have been a number of significant developments.

Firstly, the ESO was relocated to DIR in late February 2001.

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233 The procedure required significant events in an investigation by WH&S officers to be documented and entered at specified times on the Department's IAS (integrated automation and document management system). The significant events included:

- The entry of initial data onto IAS (immediate);
- The determination of the relevant priority and action strategy by the District Manager (immediate);
- The carrying out of an initial investigation by an Inspector (5 days);
- The preparation of an Incident Report (Report) by the Inspector (20 days);
- The forwarding of the Report to the District Manager for review (5 days);
- The review of the Report by the District Manager (5 days);
- The review of the Report by the Area Manager (5 days);
- The review of the Report by the Area Prosecutions Officer (14 days); and
- The preparation of a Breach Report for commencement of legal proceedings and approval by Area Manager (within 10 weeks of the date of the accident).

234 The October 2000 Electrical Safety Taskforce Issues Paper referred to the existence of an ESO policy document concerning prosecutions.

235 Compliance Policy, Electrical Safety Office, November 2000.

Secondly, DIR developed an electronic Compliance and Investigations System (CIS). The CIS outlines the requirements for event/case management and data entry into the system. It specifically deals with:

- issues of case management;
- timeframes for specific tasks and particular stages of the investigation process;
- case management meetings;
- prosecution decisions; and
- the role of inspectors, district managers and regional investigations managers.

The CIS is a well-constructed case management system, but like all such systems, is dependent upon quality information inputs at appropriate times for effectiveness. One of the ways DIR intends achieving this is by undertaking monthly audits of investigations.

An ongoing challenge for DIR management will be to ensure that Investigation Report Audits, described in the CIS, are conducted on a monthly basis. These audits require the regional investigations manager to:

- select approximately 10% of case reports that have not been recommended for prosecution and determine if the investigation findings are valid and decisions made in accordance with the investigation and prosecution policies;

- provide the findings of the audit to the regional manager; and

- monitor the computer system to ensure that cases for their district are completed within the required timeframes and that the status of cases on the system is correct.

Finally, DIR produced[236] an Investigation Skills Training Manual[237] which includes detailed information about the CIS.

6.2 Investigative planning

Effective investigative procedures require officers to properly plan their investigations. Investigative planning is critical to the success of any investigation. An investigative plan is the primary planning tool available to an investigator. It is essential that such a plan is prepared **before** an investigation of any complexity is commenced.

As stated[238] by the New South Wales Ombudsman:

236 March 2002.

237 The Manual is in two parts, regular and advanced.

238 *"Investigating Complaints – A Manual for Investigators"* - NSW Ombudsman 2004.

The good investigation starts with careful planning and preparation, a clear understanding of the parameters of the investigation, and with proper authority. Care and attention spent in getting it right at the outset will avoid considerable difficulties later on.

6.2.1 Purposes of investigation plan

An investigative plan is essentially a “road map” for the investigation and should set out its scope or terms of reference. It should also indicate the nature of the issues to be addressed and the investigation’s objectives so that there is a clear understanding of when the investigation will be concluded.

A good investigative plan[239] should:

- clarify what is being alleged;
- set out the terms of reference or scope of the investigation and its objectives;
- ensure that the objectives are relevant, achievable and within jurisdiction;
- set out the steps the investigation should follow to ensure that it is conducted in a methodical and professional manner;
- identify the potential avenues of inquiry;
- identify the resources required to conduct the investigation;
- identify any opportunities for people to remove, destroy or alter evidence and ways of minimising those opportunities;
- identify any potential problems investigators may encounter in making their inquiries;
- identify what, if any, redress should be provided for anyone who has suffered detriment as a result of the conduct being investigated;
- allow the investigator to stay focused on the job and alert them to any potential problems prior to encountering them;
- facilitate effective supervision, by informing supervisors of investigative strategies and timelines to be met during the investigation;
- be in a standard format that is flexible enough to be adapted for different types of investigations;

239 Chapter 6, Establishing the framework for the investigation in *Investigating Complaints – A Manual for Investigators*, NSW Ombudsman 2004.

- identify any legislation, regulation, code of conduct or standard benchmark against which evidence should be measured and compared;

- identify whether public interest disclosures have been made;

- identify the elements of any potential offence or defence; and

- canvas potential findings.

As mentioned in the above list, the investigation plan should identify the elements of any potential offences. This assists investigative planning by identifying the evidence required to substantiate or disprove those offences.

This process involves examining each word or phrase in a potential offence and determining the particular issues of fact that need to be established to properly investigate the offence.

In order to successfully prosecute an offence, it is necessary to prove each element to the appropriate standard[240]. Some elements are common to every alleged offence such as the time, date and place of the alleged offence and the identity of the person or entity alleged to have committed the offence.

Any possible statutory defences, exemptions, or excuses under the relevant legislation should also be identified and considered. These should also be broken down into their elements. Investigators should turn their mind to the evidence required to negate any defence in the course of the investigation.

6.2.2 What we found

Lack of investigative planning was a common theme of the WH&S and ESO investigations we examined in the course of the WEP. None of the investigations seemed to have been planned in any formal sense. While DIR suggested[241] that there were "generic" strategies in place when responding to notifications that "may have been taken for granted" by officers, there was little evidence that the inspectors or their supervisors had considered any of the issues that should be addressed in developing an investigation plan.

When interviewed by my officers, a majority of DIR officers failed to demonstrate an adequate understanding of basic investigative planning principles. It was apparent that investigative planning was not a tool utilised by officers or reinforced by their managers.

240 Usually the criminal standard.

241 In response to Cases 1 and 2.

6.2.3 What has changed

The concept of investigative planning is now specifically dealt with in the DIR Investigation Skills Training Manual[242]. The manual addresses all of the issues necessary for the development of an effective investigative plan.

6.3 Investigative skills and expertise

An investigation is a thorough and logical gathering of information followed by an objective assessment of that information to reach a valid conclusion.

Generally, an investigator within a regulatory agency is responsible for gathering all relevant information pertaining to a potential breach and, at the conclusion of that information gathering exercise, to report his or her findings and, if appropriate, make relevant recommendations.

Any good decision-making framework should make provision for the proper training and development of officers to ensure they have the skills and expertise to perform their functions competently.

6.3.1 Training issues

Training provided to investigators in regulatory agencies should cover the following principles and issues[243]:

- the fact that the system in which they work is one demanding internal and external[244] accountability and any decision made or action taken by them may be reviewed or questioned by other individuals and bodies;

- their principal duty is to the rule of law and the courts of Queensland;

- their primary task is to identify the truth about an alleged breach of the law and not to seek at the outset to either implicate or exonerate any person or entity. In other words, they are required to perform their tasks in an impartial, independent and objective manner and not identify personally with any party;

- they are required to conduct all investigations in a lawful and ethical manner and as expeditiously as possible;

- they are required to declare to their manager any potential personal conflict of interest immediately they become aware of it;

- facts in dispute that could be decisive or relevant to the outcome should be checked and not accepted at face value;

242 Chapter 14.

243 List compiled from *Investigating Complaints – A Manual for Investigators*, NSW Ombudsman 2004; and *Facing The Facts* A Crime and Misconduct Commission Guide for dealing with suspected misconduct in Queensland Public Sector Agencies 2004.

244 For example, Crime and Misconduct Commission, Queensland Audit Office, Queensland Ombudsman.

- they are not mediators, conciliators or advisors - the procedures used in these processes are generally inappropriate to the investigation of a statutory offence;

- they are required to genuinely listen to both sides and give thorough and rational consideration to what is being said;

- they should not form an opinion until all of the facts have been gathered;

- they should never offer opinions or advice to any person while conducting an investigation; and

- the investigation report that they prepare should be a stand-alone document upon which management is able to make proper and informed decisions.

6.3.2 What we found

In Cases 1 and 2 of the WEP, the former Ombudsman expressed concerns about the investigative skills and expertise of the DIR staff who had been interviewed. He stated[245]:

> Concerns were expressed that WH&S is apparently in the habit of recruiting, as Inspectors, persons who hold technical trade qualifications, such as electricians, or other like technical experience.
>
> I have not conducted any independent investigation into whether this practice exists, whether it is appropriate and what impact it may or may not have had on the WH&S investigation of this matter.
>
> However, I would say that the conduct of investigations is a field of expertise in itself, and includes the appropriate sourcing, use and management of witnesses, including technical experts, to develop a brief of evidence for prosecution. My experience suggests that persons with trade qualifications do not necessarily make the best investigators without the benefit of additional training.
>
> In other words, if such a recruitment practice exists, it would be a cause for concern and would require further review.

One of the recommendations made by the former Ombudsman in Cases 1 and 2 was that, as part of the management and strategic review of WH&S and the ESO, the Ministerial Reviewer assess:

> the competency of existing staff employed in compliance/ enforcement roles within WH&S and the ESO be assessed to determine whether all officers possess the appropriate skills, knowledge and abilities to perform electrical investigations and any identified deficiencies should be addressed by training and professional development.

245 Page 34 of Case 1.

In the final report of the Ministerial Review of the Division of WH&S and the ESO, the Ministerial Reviewer stated[246]:

> The system of recruitment and selection for inspectors has changed over the years, in direct response to the changing nature of the inspector's work and the availability of health and safety graduates from universities. In the past, industry experience and a trade background were highly regarded with a view that the more technical health and safety aspects could be obtained on the job. The offering of tertiary courses in occupational health and safety has provided new recruitment pools with a far greater emphasis on technical knowledge with applicants possessing little to no industry training or background. The shift in recruitment strategies and skills has also reflected the change in the legislative framework from industry-specific "prescriptive" style legislation toward a more "self regulatory" Roben's style framework as embodied in the 1995 Workplace Health and Safety Act.
>
> The difficulty this shift has created is that there now appears to be "two schools" of inspectors. The first is typically male, older, and with a trade background with many years of industry experience. The second group are generally younger, both male and female, tertiary qualified and endowed with excellent written and interpersonal skills but limited industry knowledge and experience. The marrying of both cultures will require a more intentional approach than that which exists at the moment. The NSW model of having all new recruits completing a 17-week Diploma within their first year of service, irrespective of background or experience, may provide some insight into managing this issue. What is clear is the increase in demand on the inspectorate in terms of knowledge and skills required to do the job.
>
> Ninety one percent of survey respondents agreed there was an "increasing complexity of inspectorial roles and functions". The respondents noted that there had been a growing list of standards and codes across all industries as well as greater focus and attention on the "Enforcement Framework". The respondents also noted less reliance on the core disciplines (Construction, Industrial, Health, Hygiene, Ergonomics, Diving and Rural) with each inspector required to be more mobile in handling issues and performing inspections across the disciplines. The respondents thought this mobility had the potential to erode their specialist skills and replace them with more generalist skills. This trend was not a positive feature of the shift in roles identified by the inspectors.

The issue of training and professional development received a great deal of attention during the Ministerial Review of WH&S and the ESO. The Ministerial Reviewer noted[247] in his final report that "although a whole range of training packages is available and delivered throughout the year, availability, geography and budget play key roles in determining how much training will be provided and who actually receives it". The Ministerial Reviewer also noted[248] that "most of the inspectors were extremely critical of the way training budgets were always the first to be cut or abandoned when regions were running over budget".

246 Pages 28 – 29.

247 Page 29.

248 Page 29.

Many WH&S and ESO officers complained when interviewed by my officers that they received little relevant training to undertake their core responsibilities. Several stated that they had never received any formal investigative training, despite the fact that they were required to read and interpret legislation, interview witnesses, prepare briefs of evidence, prepare court documents and give evidence on behalf of their department before a court, tribunal or coronial inquest.

The Ministerial Reviewer stated[249] in his final report that "65% of respondents believed that they received insufficient training to function effectively as an inspector".

6.3.3 What has changed

There have been a number of significant developments in relation to training and knowledge development.

Firstly, a comprehensive Investigation Skills Training Manual was produced. The manual is well structured and provides a valuable tool for inspectors.

Secondly, an investigation skills training program was developed in conjunction with the manual and DIR investigators participated in formal investigative training.

DIR explained[250] the changes that had taken place in the following way:

> One of the major findings of the Ombudsman's reports and the Management Reviews was the reduced capacity of WH&S and ESO to conduct comprehensive investigations and inspectors' lack of confidence to investigate complex and high profile cases. In response, DIR developed a competency development regime in the discipline of conducting investigations, aimed at achieving credibility through professional, accountable and effective investigations. This regime consists of three weeks of intensive investigation skills training.
>
> Two-week investigations course
> A two-week Investigation Skills course has been developed for Inspectors across the State. Participation in this course is mandatory for both new and existing inspectors, irrespective of their previous training.
>
> The aim of the course is for Inspectors to develop the competencies required to investigate cases. The course supplements inspectors' technical knowledge and concentrates on the practical and process skills relating to incident investigation and auditing. The competencies developed in the course articulate with the Diploma in Government (Workplace Inspection).
>
> All inspectors from WH&S and ESO have successfully completed the course. This course is recognised within Queensland and other Australian

249 Page 29.

250 Appendix M.

occupational health and safety jurisdictions as an excellent, high quality, investigations course.

Advanced investigations skills course
This course builds upon the initial two-week training block. It is targeted at Investigators and other staff expected to conduct more complex investigations. This one-week program focuses primarily on the development of competencies required for magistrate's court and coronial court involvement.

In November 2000, investigative staff within WHSQ received specialised training regarding interpersonal communication with grieving families, friends and associates of persons who have died or been seriously injured in the workplace. This training now forms an integral component of the advanced investigations training developed by WHSQ.

Auditing course
In 2002 ESO inspectors completed an International Standards Organisation (ISO) 9001 auditing course. This provided the inspectorate with the necessary skills and knowledge to conduct audits on the target areas of high voltage and hazardous areas as well as electrical contractor systems. The ISO training also qualifies ESO inspectors to assess accredited auditors of these target areas against specified performance criteria to ascertain levels of compliance and effectiveness.

The training regime and the manuals have addressed major deficiencies in the previous system.

An ongoing challenge for DIR will be to ensure that training levels are maintained for all officers.

6.4 Access to experts

6.4.1 Use of legal advice

It is incumbent on public agencies to seek legal advice in appropriate cases, for example, to clarify uncertainty as to the agency's legal rights, obligations or liabilities.

As a general proposition, where legal advice is obtained by an agency concerning a question of law, the agency should act in accordance with that advice, in so far as it is consistent with the public interest.

6.4.1.1 What we found

On numerous occasions throughout the WEP, it was apparent that WH&S and the ESO had either failed to obtain legal advice when they should have done so or failed to follow the legal advice they had obtained. For example:

- WH&S failed to obtain legal advice on the meaning of the term "workplace" in the WH&S Act[251] even though the concept of a "workplace" was a significant jurisdictional issue;

- WH&S decided that AK[252] was an independent contractor rather than a worker despite having obtained legal advice to conduct further inquiries about the nature of the employment relationship that existed which was relevant to the obligations owed to AK;

- The ESO failed to obtain legal advice about the meaning of the term "electrical work" under the *Electricity Act*[253] even though the interpretation of the term was determinative of how the ESO would respond to incidents; and

- The ESO failed to act upon legal advice that it take steps to clarify what the various types of licences for electrical workers entitled those workers to do[254].

6.4.1.2 What has changed

A Legal and Prosecutions Services Unit (LPSU) was established within DIR. The Ministerial Reviewer identified a number of shortcomings with the LPSU during his review. He convened a workshop to address these issues and stated[255] in his final report that:

> The investigation and prosecution workshop concluded that the best investigation process required a specialist team of investigators under the leadership of a case manager. The specific nature of the case and the context of the incident are critical factors in determining the exact makeup of the investigation team. Technical assistance in the form of specialist skills (engineering and electrical) may be required depending on the circumstances. **The provision of a Legal Officer to become involved in the investigation process as soon as possible after the incident was also identified as a key feature in any "best practice" model.** [emphasis added] The proposals referred to above have all been considered in the development of a more streamlined investigation and prosecution process with direct-line management accountability to State Office.
>
> The new process consists of three stages. The first stage involves the notification of the Priority One incident to the Assistant Regional Director (Workplace Health and Safety) who in turn appoints the Investigations and Prosecutions Case Manager, arranges for the District Manager to appoint one to two inspectors and a technical advisor where necessary. **The Assistant Regional Director is responsible for contacting the Director of Prosecutions who will nominate a Legal Officer to join the investigation team.** [emphasis added] The Investigation and Prosecution Case Manager essentially will become the leader of the investigation team.

251 Cases 8 – 11.

252 The worker in Case 2.

253 Case 3.

254 Case 12.

255 Pages 42 – 43.

> The model outlined below acknowledges a new category of inspector known as a "Specialist Investigator". The creation of this position is in response to the direct criticism from the Ombudsman regarding the lack of specialist investigation training or acknowledgement that this type of work requires specialist skills and recognition. The role of Specialist Investigator should only be conferred on those staff who have undergone advanced investigation training and been selected through a rigorous selection process. The "other inspector" role is to assist the investigation team and be mentored in the investigation process.
>
> The second stage of the investigation process concerns the investigation itself and the preparation of an investigation report. The Case Manager is responsible for driving the investigation and ensuring all of the relevant aspects of the case are covered and examined within strict time frames. **The Legal Officer, having already been appointed to the team, will provide legal advice and guidance but will not be in charge of the investigation.** [emphasis added] If any conflict arises between the Case Manager and the Legal Officer in terms of the investigation, then the matter shall be referred to the Director of Prosecutions for determination. When the investigation report is completed, a copy shall be furnished to the Assistant Regional Director for information purposes only and the Director of Prosecutions will be responsible for deciding what further action is required.
>
> If the Director of Prosecutions decides to lay a complaint, the matter is referred back to the Case Manager for action. A guilty plea by the defendant will be handled by the Case Manager, with a not guilty plea being referred back to the Director of Prosecutions for determination by the Legal Unit.

The Ministerial Reviewer recommended that a Director of Prosecutions be appointed to lead the LPSU. That appointment has since been made.

DIR's Investigation Skills Training Manual also specifically deals with the role of legal officers in case conferences[256].

An ongoing challenge for DIR will be to ensure that the LPSU is adequately resourced and maintained.

6.4.2 Issues relating to use of other experts

Our investigations identified several issues relating to access to and the use of technical experts by both WH&S and the ESO.

6.4.2.1 What we found

I formed the opinion that DIR's practice of utilising its investigators to provide technical and/or expert evidence at coronial inquests or tribunals was inappropriate.

256 Page 245.

In Case 4, I criticised the fact that DIR had put forward the inspector who investigated the incident as a technical expert in the coronial inquest. I noted in my report that a similar thing had occurred in Case 1. I stated[257]:

> In [Case 1] the same Inspector who investigated this incident was required to give evidence at the inquest into the death of NS about technical aspects of safety switches[258].
>
> The opinion he offered was significantly at odds with that already provided by experts from Energex and the ESO and his evidence was attacked on that basis. His misinformed opinion about safety switches undermined the weight of the rest of his evidence[259].
>
> Therefore, within the context of this investigation [i.e. Case 4], while I am not troubled by the accuracy of any factual information in the Inspector's prosecution report, the fact that he was put in the position of having to provide evidence, again, in a dual capacity, is concerning. In my opinion, the necessity for a WH&S inspector to provide expert opinion in any case he/she has investigated should be avoided because any challenge to an inspector's expert evidence is likely to adversely affect the credibility of his/her evidence about the general investigation.
>
> It is likely this problem would have occurred in this case, had the prosecution proceeded, particularly as a protracted debate ensued between the Inspector and the WH&S Senior Principal Adviser Technology (SPA) about a range of issues.

In my investigation reports on Cases 4 and 9 to 11, I refer to another problem with the ESO's approach to the use of experts. I noted that the ESO had advised the coroners, without any qualification, that particular employees of electrical entities would be "an appropriate witness to be called to any inquest" into an incident, even though their employer controlled or operated the infrastructure involved in the incident. In relation to this issue I stated in my report on Cases 9 to 11[260]:

> The Energex investigator was clearly a relevant witness, but the ESO's endorsement of him as "an appropriate witness" suggests he was being put forward by the ESO as appropriate in the sense of being an independent witness. He was not independent because of his connection with Energex. Such advice should never have been sent to the Coroner without some qualification.

Similarly, in Case 4, I stated[261]:

> The ESO placed full reliance on the SEQEB internal investigation and sent letters to the Queensland Police Commissioner and the Coroner endorsing these findings and advising that the SEQEB internal investigator would be "an appropriate person" to call as a witness in any proceedings.

257 Page 25 of Case 4.

258 Residual currency devices (RCD).

259 The Inspector's superiors also later advised that they did not concur with his opinion.

260 Page 47.

261 Page 85.

In the same case I highlighted[262] a further problem with the ESO's use of experts, namely, that:

> no effort was made by the ESO to establish whether the SEQEB internal investigator was suitably qualified or experienced to conduct the investigation.

As a result, when the SEQEB investigator was called to give evidence at the inquest, he was unable to answer many questions he was asked of a technical nature.

I also recommended in Case 4 that DIR establish and maintain a central register of all internal persons who were qualified to provide technical assistance and expert advice within the investigation process and details of any external experts who may have been assessed during previous investigations.

6.4.2.2 What has changed

There have been significant improvements in this area.

The DIR Investigation Skills Training Manual comprehensively addresses[263] the use of experts. The manual points out that the role of the expert and investigator during an investigation are different. It correctly states[264] that "the expert should be providing an opinion based on the area of expertise requested by the inspector and facts of the case". The manual also provides[265] that:

> Generally, no one person has all the skills and knowledge to draw the investigation to a successful conclusion. An approach where the investigator relies on expert opinion is needed. The process below should be followed to determine what assistance is required.
>
> 1. Following assessment of the incident, the inspector and the Regional Investigations Manager determine what specialist assistance is required. Specialist assistance may come from within the organisation, or outside, or both. In a major investigation it is good practice to draw upon the specialised knowledge, skills, experience, training, or qualifications in a particular matter that a specialist assistant may provide. This is especially important because primary evidence, such as that provided by specialist assistance (e.g. engineers, scientific officers), may be rigorously tested under cross-examination in Court.
>
> 2. The Regional Investigations Manager will organise relevant resources and arrange for appropriate specialists to attend.
>
> 3. The specialist should attend the site as soon as possible.

262 Page 85.

263 Chapter 14 – Investigating incidents.

264 Page 242.

265 Page 240.

4. The early involvement of the Regional Investigations Manager / Legal Officer may pre-empt some of the legal difficulties encountered in these complex matters.

6.5 Supervision

An appropriate supervisory structure is an important component of any good decision-making system. A best practice investigative process for a regulatory agency generally employs a multi-tiered approach to decision-making. Officers at each level are required to bring a different perspective to the issues in question and each officer is expected to make an important contribution to the overall process.

6.5.1 What we found

All cases in the WEP demonstrated some instances where managers appeared to have merely adopted an officer's opinion without critical analysis or value adding. On these occasions, there was no evidence that supervisors had undertaken any objective assessment of information provided to them or sought further clarification of critical issues. Typically, the only notations made on written reports by managers were brief comments like "noted" or "agreed". On some occasions, there was no evidence at all that a manager had actually endorsed the opinion or recommendation made by an officer.

By way of example, in Cases 6 and 7 my report stated[266]:

> The inspector had completed his investigation of the incident by 25 May 1999. He prepared a Workplace Incident Report that included Summary Findings and various appendices. The covering letter to his Assistant Regional Director (ARD) dated 24 May 1999 stated as follows:
>
> > "The attached incident report is forwarded for your attention.
> >
> > Although there may be a breach of the Workplace Health and Safety Act it is considered unlikely that sufficient evidence to support a successful prosecution could be gathered. Therefore, no further action is recommended."
>
> On 25 May 1999, the District Manager endorsed his support of the inspector's recommendation. He signed and marked the report **"Forwarded - recommendation supported"**. [emphasis added]
> On 10 June 1999, the Assistant Regional Director (ARD) endorsed the report "**noted and accepted**". [emphasis added]
>
> No prosecution action was taken against either of the employers or the principal contractor. Any action is now statute barred.

In these cases, no explanation appeared within the WH&S file indicating the basis on which the investigator had reached his conclusion or how both the District Manager and the Assistant Regional Director came to a similar view.

266 Page 45.

When interviewed, some officers suggested that their managers had less investigative experience than they had and that their managers had relied upon the investigators' opinions because of their technical or trade background. The lack of investigative expertise of these officers and their managers' ready acceptance of their recommendations led to the investigations being concluded prematurely before all reasonable and obvious avenues of inquiry had been explored.

Some officers whom my officers interviewed said that generally, they were given as much credit for closing a file and conducting a "timely investigation" as they were for undertaking a detailed investigation of an incident with a view to commencing a prosecution. Many complainants alleged that this emphasis on closing files was driven by management who adopted a "blame the victim" approach that utilised and repeated a number of standard phrases without providing sound reasons or referring to relevant legislation to support their decisions.

Our investigation showed that WH&S officers used a number of common phrases to justify the termination of investigations and close files, for example:

- the evidence died with the worker;
- the incident was due to circumstances over which there was no control;
- there was likely operator error; and
- it is considered unlikely that sufficient evidence to support a successful prosecution could be gathered.

However, when each of these reasons was explored with the officers and their managers, there was generally an inability to specifically explain in reference to particular incidents:

- what evidence died with the worker;
- how the incident could be considered to be due to circumstances over which there was no control in situations where an employer had an obligation to ensure the workplace health and safety of an employee;
- why the issue of training was not relevant to a finding of likely operator error; and
- what investigative options had been considered before concluding that it was unlikely that sufficient evidence could be gathered to support a successful prosecution.

6.5.2 What has changed

DIR has undergone significant organisational restructure.

The Ministerial Reviewer discussed this issue in considerable detail in Chapter 3 of his final report. In the executive summary he stated:

> The main issues considered the balance between the centralising of certain key services with the desire to provide decentralised customer service to the major stakeholders located in the regions. This balance proved to be an elusive concept with the recognition that some structural reforms were required to ensure greater consistency and accountability throughout [WH&S]. The centralisation of direct-line management accountability and the allocation of a separate health and safety budget were identified as critical platforms in re-establishing a consistent and professional health and safety service within a workable structure.

DIR has stated[267] that these changes have resulted in:

- simplified reporting relationships;
- greater accountability for each level of management;
- greater emphasis on the delivery of services by introducing "direct line" management responsibilities between State Office and the Regions;
- provision of discrete budget allocations and controls to regions; and
- the establishment of the LPSU[268] that provides legal services and support to both WH&S and the ESO on investigations and prosecutions and has direct line reporting to the General Manager of WH&S.

DIR's Investigation Skills Training Manual also reinforces[269] the point that:

> The Division maintains – and operates within – a multi-tiered decision-making process of prosecution. There are several levels at which the decision to prosecute may be made, and because each level has a different perspective on the matter under investigation, each has an important part to play in the inter-layered series of processes. These levels are:
>
> - Inspector;
> - District Manager;
> - Regional Investigations Manager; and
> - Director – Legal Unit.

The manual goes on to outline the respective responsibilities of each of these officers and, in so doing, provides an effective supervisory structure.

267 Appendix M.

268 Legal and Prosecutions Services Unit.

269 Page 259.

6.6 Role of the regulator

6.6.1 Electricity Act 1994

At the relevant time, s.62 of the *Electricity Act* provided that "the chief executive[270] of the department is the regulator". In practice, most of the electrical safety regulatory functions were delegated[271] to officers of the ESO.

The regulator's functions were described in s.63 of the *Electricity Act* and included obligations "to ensure the safety requirements under this Act are complied with" and "to monitor compliance with this Act".

The *Electricity Act* required that all electrical incidents be reported[272] to the regulator.

Part 10 of the *Electricity Act* dealt with "authorised persons". Section 71(1) of the *Electricity Act* provided that the regulator could appoint officers and employees of the public service and employees of electricity entities as authorised persons. The only description of an "authorised person" in the *Electricity Act*, was provided in s.71(2), which stated that they were persons who the regulator considered had "the necessary expertise or experience".

Under Parts 1 and 2 of Chapter 7 of the *Electricity Act*[273], authorised persons were given powers to investigate offences.

Section 171(1) of the *Electricity Act* provided that on receiving a report of an incident, an electricity entity must ensure an authorised person immediately investigated the incident. Subsection (2) then required the electricity entity to provide that report to the regulator.

On 22 February 1995, eight persons employed by the predecessor to the ESO, namely the Office of the Electricity Regulator, were appointed as "Authorised Persons" pursuant to Part 10, Chapter 2 of the *Electricity Act* to exercise **all of the powers** [emphasis added] set out in Chapter 7 of that Act.

At the relevant time, Chapter 7 of the *Electricity Act* conferred upon authorised persons a range of general powers to investigate offences, including:

- general authority to conduct investigations;
- ability to obtain search warrants;
- seizure of certain evidence without warrant;
- special powers of entry to investigate electrical accidents;

270 The D-G of DME.

271 Section 64 of the Electricity Act.

272 Sections 167 - 171.

273 Sections 144 - 165 inclusive.

- special powers of entry to investigate electrical articles;
- requirement of persons to provide their name and address; and
- requirement of persons to produce documents.

The October 2000 Electrical Safety Taskforce Issues Paper stated[274] that the ESO had "similar responsibilities" to that of WH&S. The Paper also stated[275] that the ESO was "required to investigate, assess the situation and prosecute when it considers it necessary".

The Paper also referred[276] to the existence of an ESO "internal policy document" concerning prosecutions that defined breaches as either trivial, non-serious or serious.

6.6.2 Regulatory compliance role

The various incidents referred to in Cases 1 to 12 of the WEP occurred between 1995 and 1999. During that period, the ESO was situated within DME, a regulatory agency.

A regulatory agency is one that has, as one of its responsibilities, a legislative obligation to enforce a statutory scheme. Discharging this role can involve the use of a wide range of methodologies. However, it is generally accepted that a regulatory agency should promote voluntary compliance with legislation administered by it as well as take enforcement action to deter non-compliance when appropriate.

The investigation of an incident is a key element of the compliance function. Investigations are undertaken for a variety of reasons, including to:

- determine the cause of an incident or event;
- encourage compliance with legislation;
- gather evidence capable of leading to prosecution by the regulatory agency;
- ensure remedial action is taken to reduce risk to the public from breaches; and/or
- act as a deterrent.

Most regulatory authorities have a variety of enforcement options[277] available to them. It is good practice for a regulatory agency to publish guidelines for

274 Page 21.

275 Page 21.

276 Page 22.

277 Sometimes presented in a format called an enforcement pyramid showing the respective resources allocated to each option.

enforcement options, usually known as a "compliance policy". Such options are usually ranked in an escalating scale and might include:

- issuing a warning for minor or first time breaches;
- issuing an infringement notice or other statutory notice requiring compliance;
- revoking an existing licence, grant, privilege/right; or
- taking prosecution action.

6.6.3 What we found

Our investigations showed that the ESO did not properly interpret or discharge its regulatory compliance role. Put simply, that role required the ESO to take prosecution action in appropriate cases.

The Final Report of the Ministerial Review of the ESO supported my conclusion and described this failure as a systemic and cultural issue within the organisation[278]:

> Perhaps the single greatest weakness identified by the review team was the general reluctance by the ESO to accept the critical findings by the Ombudsman in relation to their almost complete failure to investigate and prosecute for breaches under their legislation. **A brief examination of the record of prosecutions over the last 5 years reveals that only 25 prosecutions were mounted during this time with 24 of them relating to licensing issues. Not one prosecution was initiated for a health and safety breach and yet we know that many breaches and non-compliance issues are reported to the ESO by Authorised Persons every day.** [emphasis added]
>
> [Table 3] shows that the average fine collected over this period was $544 for licensing breaches and $400 for the other breach. This amount would not come anywhere near the real cost of having pursued this breach in the first place. The final column notes the average cost that was collected through this process. The figure is so low that no comment needs to be made.
>
> **Table 3: ESO prosecutions last 5 years**

Type of Breach 1995-2000	No. of breaches	Average fine imposed	Average costs collected
Licensing issues	24	$544.00	$48.00
Illegally disconnecting power	1	$400.00	$57.00

> While the review team recognise that the record of prosecutions is only one measure, the table above demonstrates far more systemic issues associated with this issue. The only breach that received any attention was in relation to licensing issues which of itself probably provides further insight into this issue.

278 Pages 35 – 36.

The Final Report of the Ministerial Review of the ESO also stated[279]:

> While the Electrical Safety Office may have been given the legislative responsibility to investigate and prosecute breaches, this role has not sat comfortably with the office. The Ombudsman was particularly critical of the almost complete neglect of the understanding or fulfilment of this role. While there may be many reasons for the reluctance of the ESO to perform this role, **the reality is that Queensland has been without an effective electrical safety regulator for a number of years with the fatality and injury rates to show**. [emphasis added]

A number of explanations were offered by ESO management and former and current officers for this position.

The former Ombudsman first identified this issue in Case 1 of the WEP. He raised his concerns with the (then) Acting Director-General of DME who suggested that it was the responsibility of the QPS to investigate electrical deaths and inform the coroner of their findings. The Acting Director-General stated[280] that:

> They [the Police] are equipped with the resources, powers and have the expertise to carry out investigations and obtain statements from witnesses and others.
>
> It has never been the practice for either authorised persons in the electricity supply industry, or officers of this Department to carry out autonomous investigations into electrocution cases for which the Police Service is accountable.

This approach was confirmed[281] by another senior ESO officer when interviewed. He advised that as far as he was aware, the ESO had only ever provided technical support for WH&S, the QPS and the coroner in relation to electrical fatalities in the workplace. Independent investigations were not undertaken.

In response to a Notice of Proposed Adverse Comment I provided to another former senior ESO officer while investigating Case 5 of the WEP, that former senior officer stated[282] that the ESO and its predecessors "**never at any time had a primary accident investigation role**" and that it "**exercised only a co-ordinating and oversight role with electricity supply entities being primarily responsible for electrical accidents investigation**". He stated that to his knowledge, the ESO and its predecessors never "**had the staffing resources required for an electrical accident investigation role**". [emphasis added]

279 Page 11.

280 Page 41 of Case 1.

281 Case 1.

282 Pages 54 – 55.

He also stated that:

- Queensland's prescriptive electrical safety legislation at the time was "**unworkable**";
- "**illegal electrical work in Queensland**" was "**common place and tolerated**"; and
- there was a need for "**comprehensive regulatory reform to permit equitable enforcement"**. [emphasis added]

Essentially, the position of the ESO was that it did not have a primary or initial incident investigation role following notification of an electrical incident. Current and former management claimed that the *Electricity Act* gave this role to authorised persons employed by the electricity entities.

However, investigation is only one aspect of the compliance role. No adequate explanation was given for the ESO's failure to take enforcement action in appropriate cases when investigations had been completed by authorised persons. As previously stated, officers have suggested a number of reasons including a lack of resources and unworkable electrical legislation.

A suitable compliance policy was developed and put in place by November 2000. There appears to be no good reason why such a policy could not have been implemented much earlier.

As well, some of the public information that was being produced by DME at this time conveyed a different impression to that which was expressed to my officers during the WEP.

For example, the 1996-97 DME Annual Report stated that the Safety and Health Division sought to improve safety and health standards by "undertaking inspections, audits and investigations". The same report said that 10 fatal accidents occurred and "were investigated".

In the 1997-98 Annual Report, it was reported that:

> The Electrical Safety Office is primarily accountable for ensuring compliance by electrical entities and electrical contractors, workers, manufacturers and suppliers with the electrical safety and licensing legislation provisions of the Electricity Act 1994, Electricity Regulation 1994 and Electricity (Electrical Articles) Regulation 1994. It is responsible for ensuring the electrical safety of the community and delivers a wide range of regulatory, advisory and support services to both industry and the community.

In Case 4 of the WEP, another ESO Senior Officer, in responding to a Notice of Proposed Adverse Comment, described how the ESO operated at the relevant time[283]:

283 Pages 94 – 95.

I accept the comments and criticisms of my response in relation to this matter. I sincerely regret the obvious shortcomings of the investigation. As you would be aware these issues identified are currently being addressed by the Department of Industrial Relations. While I do not disagree with your findings, and accept responsibility for my role in this tragedy, I believe that the issues are best seen within the context of the organisation I was a part of. In particular, a review of the focus and strategy of the Electrical Safety Office (ESO) would help clarify some of the more contentious issues regarding my actions.

I commenced employment with the ESO in [details deleted]. At no stage was my role ever couched in terms of investigation and enforcement. My job as [position title] was to facilitate safety improvements. This involved identifying shortcomings with safety standards and work procedures within an environment of "no blame" and facilitating improvements within the electrical industry and the broader community.

The philosophy and culture of the ESO is best described in our own strategic plan of the time (1994) which stated:

> "We aim to minimize electrical accidents in the community by providing public education and safe power supply systems and by ensuring competent electrical contractors and workers".

I note in particular the comments made by [name deleted] quoted in your preliminary report in section 7.7.1 where he states:

> "The whole focus of the Department was to gather statistics, to analyse them and to prepare programs to improve electrical safety - that was the whole focus. It wasn't to find if it could blame somebody, if it could prosecute somebody. It has never been set up that way".

While not in any way defending those comments, they truly reflect my understanding of the role that the ESO was supposed to play. It was a "no blame" culture where the parties are encouraged to communicate openly to promote electrical safety.

The function and role of the ESO was to assist and encourage all of the stakeholders within the electrical industry (including consumers) to use and work safely with electricity. While an investigative function was included within my job, the entire purpose of such a function was to assist in injury prevention strategies and advice without any thought given to enforcement or prosecution. We adopted the "no blame" approach so that issues would be openly raised and addressed without any thought of punitive action or legal consequences.

My role and that of the ESO was not seen as one that had any significant enforcement capacity or role. The ESO relied on other parties to conduct investigations and we only provided technical input and usually upon request. There was never any intention of investigating incidents for the purpose of prosecution. **The ESO openly accepted investigative reports provided by the electrical entities themselves without any thought given to the potential conflict of interest such a response might engender**. [emphasis added] While this response may seem completely inadequate, it accurately reflects the operational activities of the ESO. The ESO only wanted to know

> what happened in an electrical event so that it could inform the industry and the community to prevent any recurrence.

The role of authorised persons, and the total reliance placed upon their reports by the ESO, were significant issues during the early stages of the WEP[284]. One concern identified by the former Ombudsman related to the effect of s.120(3) of the *Electricity Act*, which provided that an electricity entity was not required to provide the regulator with information that "might tend to incriminate the entity". Authorised persons employed by electricity entities commonly investigated incidents involving infrastructure controlled or operated by their employers[285].

The issue was later addressed by both the Electrical Safety Taskforce and the Ministerial Reviewer.

In the Final Report of the Ministerial Review of the ESO, the Ministerial Reviewer stated[286]:

> The role and function of "authorised persons" has come under heavy scrutiny since the release of the two Ombudsman's reports into electrical deaths. The bulk of the criticisms relate to the perception (and reality in some cases) that the authorised person is often exposed to the potential conflict of interest associated with being asked to investigate electrical incidents and submit investigation reports to the regulator, in relation to incidents concerning the authorised persons' own employer.
> …
>
> In accordance with the provisions of the Electricity Act, an electricity entity is required to investigate the cause of an electrical accident and report the accident and the findings to the regulator. This function is carried out by the entity using its authorised persons, employed by the entity to investigate and prepare the report. The use of authorised persons in this manner creates a totally untenable situation whenever the investigation concerns any aspect of electricity supply or distribution. The employers of the authorised persons commission the report, and are responsible for the employment of the authorised person whose role is to independently investigate the cause and circumstances leading up to the incident. Until recently there has been on a number of occasions where the ESO has relied entirely on the reports of the distributor's own authorised person in assisting their investigation.
>
> This system of investigation can be jeopardised as there is an ability following an investigation for an electricity entity to refuse to pass the report to the ESO. This action would be consistent with section 120(3) of the Electricity Act. The relevant section acknowledges that incident investigation reports do not have to be furnished to the ESO if the information would incriminate the entity. This provision contradicts section 171(2) of the Electricity Act that requires the electricity entity to provide the Electrical Safety Office with the report within 7 days of receiving it.

284 In Case 2, the former Ombudsman formed an opinion that the ESO's complete reliance upon authorised persons employed by an electricity entity to investigate incidents and prepare a report for it was a practice requiring review.

285 Cases 3, 4 and 12.

286 Pages 30 – 31.

> Another issue that has contributed to this problem has been the practice of the ESO to generally rely on the furnished reports provided by the authorised persons rather than conduct their own investigation. The reliance upon the authorised person to undertake incident investigations on behalf of the ESO has been severely criticised by the Ombudsman. **While it may be argued that the ESO was not set up to carry out investigations, it is clearly an intention of the legislation and has simply been ignored or overlooked for many years.** [emphasis added] The legislative role is quite clear and strikes at the heart of the notion of "independence" as noted in section 3 of this report. The reliance upon authorised persons to conduct incident investigations has ceased. The review team supports this action.

6.6.4 What has changed

There have been a number of significant reforms.

The investigation and enforcement framework that existed at the time of the WEP investigations has been abolished.

As previously stated, the ESO was relocated to DIR in late February 2001. Accordingly, there is now a single approach to the investigation of all electrical incidents.

Stand-alone electrical safety legislation, namely the *Electrical Safety Act,* has been enacted. This legislation introduced a raft of reforms including:

- the imposition of clearly defined obligations on a wide range of persons for electrical safety;
- the recognition of DIR's legislative compliance role;
- the creation of the office of the Commissioner for Electrical Safety and an Electrical Safety Board and its committees to advise the Minister on ways to improve electrical safety replaced the role of the regulator;
- significant alteration to the role and functions of authorised persons following amendment to the *Electricity Act*. Accordingly, the potential conflict of interest situation identified by the former Ombudsman has been addressed; and
- significant changes to the role and functions of the regulator.

6.7 Record keeping

Every regulatory system must give prominence to the need to make and keep appropriate records.

The *Public Records Act 2002*[287] and good administrative practice require that public agencies make and keep "full and accurate records". Throughout the

287 Part 7 commenced on 24 April 2002 and the remaining provisions commenced 1 July 2002 and repealed the *Libraries and Archives Act 1988*.

period of the WEP, the *Libraries and Archives Act 1988* was in force and placed an identical obligation upon agencies to make and keep "full and accurate records[288]".

A report being prepared for the purposes of the Better Decisions Project describes the benefits of good record keeping in the following way:

> There are well-established benefits of government agencies maintaining comprehensive records of both their decisions, and the processes undertaken in making those decisions. Similarly, there are serious risks for agencies that fail to properly document their decisions, and decision-making processes.
>
> Some of the benefits of proper record keeping are as follows:
>
> - Effective record keeping leads to improved decision-making by providing decision-makers with comprehensive, detailed information on which to base their decisions;
> - A proper record of the steps taken to arrive at a particular decision assists the decision-maker to prepare a comprehensive statement of reasons;
> - Proper records enable the agency to establish how particular decisions were made, in the event that the agency needs to revisit a matter for any reason in the future;
> - Similarly, proper records assist review bodies to understand why and how a decision was made;
> - Proper record keeping enhances transparency in government by enabling agencies to respond meaningfully to requests under the Freedom of Information Act 1992; and
> - Accountability in government is also enhanced by agencies maintaining proper records of decisions and decision-making processes.

6.7.1 What we found

There were many examples throughout the WEP of poor record keeping practices. In particular, file construction and maintenance were problematical and many files delivered by DIR to my office for examination exhibited an illogical and confused construction. For example, in most cases:

- there was no way of identifying whether the files were complete;
- the location of physical evidence was not recorded (presumably the officer in each case knew of its location);
- the significance of various named individuals to the investigation was not always apparent;

288 Section 52(1).

- the dates of file movements and reviews were not consistently recorded;

- there were few file notes despite the fact that a number of actions had been undertaken and some notes included personal opinions or value judgments that appeared irrelevant to the investigation; and

- facts were not recorded clearly, and where opinions were recorded, they were generally not accompanied by any explanation of the basis on which the opinions were held.

The importance of record keeping in the context of good administrative practice was also highlighted by criticisms of WH&S file construction and prosecution briefs made by a coroner[289] in an unrelated inquest held in January 2001. In my experience, poor record keeping practices waste court time and, more significantly, increase the likelihood of matters of significance being overlooked by officers who are required to give evidence.

The final report of the Ministerial Review of the Division of WH&S and the ESO also addressed this issue. It stated[290]:

> During the course of the review, contact was made with the Brisbane Coroner, Mr Michael Halliday, who identified a number of issues in relation to the preparation and submission of investigation reports provided by the inspectorate. The Coroner was particularly critical of the way in which the investigation reports were tabulated and submitted.

One particular example arose during an interview between my officers and a WH&S inspector. The WH&S inspector was repeatedly unable to locate documents relevant to the WH&S investigation he wished to draw to my officers' attention. The following transcript reflects the inspector's dilemma:

WI[291]	*…I investigated this incident and my report is attached. Now, if these things are in the proper order it would be sitting right at the beginning of one of them.*
MW[292]	*It would be nice wouldn't it.*
WI	*All I've got here is a mishmash of documents all over the place.*
MW	*Yes.*
WI	*Oh, well, can't find it... Now, it should be on the file. It's not evident on the file…I am sure it's somewhere in there. If the file was in the right order I'd be able to point it out to you...*

289 Inquest into the death of John William Raaen.

290 Page 38.

291 The WH&S inspector.

292 My Senior Investigator.

The WH&S inspector was examining an identical copy of the original file that was delivered to my office.

6.7.2 What has changed

The DIR Investigation Skills Training Manual[293] deals extensively with the subject of record keeping. All documents received or created relating to a case are required to be handled in accordance with a documented procedure[294]. The manual also reinforces that:

- during an investigation, inspectors must collect information and later make assessments based upon the information gathered;
- senior management and others make decisions based upon information gathered; and
- courts and tribunals also make decisions based upon information gathered and presented to it.

The manual deals with how records are to be created, maintained and secured and provides a comprehensive and practical explanation of what needs to be done by officers to ensure their record keeping practices are in accordance with the *Public Records Act 2002* and Information Standard 40 – Record keeping.

The ongoing challenge for DIR management will be to maintain a program of managerial audits to detect and rectify poor record keeping practices.

6.8 Legislative framework

Many administrative decision-making systems, particularly those with regulatory functions such as licensing, registration and compliance, are based in legislation and specialised policy.

6.8.1 Previous legislation

Prior to the enactment of the *Electrical Safety Act*, electrical safety in Queensland was principally governed by two related[295] pieces of legislation, namely the *Electricity Act* and the WH&S Act.

A principal purpose of the *Electricity Act* was to regulate electricity generators, transmitters and distributors. One of the primary purposes of the WH&S Act was to minimise persons' exposure to the risks of death or injury caused by hazards in the workplace, including electrical hazards.

293 Chapter 10.

294 BD-CP-10: Records Management.

295 In the context of an electrical incident at a workplace.

6.8.1.1 What we found

I formed the opinion that the previous legislative framework was inadequate for a number of reasons. These are included in the list below.

Two of my senior officers were members of Reference Groups established by the Ministerial Review. The functions of these Groups included the review of legislation. There was general consensus among stakeholders that the *Electricity Act* did not provide an adequate framework for setting or enforcing appropriate safety standards. In the Final Report of the Ministerial Review of the ESO, the Ministerial Reviewer summarised[296] these shortcomings as follows:

- The Electricity Act currently requires the appointment of a regulator (Director-General of a government department) who has both commercial and safety functions;
- The Electricity Act and Electricity Regulation 1994 are more than 5 years old and require updating and review;
- There is considerable confusion between the two agencies (Division of Workplace Health and Safety and the Electrical Safety Office) with overlapping jurisdictions of the Electricity Act and Electricity Regulation 1994 and the Workplace Health and Safety Act 1995;
- There are perceived conflicts of interest associated with the appointment of "authorised persons" whose key role is to conduct electrical investigations on behalf of the ESO including the investigation of alleged breaches that may have been committed by their own employer;
- Variable penalty provisions for similar offences across both jurisdictions with the Electricity Act having significantly weaker penalties;
- The current framework causes confusion and ambiguity in relation to which agency assumes primary responsibility for investigation and prosecution of electrical incidents;
- Internal inconsistencies within the Electricity Act with breaches causing a fatality resulting in maximum fines of 20 penalty units compared with 40 penalty units applying to anyone caught climbing a pole;
- The questionable legal status of electricity codes of practice;
- Confusion over what standards are legally enforceable in the first instance;
- Inconsistency between jurisdictions in relation to the application of the Criminal Code;
- The powers associated with an investigation are fairly broad in nature, however the powers of authorised persons are limited in that they do not have the authority to enforce compliance with instructions;
- While there is an obligation on the electricity entity to furnish a report prepared by the "Authorised Person" to the Electrical Safety Office there also exists a provision for the electricity entity not to pass the report on if it might tend to incriminate the entity.

The deficiencies identified in the list above are so overwhelming that the case for legislative reform is fundamental as an outcome of the Review. The question that is screaming to be asked is not whether we should have a

296 Page 12.

separate Electrical Safety Act but what form should some of the key principles and guidelines take that best reflects the needs of a modern regulator and provide a special focus on electrical safety.

6.8.1.2 What has changed

The legislative framework has been significantly reformed.

Both the *Electricity Act* and the WH&S Act have been substantially amended to address the shortcomings identified by the Ministerial Reviewer and by our investigations. A separate *Electrical Safety Act* to regulate safety matters in the electricity industry has been enacted. The new legislative framework reflects modern enforcement methods.

The Explanatory Notes to the Electrical Safety Bill 2002 described the legislative framework as including:

- imposing obligations on persons who may affect the electrical safety of others by acts or omissions;
- making regulations, ministerial notices and codes of practice about electrical safety;
- introducing safety management systems for prescribed electricity entities;
- providing for the safety of all persons through licensing and discipline of persons who perform electrical work;
- providing consumer protection for failures of persons who perform electrical work to properly perform or complete the work;
- providing for the appointment of a Commissioner of Electrical Safety to advise the Minister on electrical safety matters and to manage the activities of the Electrical Safety Board and its committees;
- establishing the Electrical Safety Board and its committees to allow industry and the community to participate in developing strategies to improve: electrical safety, standards of electrical equipment and licensing; and to promote awareness of electrical safety.

6.8.2 Consistency of penalties

As a general legislative principle, penalties for like offences should be consistent.

6.8.2.1 What we found

I formed the opinion that there were numerous examples of inconsistent penalties in the WH&S Act and the *Electricity Act*.

In Case 3, I recommended that "there should be consistency in the amount of the penalties that may be imposed under the WH&S Act and the *Electricity Act* for like offences".

I stated[297] in my report that:

> I found the penalties imposed for a breach of the *WH&S Act* are far greater than for a similar breach of the *Elect Reg*. … I have not undertaken an exhaustive review of this point and for this reason I recommend that the inconsistencies identified in this report be addressed in the proposed new Electrical Safety legislation.

As an example, my report referred to s.24 of the WH&S Act and ss.126 and 128 of the Electricity Reg. The penalty for failing to ensure the workplace health and safety of an employee (s.24) under the WH&S Act was 500 penalty units or 1 year's imprisonment if the breach caused bodily harm (or 800 penalty units or 2 years' imprisonment if the breach caused death or grievous bodily harm). However, the penalty under the Electricity Reg for failing to take reasonable steps to ensure a person can work safely (s.126) or for failing to ensure electrical work is not performed in proximity to exposed high voltage conductors (s.128) was only 20 penalty units.

The final report of the Ministerial Review of the ESO also discussed this issue and highlighted additional inconsistencies.

6.8.2.2 What has changed

As previously stated, the legislative framework has been significantly reformed with the enactment of the *Electrical Safety Act* and the amendment of the WH&S Act and the *Electricity Act*.

The inconsistencies in penalties identified throughout the WEP and by the Ministerial Reviewer have been addressed.

6.8.3 Clarity of definitions

A good legislative scheme clearly defines key terms and concepts so that the agency administering the scheme fully understands its responsibilities.

6.8.3.1 What we found

There were three principal examples in the WEP where the interpretation of key words caused difficulties for both WH&S and the ESO. They were:

- In Cases 8 to 11 the definition of a "workplace" in the WH&S Act;
- In Case 3 the definition of "electrical work" in the *Electricity Act*; and

297 Page 124.

- In Case 12 whether the definition of “electric line” included “overhead electric lines” in the *Electricity Act* and Regulation.

I have already dealt with the interpretation of these definitions in this Report.

6.8.3.2 What has changed

The enactment of the *Electrical Safety Act* and the amendment of the WH&S Act and the *Electricity Act* have addressed[298] the meaning of these key terms.

6.8.4 Regulatory compliance duplication

If two or more agencies have responsibilities for administering the same legislative scheme or related schemes, the legislation should ensure that there is no duplication of effort.

6.8.4.1 What we found

Duplication of roles and activities between WH&S and the ESO was a recurring theme throughout the WEP. As obvious example of this is where a worker is injured in an **electrical** incident at a **workplace**. In such a case, both WH&S and the ESO had a legislative obligation to assess what had occurred and take appropriate action.

The investigation of a fatal electrical incident could also involve the QPS[299] and authorised persons employed by an electricity entity.

In Cases 1 and 2, the former Ombudsman expressed an opinion that there was a lack of coordination between the WH&S and the ESO in relation to the investigation of electrical incidents. The former Ombudsman also stated that a single agency should be responsible for such investigations.

The Electrical Safety Taskforce identified[300] similar problems in its final report:

> As a result of inquiries made during the course of studying the systems of investigation it has been found that, due to different applicable legislation, there are differing standards applying between the ESO and WH&S and there are files where conflicting views can be found. If this were to be exploited by a person or an electricity entity, an electrical contractor or any employer then both organisations as agencies of Government would be questioned and at least one found to be inadequate or over zealous.
>
> A prime example of this situation is found in the investigation by both agencies into the fatal accident of [AM]. What transpired was a situation where the accident was investigated by WH&S and at the same time by the ESO. The WH&S at one point of its investigation reached a view where a prosecution against the employer should be initiated, however another

298 In Case 12, DIR has requested the Commissioner for Electrical Safety to consider whether any amendment is required to the definition having regard to the opinions expressed and issues for investigation that were identified in that case.

299 Who would normally be required to prepare a report for a coroner.

300 Pages 41 – 42.

direction was taken when advice was given by its Technical Advisor and considerations of the views expressed by the ESO. Ostensibly it is argued that the employee contribution to the accident and the failure of adequate supervision would prevent a successful prosecution.

The Final Report of the Ministerial Review of the ESO also supported these views and stated[301] that the problems were:

- The failure by both agencies to adequately investigate electrical fatalities in Queensland;
- Overlapping legislative jurisdictions with different penalty regimes for similar offences;
- Confusion over which agency has primacy in investigating and prosecuting accidents of electrical origin;
- A lack of understanding by those involved in the delivery of safety due in part to the need to read the Electricity Act in conjunction with the Workplace Health and Safety Act;
- Perceived conflicts of interest especially in relation to the role and function of "Authorised Persons" where employees of electrical authorities are required to carry out accident investigations into incidents regarding their own employers;
- Confusion over who has the power to seize articles; and
- No protocol for resolving issues or taking lead agency responsibility for safety investigations between the Electrical Safety Office and the Division of Workplace Health and Safety.

6.8.4.2 What has changed

Regulatory duplication has been addressed by DIR in several ways.

Firstly, WH&S and the ESO have been placed within the same department, DIR.

Secondly, the *Electrical Safety Act* and the amendment of the WH&S Act and the *Electricity Act* have addressed the legislative problems relating to the duplication of investigative responsibilities.

Thirdly, new management systems have been put in place, including systems to ensure more effective internal communication and information sharing throughout DIR. For example, all regional managers from the ESO and WH&S now participate in regular conferences.

Fourthly, the LPSU was established to provide legal services and support to both WH&S and the ESO on investigations and prosecutions. The unit reports

301 Pages 41 – 42.

directly to the general manager of WH&S. An improved enforcement framework has been developed.

Finally, protocols exist between DIR and the QPS to address the issue of investigative duplication.

6.8.5 Multiple guidelines and manuals

The incident[302] that resulted in the death of SG occurred at a workplace and involved electricity and the use of an EWP. The legislation applicable to the incident included the WH&S Act, the WH&S Reg, the *Electricity Act* and the Electricity Reg.

In addition to this legislative framework, various guidelines and manuals were in existence at the time of the incident and used by persons in the electrical industry. They included the:

- 1986 SEQEB Manual
- 1989 QEC EPV Guidelines
- 1991 QEC Guidelines
- 1994 AS2550.1
- 1995 DME Safety Guides
- 1996 Energex GAP Manual
- 1996 DME CA Guidelines.

None of the above guidelines or manuals was either a compliance standard[303] or an advisory standard[304] as those terms were defined in the WH&S Act.

These documents contained multiple requirements and placed a range of additional obligations upon persons at workplaces involving electricity and the use of an EWP.

Sections 26 and 27 of the WH&S Act set out the various ways in which a person's workplace health and safety obligations could be discharged.

Section 26 applies if a compliance standard prescribed a way of preventing or minimising exposure to a risk or if an advisory standard stated a way of identifying and managing exposure to a risk.

Section 27 applies in instances where there is no compliance standard or advisory standard. Section 27(3) is a "catch-all" provision. It states that an obligation, such as those imposed on an employer by s.28, is only discharged if the person who owes it:

> takes reasonable precautions, and exercises proper diligence, to ensure the obligation is discharged.

302 Case 12.

303 Part 4 of the WH&S Act. Only the Governor in Council can make a compliance standard.

304 Part 5 of the WH&S Act. Only the Minister can make an advisory standard.

People who had obligations under the Act sought guidance from the guidelines and manuals to help them discharge their obligations.

6.8.5.1 What we found

The guidelines and manuals contained numerous overlapping requirements and were the source of considerable confusion in the industry. For example, it was apparent during the investigation of Case 12 that there was significant disagreement among relevant stakeholders as to:

- the personnel required at a workplace to assist a worker undertaking electrical work on overhead electric lines from an EWP;
- what the exact role of such personnel at the workplace entailed; and
- whether several roles could be performed by one co-worker simultaneously (for example, competent assistant and ground observer).

This confusion was also evident at the coronial inquest into the death of SG where various witnesses provided differing interpretations of what each of these workplace roles entailed.

6.8.5.2 What has changed

I recommended in Case 12 that DIR request the Commissioner for Electrical Safety to review whether the *Electrical Safety Act 2002*, the Electrical Safety Regulation 2002 or any of the Codes of Practice required amendment in light of the opinions I had expressed in my report about overlapping requirements and confusion about their interpretation.

DIR accepted this recommendation and requested the Commissioner to examine the issue.

The Commissioner recently advised[305] me that he is still considering this recommendation and expects to complete his review in the 2005-06 reporting year.

6.9 Regulatory strategy

In most regulatory schemes, the agency responsible for administering the scheme needs to be both proactive and reactive. An agency needs to be able to react effectively to reported breaches of the scheme but it also needs to act on its own initiative by implementing strategies to audit compliance with the scheme.

In the case of WH&S, workplace audits were an integral part of their compliance program.

305 See 7.1.4.2.

6.9.1 What we found

The nature, quality and frequency of workplace audits conducted by WH&S were issues identified by the former Ombudsman in Cases 1 and 2 of the WEP as needing attention.

6.9.1.1 Delay

In Case 1 of the WEP, the former Ombudsman noted that the workplace where the incident occurred was not audited by WH&S until about five months after the incident.

That audit identified a number of problems[306] at the workplace, including the absence of a procedure for reporting faulty equipment. Case 1 involved a vacuum cleaner that had been allegedly tampered with by a person or persons unknown, as a result of which live electrical workings had been exposed. A safety switch was not installed at the workplace.

The vacuum cleaner had been sent to Energex for a technical examination but the results were not used by WH&S because a decision had already been made to close the investigation. The audit results were also not provided to the coroner at the inquest.

The former Ombudsman formed the view that a workplace audit should have been conducted by WH&S either on the day of, or as soon as possible after, the incident. He also stated that this failure exacerbated the other investigative deficiencies he had identified. Overall, he found that the audit process had not been coordinated with the workplace investigation even though the results of the audit were relevant to the investigation.

6.9.1.2 Prior warning

Again, in Case 1, the complainants alleged that employees at the workplace had received a warning from WH&S that a workplace audit was to be performed on a particular day. This allegation was put to a WH&S senior officer at interview who conceded that not only had a warning been given to the employer, but that it was standard practice to do so.

In response to the provisional report of the former Ombudsman, WH&S replied[307] that:

> Poor health and safety performance is generally systemic within the workplace and not subject to instantaneous remedy.
>
> From an operational perspective the Division uses different types of auditing strategies to achieve its objectives. Enterprise audits of larger workplaces can take a full day and require the assistance of senior management. The

306 19 improvement and 4 prohibition notices were issued.

307 By letter dated 8 December 2000.

> Department could waste considerable resources in arriving at a workplace to conduct an intensive audit if the appropriate personnel were not present from the company. This is especially true in regional and remote areas where inspectors have to travel considerable distances to conduct audits.
>
> Another strategy adopted by the Division is a safety blitz audit where a specific hazard is audited within a large number of workplaces. These audits are, as a rule, conducted without notice to the workplace as the presence of specific personnel is normally not required in respect of the audit process.

Notwithstanding these comments, the former Ombudsman recommended[308] that the giving of advance warnings of workplace audits should cease immediately in relation to all but essential cases. WH&S responded by stating[309] "most inspections currently do not involve advance warnings. This practice where it does occur will be reviewed as part of [the strategic review]".

6.9.2 What has changed

There have been a number of significant improvements in relation to compliance activity. Many of these accompanied the introduction of the *Electrical Safety Act*.

A detailed summary of DIR's compliance activities appears in Appendix M[310]. Audits include safety blitzes of specific equipment and targeted industry assessments in accordance with an agreed audit compliance program approved by the respective regional managers and the WH&S general manager.

As a general comment, the statistics contained in Appendix M demonstrate an increasing number of workplace audits each year commensurate with an escalating number of improvement notices, prohibition and electrical safety protection notices and on the spot fines being issued. In some cases, activity is more than double the level at the commencement of the WEP.

6.10 WH&S regional model

A regulatory agency's organisational structure must be conducive to the effective performance of its responsibilities. Responsibilities of organisational units need to be clearly defined and processes need to be in place to provide effective internal communication.

6.10.1 What we found

The regional management model that was in place at the commencement of the WEP was the subject of specific criticism by a number of WH&S officers.

308 Recommendation 6.

309 By letter dated 2 March 2001.

310 Paragraphs 5.8 – 5.10.

At interview[311], a former WH&S senior officer described the regional model in place as "the biggest disaster WH&S ever had". He claimed that regionalisation was the major source of resource problems in relation to investigative activity and that it was directly responsible for a lack of coordination within WH&S. Other senior officers expressed[312] similar views.

The former Ombudsman stated in Case 1 that, while the subject of the regional model was beyond the scope of his investigation, he had reported these comments for the information of the Ministerial Review as the issue could be linked to the workload and resourcing issues that were being raised by a number of WH&S officers.

In Case 3, several officers raised what appeared to be valid problems stemming from the regional model and, therefore, I recommended that DIR address the issue.

The Ministerial Reviewer expended considerable resources during his review examining this issue[313] and made a number of recommendations[314].

6.10.2 What has changed

DIR adopted a new regional model and underwent a significant organisational restructure. DIR has advised that these changes have resulted in:

- simplified reporting relationships;
- greater accountability for each level of management;
- direct line management responsibilities between state office and the regions; and
- provision of discrete budget allocations to, and devolution of control, to the regions.

Importantly, DIR has stated[315] that the new structure "helped considerably in the implementation of the *Electrical Safety Act*" and other workplace health and safety reforms.

6.11 Regulatory capture

"Regulatory capture" is the theory that a regulatory agency and the industry it regulates build working relationships that have the potential to lead to the agency becoming unwilling to perform its compliance tasks diligently and impartially so as to avoid jeopardising the relationship.

311 Case 1.

312 Case 3.

313 Chapter 3 of the Final Report of the Ministerial Review of WH&S and the ESO.

314 See Appendix B.

315 See Appendix M.

6.11.1 What we found

A number of complainants in the WEP alleged that the ESO particularly was "captured" by the electricity entities it was required to regulate. Some complainants also suggested that WH&S appeared either unwilling or ill equipped to investigate incidents involving infrastructure controlled or operated by electricity entities.

One former senior ESO officer advised[316] me that despite his extensive electricity supply experience of almost four decades, he was "unaware of the regulator pursuing the prosecution of an electricity entity".

Neither the former Ombudsman nor myself formed any opinions or made any recommendations about this issue. However, the Ministerial Reviewer raised this issue in the Final Report of the Ministerial Review of the ESO when discussing the absence of compliance activity within the ESO during the five year period ending June 2001. He stated[317]:

> It is difficult to pinpoint one single cause for this obvious reluctance to assume the regulatory role. One suggestion for the seeming reluctance to become involved with investigations and prosecutions relates to the issue of regulatory capture. The theory of regulatory capture espouses the view that regulatory organisations particular within the context of a single industry become "captured' by the industry itself and are unable or unwilling to perform any tasks that may jeopardise the relationship between the entities. A recent article by Briody, M. and Prenzler, states:
>
> *Capture theory describes the process by which government agencies responsible for corporate regulation, serving the interest of the corporate regulation, shift from enforcing public interest law to serving the interests of the corporate identities being "regulated".*
>
> While it hard to argue against the theory, any future role of the ESO will have to be particularly vigilant in ensuring such a situation never occurs again. The continuing and hopefully closer arrangement between the ESO and WH&S may provide some light that ensures the ESO understands its role as regulator. This may hold one of the keys to resolving this complex issue.

6.11.2 What has changed

There have been a number of reforms that have directly and indirectly addressed this issue.

Firstly, WH&S and the ESO have been placed within DIR.

Secondly, the enactment of the *Electrical Safety Act* and the development of Safety Management Systems which are required to be audited independently have created an improved policy and enforcement framework.

316 In Case 4.

317 Page 36.

Thirdly, DIR has changed its policy so that officers of electricity entities seconded to or employed temporarily by the ESO are no longer involved in investigations that relate to infrastructure controlled or operated by their electricity entity.

DIR has recently advised that enforcement action has been initiated[318] on six occasions in respect of electricity entities since the commencement of the *Electrical Safety Act*, suggesting that there is no longer a reluctance to take such action, if appropriate.

6.12 Complaint handling

A complaints management system is the way individual complaints are dealt with by an agency and encompasses its policy, procedures and practices and the technology applied to that function. Good complaints management is an integral part of quality customer service and also provides benefits for the agency and staff. Effective systems enable poor decisions to be quickly and efficiently rectified and deliver information identifying areas for improvement.

All of the complainants in the WEP had at one stage sought an internal review by the WH&S and/or the ESO of a decision or decisions involving their relatives.

6.12.1 What we found

WH&S and the ESO did not have adequate complaints management systems at the relevant time.

One of the recommendations that I made in Case 4 related to DIR's internal review mechanism and its complaints management system. The recommendation was:

> In consultation with the Ombudsman's Office, DIR establish an effective internal review process to deal with complaints that cannot be dealt with under Part 11 of the Workplace Health & Safety Act 1995, including complaints about the quality of WH&S investigations.

DIR accepted my recommendation.

6.12.2 What has changed

DIR is one of 11 agencies participating in Phase 1 of my Office's Complaints Management Project. In consultation with my Office, DIR and the other agencies are in the process of implementing effective complaints management systems.

In early 2003, my Office prepared a series of Fact Sheets to assist participating agencies to establish effective complaints management systems.

318 DIR has advised that 4 matters have been finalised and 2 are presently before courts.

We also prepared a publication titled *Developing Effective Complaints Management Policy and Procedures*. Based upon that material and consultations with my officers, DIR prepared a draft Complaint Management Policy for Workplace Health and Safety.

My officers then reviewed DIR's policy and identified certain areas that required improvement. DIR accepted most of the proposed changes and on 7 February 2005 advised my officers by email as follows:

> The original policy was endorsed by EBT [Executive Business Team] on 6 January 2005. The current changes resulting from the Ombudsman's review were approved by the DG on 7 December 2004. Both of these are reflected in the procedures document.
>
> As far as the department is concerned, the policy is implemented already and will be tested on a case by case basis as complaints are received and reporting to the executive occurs.
>
> Training in complaints management will be incorporated into the induction process which is being reviewed in a number of areas as we speak. In order to educate current staff the Director, Workforce Capability Unit and [the author] will be giving a presentation on the DIR complaints management procedure to the Regional Managers and Senior Business Services Officers at an upcoming "Face to Face" conference on the 14 April 2005. Further to this, the Workforce Capability Unit is developing an internal awareness package that will be incorporated into the departmental training calendar.

DIR has recently finalised its complaints handling policy and procedures. We have reviewed those documents and are satisfied that they comply with recognised national standards for complaints management.

6.13 Corporate communication

It is well established that effective communication with clients, staff and other stakeholders enhances the ability of an agency to successfully carry out its functions and to achieve its goals. In the context of the public sector, it is also clear that the community expects to be able to communicate freely, easily, and meaningfully with agencies and decision-makers.

6.13.1 What we found

Case 3 involved the fatal electrocution of TM who was carrying out work from the basket of an EWP on an overhead illuminated advertising sign containing fluorescent light sticks. WH&S formed a view that there was insufficient evidence to warrant a prosecution against TM's employer. However, this view was not communicated to TM's parents. They first became aware of WH&S's decision when they read two newspaper articles.

I formed a number of opinions[319] about the media policy that WH&S had in place at the time, namely:

319 Opinions 4 – 7 – see Appendix F.

- The WH&S media policy allowed the [position title deleted] an inappropriate level of autonomy in making media releases and an inappropriate level of access to non-delegated decision-makers for the purpose of preparing media briefings.

- The release of information to the media was mismanaged by [position title deleted], who:

    - sought comment from persons who were not delegated to make a final decision in relation to the future direction of the investigation; and

    - provided the information to the media prior to any communication being made to [TM's parents]. Such information was contrary to WH&S's ultimate position in relation to the investigation, necessitating a "backflip".

- The WH&S media policy failed to acknowledge the interests of the next of kin by ignoring their legitimate expectation that they would be informed about the outcome of an investigation before the information was released in a public forum.

- The WH&S media policy failed to acknowledge the potentially serious implications of making a public statement about the health and safety aspects of a particular workplace environment prior to the expiration of the statutory limitation period for the commencement of court proceedings. An incorrect media report (as occurred in this matter) could result in an employer being given tacit approval by WH&S to continue using unsafe work practices.

I recommended that the media policy and procedures be replaced by a media policy that addressed each of the issues I had raised.

DIR accepted my recommendation.

6.13.2 What has changed

DIR has developed new communication procedures for dealing with the relatives and friends of deceased and injured workers during an investigation. A booklet has been prepared called *"Response to a Death in the Workplace"*.

The new procedures are contained[320] in the DIR Advanced Investigation Skills Training Manual. The procedures address the deficiencies that I had identified.

320 Chapter 6.

6.14 Independent safety regulator

Section 62 of the *Electricity Act* appointed the chief executive of DME as "the regulator".

The regulator's functions were set out in s.63 of the Act. Section 64 of the Act allowed the regulator to delegate his powers to an officer of the department, an authorised person or an employee of an electricity entity if the regulator was satisfied that the delegate had the expertise and experience necessary to perform the function.

6.14.1 What we found

In Case 3, I recommended that an independent safety regulator be established. I made this recommendation because I had also recommended in the same case that there should be separate electrical safety legislation to regulate safety matters pertaining to the electrical industry. I felt that the establishment of a fresh legislative framework also required the appointment of an independent regulator who was not concerned with the commercial aspects of electricity generation and supply.

The ESO Reference Group (of which one of my officers was a member) had also provided a joint submission to the Ministerial Reviewer supporting the appointment of an Independent Safety Regulator. That submission was referred to in the Final Report of the Ministerial Review of the ESO. There was widespread stakeholder support for the appointment. Accordingly, the Ministerial Reviewer recommended[321]:

> That an independent electrical safety regulator be established with the status of a Statutory Officer, under the authority and control of the Minister for Industrial Relations. The role should have broad standard setting powers that regulates the electrical industry as well as offer future advice to the Minister on how to improve the health and safety performance of the electrical industry.

6.14.2 What has changed

The *Electrical Safety Act* was enacted. This Act created[322] an independent office of Commissioner for Electrical Safety to advise the Minister on electrical safety matters and to manage the activities of the Electrical Safety Board and its committees. The Commissioner also chairs the Electrical Safety Board and the Electrical Licensing Committee. The Act provides that the Commissioner has the necessary powers to carry out his or her functions.

Mr Jack Camp was appointed as the first Commissioner for Electrical Safety in Queensland in 2002.

321 Recommendation 3.2.

322 Parts 6 – 7.

6.15 Resourcing

Resourcing, or more particularly, the lack of resources to adequately undertake regulatory compliance, was a common complaint raised by officers and managers of both WH&S and the ESO throughout the WEP.

6.15.1 What we found

The former Ombudsman identified the issue in Cases 1 and 2 of the WEP. He recommended that there be a comprehensive management and strategic review of both WH&S and the ESO. He requested the reviewer to address resourcing issues and any other matters that impacted on the economy, efficiency and effectiveness of the discharge of the core responsibility.

Resourcing was a significant issue considered during the Ministerial Review and the Final Reports dealing with WH&S and the ESO discussed the issue in some detail.

6.15.2 What has changed

Investigative resources have been significantly increased.

DIR now undertakes a range of activities that were not performed before 2000.

A new legislative framework has been put in place accompanied by an organisational restructure.

DIR's full response detailing the increased resources is set out in Appendix M.

6.16 Risk management

Risk management is an integral part of good management and can be applied to any administrative function as a means of avoiding or mitigating potential problems.

A regulatory agency that takes a risk management approach to its enforcement activities will prioritise all notifications of alleged legislative breaches according to a formula, scale or model. A typical model requires various weighted factors to be taken into account before a notification is investigated.

Prioritisation is an essential component of compliance work because investigation and prosecution resources are finite and, as a general rule, a regulatory agency needs to consider how it can best devote resources firstly to very serious cases[323], secondly to less serious cases and thirdly to those cases where commonsense dictates that a less formal process would be appropriate.

323 For example, fatalities and serious bodily harm.

Important features of a risk management approach within a regulatory agency include:

- establishing investigative procedures, for example, in an investigations manual containing a comprehensive package of forms and precedents and enforcement option guidelines;
- providing training in investigation skills and statutory enforcement; and
- implementing well defined systems for record keeping and managing information/cases.

6.16.1 What we found

Effective risk management was not evident in the investigations of the nine incidents by the two agencies. The principles outlined above were not sufficiently observed.

Many officers when interviewed conceded that both WH&S and the ESO had inadequate systems. They complained about an absence of guidelines and policy. The also stated that until recently, there was no comprehensive investigations manual to assist them to undertake investigations and adequately perform their duties. They also stated that training was minimal and recruitment was problematical.

6.16.2 What has changed

DIR has introduced a comprehensive Investigation Skills Training Manual. These manuals provide clear, consistent advice and guidelines to investigators and their managers.

The manuals:

- identify and describe the legislative framework being administered;
- describe the duties of an investigator;
- identify guiding principles for an investigator to follow, including common pitfalls;
- explain the agency's compliance policy and the reasons for investigating an issue;
- explain the concept of identifying the elements of offences and the steps involved;
- explain the need to identify the elements of possible defences as well;

- discuss the rules of evidence, particularly issues like the standard and onus of proof, rules of relevance and admissibility, weight, facts in issue and the types of evidence available;

- explain how the investigation will be managed in terms of accountability, timeframes and case management;

- guide how an investigation is planned;

- describe methods of note taking and recording of information;

- discuss whether site inspections should be undertaken;

- guide how physical evidence is best secured and handled;

- guide how and which persons are interviewed;

- guide how to prepare an investigative report or a brief of evidence; and

- are compatible with and codify the CIS system.

6.17 Statistics on electrical fatalities

Two of the critical indicators[324] of the effectiveness of changes made to the electrical safety system in Queensland are the number of deaths from electrocution per year and the number of fatalities per million of population expressed as a percentage.

6.17.1 1991-92 to 2000-01

The November 2001 DIR Issues Paper confirmed[325] that statistical data collated by the ESO for the 10 year period 1991-92 to 2000-01 showed 116 electrical fatalities during that period. The following causes were identified:

- **Appliances** accounted for 43 fatalities, with 16 relating to unlicensed electrical work and 9 to a lack of maintenance.

- **Contact with overhead lines** accounted for 40 fatalities, with 11 relating to work near lines in rural workplaces, 5 to work near service connections, 5 to work involving cranes and 5 to fallen lines due to storms.

- **Fixed wiring** accounted for 24 fatalities, with 9 relating to damage to wiring, 9 to unlicensed electrical work and 6 to working live by a licensed contractor/worker.

324 There are a range of valid indicators.

325 Page 4 of the November 2001 DIR Issues Paper.

The findings of my investigations and those of both the Electrical Safety Taskforce and the Ministerial Review demonstrate that, from any perspective, Queensland's electrical safety system at the commencement of the WEP was unacceptable and required urgent attention.

6.17.2 2002-03

There was one electrical fatality in Queensland in the 2002-03 reporting year. The *Electrical Safety Act* was passed during this period.

6.17.3 2003-04

There were two electrical fatalities in Queensland during the 2003-04 reporting year. Both of these involved appliances.

During the same period, New South Wales had 11 electrical fatalities. Western Australia had three electrical fatalities and each of the remaining States[326] and Territories had one electrical fatality each.

As a percentage of fatalities per million of population, Queensland had the second lowest rate in Australia[327].

6.17.4 2004-05

There were seven fatal electrocutions in Queensland in this period[328]. Three of these incidents involved electrical workers. Two involved members of the public (one allegedly engaged in criminal activity) and the other two incidents involved non-electrical workers.

Five of the fatalities involved fixed wiring and one involved contact with live overhead power lines[329].

However, there does not appear to be any common theme in these fatalities (for example, workplace health and safety) as there was in the workplace incidents discussed in this Report.

DIR has suggested that a safety switch "would have controlled the electrical safety risk" in six of the seven fatal electrical incidents that occurred. Two of the fatalities occurred at separate residences where safety switches were not installed. I have discussed the issue of safety switches in residential premises in 7.2.2.

326 Tasmania had no electrical fatalities during this period.

327 Tasmania has been excluded from these calculations as it recorded no deaths during the period.

328 Current to 17 June 2005 – information supplied by DIR.

329 Male farm worker killed when the grain auger he was operating contacted live overhead high voltage power lines.

Chapter 7: Implementation to date and what remains to be done

7.1 Response from Commissioner for Electrical Safety

A number of issues were referred to the Commissioner for Electrical Safety, Mr Jack Camp, throughout the WEP. Those issues and the Commissioner's response[330] are set out below.

7.1.1 Cases 6 and 7

In Cases 6 and 7 of the WEP, I recommended that:

> The Commissioner for Electrical Safety consider the safety issues raised in Part 6 of this report with a view to recommending to the Minister that measures be prescribed to address those issues in relevant Codes of Practice under the *Electrical Safety Act 2002*.

The various safety issues raised in Part 6 of that report included:

- ensuring appropriate consultation occurs between an employer and the relevant electricity entity and clarification of their respective obligations where the employer is carrying on business in proximity to overhead power lines;
- de-energising, re-gridding or undergrounding overhead HV power lines;
- earthing of mobile cranes used in proximity to overhead power lines;
- use of a safety observer when work is being carried out in close proximity to or on overhead power lines;
- action to restrict movement of mobile cranes working under power lines; and
- use of insulated swivels on cranes.

7.1.2 Commissioner's response

7.1.2.1 Completed work

The Commissioner provided the following information regarding safety issues that have been addressed:

> **Various Crane Safety issues raised in WEP Cases 6 and 7**
>
> The Code of Practice entitled "Working near Exposed Live Parts" provides practical ways to meet requirements for consultation between employers and relevant supply entities when performing work around power lines as provided

330 By letter dated 8 June 2005.

for in the Electrical Safety Regulation 2002. It also uses de-energising of power lines as a first example of eliminating a hazard as part of the risk management process.

The use of a safety observer is also provided in the Electrical Safety Regulation 2002 and the Code of Practice, as are actions to restrict crane movement and the use of insulated swivels.

Compliance Audits of the Crane Industry

Under the Electrical Safety Audit Program and in conjunction with Workplace Health and Safety Queensland (WHSQ), audits of crane operations and safe approach distances to power lines were conducted in 2005. These distances are provided in the Electrical Safety Regulation 2002 and the Code of Practice entitled “Working near Exposed Live Parts”.

Crane Safety Video

As part of a program to increase the awareness of crane and other equipment operators the crane industry and building industry peak bodies were consulted on the relevance and suitability of a safety video entitled “Look Up and Live, Look Down and Survive”. This was released in late 2004 to key stakeholders. The video promotes a greater awareness amongst crane and related industries of methods to avoid the hazards of energised power lines, including the hazards of digging near underground power lines.

One hundred videos and fifty DVDs were provided to peak industry bodies during November and December 2004. Further releases are planned for mid 2005.

7.1.2.2 Work in progress

The Commissioner provided the following information regarding the ongoing work being undertaken:

The recommendation stated that “The Commissioner for Electrical Safety consider the issues raised in Part 6 of this report with a view to recommending to the Minister that measures be prescribed to address those issues in relevant Codes of Practice under the Electrical Safety Act 2002.”

The Electrical Safety Office took a broad approach to determining potential solutions by consulting with the building peak bodies and electricity supply industries. This process agreed on a number of strategies and placed a priority to put preventative measures in place that remove the electrical hazard before work with cranes and similar equipment commenced. It also identified that an increased industry awareness to avoid hazards was required, as well as potential means of reducing the impact if contact with power lines occurs.

The strategies that were identified include:

1. Council Planning Schemes

This involves the inclusion of appropriate wording into council planning schemes that require developers and builders to consider crane and other

plant safety and overhead power lines when submitting an application for planning approval.

The Electrical Safety Office has worked directly with the Local Government Association of Queensland to encourage councils to include working in council planning schemes or related documentation. The Electrical Safety Office has sent letters to all councils to encourage them to adopt appropriate wording or supply brochures provided to them by the Electrical Safety Office to the general public. The Electrical Safety Office has received positive feedback from a number of councils on both strategies.

The Electrical Safety Office has negotiated amendments to relevant documentation with the Brisbane City and Gold Coast City Councils which both councils have agreed to make available as case studies to other councils considering amending their documentation.

It is expected that this issue will be resolved in 2005-06.

2. Application for Electricity Supply

This involves the inclusion of crane and other plant safety as a matter when developers and/or builders apply to an electricity entity for temporary supply of power before building work commences on the site.

The Electrical Safety Office has worked with Energex and Ergon to amend their existing documents relating to applications for the temporary supply of power. Energex have implemented these changes. Ergon is currently considering appropriate amendments and have been supportive of this process and its intended outcomes. Completion is expected in late 2005.

3. Connection of Cranes to an Earth Lead

The connection of a lead between a crane and the earth is potentially one way of improving the electrical safety when a crane inadvertently contacts a power line. However, this can also introduce other risks to workers nearby.

To address this issue, the Electrical Safety Office is working with a nationally based project under the governance of the Energy Networks Association to address the technical issues of electrically connecting a crane to earth by a lead. This project is known as Earthing of Mobile Plant in the Electricity Supply Industry'.

A consultant has been engaged to conduct the work in Victoria. A draft report is due mid 2005 for consideration by the national electricity supply industry and issues identified will also be examined for application to cranes and similar equipment that are outside of the electricity supply industry.

Timing for resolution will be dependent upon the initial findings of the consultant's report.

4. Movement Limiting Devices

This involves the inclusion of advice into a code of practice for devices that detect the proximity of electricity and limit the movement of plant.

These devices are not commercially available but are under development and currently undergoing industrial trials interstate. The Electrical Safety Office is monitoring these developments and will assess the suitability for a code of

practice once they are available.

5. Review of requirements for working near exposed live parts

In the light of industry feedback obtained from stakeholders over time, a project has been established to review the requirements for working near exposed live parts. This project will review the content of the Code of Practice entitled "Working near Exposed Live Parts" and the safe approach distance provisions in the Electrical Safety Regulation 2002 in order to simplify and clarify the readability of the requirements.

This work is expected to be completed by late 2005.

7.1.3 Case 12

In Case 12 of the WEP, I recommended that:

DIR request the Commissioner for Electrical Safety to review:

1. Whether the issues of concern expressed in the Electrical Safety Alert relating to the design and operation of EWPs and their suitability for undertaking work in proximity to overhead electric lines are still valid and, if so, what action should be taken to ensure the health and safety of electrical workers using EWPs for overhead line work.

2. The adequacy of current training programs for electrical workers in the operation of EWPs.

3. Any inconsistencies, ambiguities and duplication in the various Guidelines and Manuals discussed in this Report.

4. Whether the ES Act, the ES Reg or any of the Codes of Practice issued under the ES Act require amendment in light of the opinions I have expressed and the issues for investigation I have identified in this Report.

7.1.4 Commissioner's response

7.1.4.1 Completed work

The Commissioner provided the following information regarding safety issues that have been addressed:

Safety Alert for the Versalift Type of EWP - [Case 12]

Recommendation 10.8.1 stated that "Whether the issues of concern expressed in the Electrical Safety Alert relating to the design and operation of EWPs and their suitability for undertaking work in proximity to overhead electrical lines are still valid and, if so, what action should be taken to ensure the health and safety of electrical workers using EWPs for overhead line work."

Recommendation 10.8.2 [required me to review] "the adequacy of current training programs for electrical workers in the operation of EWPs".

Due to the complexity of recommendation 10.8, the Electrical Safety Office divided it into four stages.

Stage 1 is limited to both recommendations above as applied to the Queensland electricity supply industry.

To address stage 1, the Electrical Safety Office engaged an independent engineering consultant, Scientific and Engineering Consultants Pty Ltd to carry out investigations. The report concluded that a very sophisticated ESI[331] training program is in place at a Federal, State and workplace level, that the design of the Australian distributed Versalift EWP models TEL-29 EIH is adequate, and that the assertion in the Safety Alert "that … the arrangement of the deadman switch … is in the same direction as that necessary to raise the boom" … is not a safety issue.

However, during the course of the investigation by Scientific and Engineering Consultants a separate issue beyond the scope of the Safety Alert was raised regarding the engine speed of the EWP. DIR investigated this issue further and determined that it has no impact on workplace health and safety, and operator standards are considered adequate.

Nevertheless, as a matter of consistency, the Electrical Safety Office will inform manufacturers and other interested stakeholders that there is a need to associate the correct engine speed with EWP design requirements.

Rural Industry awareness of safe approach distances

The Electrical Safety Office consulted extensively with rural industry stakeholders to assist them in their development of training packages for cane and cotton workers. This was done as part of activities to promote and improve compliance with electrical safety legislation in the rural community and as a priority to work with industry organisations to develop practical means for compliance.

The awareness training short courses are available to rural workers to help them comply when working around exposed live power lines.

7.1.4.2 Work in progress

The Commissioner provided the following information regarding safety issues that are in the course of being addressed:

Suitability of guidelines and legislation for EWPs - [Case 12]

As explained above, due to the complexity of recommendation 10.8, the Electrical Safety Office divided it into four stages. Stage 1 is now complete and the others stages are being progressed.

Stage 2 examines the adequacy of training for electrical workers using other types of EWPs in the Queensland electricity supply industry. Stage 3 examines inconsistencies, ambiguities, and duplication in the various guides and manuals discussed in the WEP Case 12 report. Stage 4 examines if the

331 Electrical Safety Industry.

current electrical safety legislation needs amendment.

The Electrical Safety Office is currently working with crane and EWP industry stakeholders as part of the overall consultation processes described above to progress stages 2, 3 and 4.

This work is expected to be completed in 2005-06.

7.1.5 Cases 8 to 11

The Director-General of DIR has referred to the Commissioner a number of other issues I raised in Cases 8, 9, 10 and 11, regarding fallen power lines.

My recommendation to the Director-General of DIR in Part 8 was that:

> DIR should undertake relevant independent research into the various types of splice joins used by electricity supply entities with a view to determining whether any of those joins are unsuitable to bear the static and dynamic loadings likely to be encountered in the geographic region in which any such entity operates.

My recommendations in Parts 9, 10 and 11 were that:

> DIR should:
>
> - undertake relevant independent research into the vegetation management policies and practices of the electricity supply entities and determine whether these are appropriate;
>
> - undertake independent research into the regulatory approaches of other State and (relevant) international jurisdictions to LV fault protection; and
>
> - consult widely with relevant academic and industry bodies on any existing, new or emerging technology that would enable the risks presented by fallen LV power lines to be removed or minimised.

7.1.6 Commissioner's response

7.1.6.1 Completed work

The Commissioner provided the following information regarding safety issues that have been addressed:

> **Research Splice Joins - Fallen Power Lines [Cases 8-11]**
>
> Recommendation 1 stated that "DIR commission relevant independent engineering research into the various types of splice joins used by electricity supply entities with a view to determining the suitability of splice join specifications for sub-tropical dynamic and static loading requirements."
>
> A suitably qualified and independent consultant was appointed and investigated this recommendation. The investigation confirmed that splice join

technology has largely been replaced by a different type of filling for a number of years. Splice joins are no longer installed on new works, except in a small number of situations where there is no substitute technology available.

The investigation also found that there is insufficient evidence to suggest that splice joins are defective or otherwise unsuitable when correctly installed. It also established that there is no reason to believe that the Australian Standard or the purchasing specifications used by Energex or Ergon Energy for these products are inadequate.

Further, the report noted that for situations where there is no substitute technology available and splice joins must be used, there are precautions that need to be taken for storage and when fitting these devices to overhead power lines to achieve their designed safety requirements.

A copy of the report was issued to both Energex and Ergon with a covering letter seeking advice of actions they propose. Responses were received which confirmed that the precautions would be followed, and that splice joins are being progressively removed during upgrades of the network. The Electrical Safety Office will audit those responses as part of its Electrical Safety Audit Program to ensure compliance.

Research Vegetation Management of Electricity Entities - Fallen Power Lines [Cases 8-11]

Recommendation 5 stated that “DIR research and monitor industry best practice in vegetation management and ensure this information is used to inform the network operator Safety Management Systems which will be implemented as required under the new Electrical Safety Act 2002”.

The Electrical Safety Office engaged a suitably qualified independent consultant to conduct a best practice study into the co-existence of electrical networks and vegetation.

The report investigated the existing statutory requirements, policies and systems of the regulatory authorities and electricity distribution entities in Queensland, NSW, Victoria, SA and ACT. It also considered systems from web based research of overseas utilities and other industries.

The investigation also benefited greatly by integrating it with a business process audit by the Electrical Safety Office of the vegetation management systems of Ergon Energy.

The report recommends that vegetation management systems must include key factors such as asset management, strategic sourcing, business process re-engineering, performance management, and project management.

A copy of the report was issued to both Energex and Ergon Energy in mid January 2005 seeking advice of actions in response to the report. Responses were received that confirmed that the report would be used to improve their vegetation management systems.

Again, for the purposes of ensuring compliance, the Electrical Safety Office has included vegetation management audits of Energex and Ergon Energy in its Electrical Safety Audit Program.

7.1.6.2 Work in progress

The Commissioner provided the following information regarding safety issues that are in the course of being addressed:

Monitoring of Emerging Technologies - Fallen Power Lines [Cases 8-11]

Recommendation 10 stated that "DIR continue to monitor existing, new and emerging technologies in the area of low voltage protection systems, consult with industry bodies, regulators from other jurisdictions and international networks to assist in informing the process".

This recommendation was approached by incorporating it into the work of The Energy Networks Association. This is a national body that reviews technical practices for electricity entities across Australia.

This process has produced a draft "National Low Voltage Electricity Network Electrical Protection Guideline" which was first published in December 2003. That document was produced collaboratively with electricity entities and safety regulators of which the Electrical Safety Office was an active participant.

The objective of the guideline is to establish a standard across the country at least equal to international best practice in an environment such as the Australian one. The guideline also explicitly recognises the dynamic nature of the technologies involved, envisages that amendments will be required both in the light of those developments and of experience.

This draft is currently undergoing further review, and should be finalised in 2005.

7.1.7 Additional comments by Commissioner

The Commissioner for Electrical Safety has advised that the following work is ongoing:

Promotion of "Look Up and Live" message

Two key priorities in the Electrical Safety Office Business Plan are:

- Promote heightened electrical safety awareness throughout the community and an increased understanding of the importance of acting on that knowledge (e.g. Key messages that underpin the ESO Communication Plan).

- Foster a culture of electrical safety throughout the community by working with industry organisations and people to develop practical means by which they can comply with electrical safety law and thus promote safety.

As part of meeting these priorities, the inclusion of specific information relating to crane and other plant safety near overhead power lines in training material has been provided for owner builders.

The Electrical Safety Office has expanded these priorities to include training material for a range of workers considered likely to be at risk of coming into contact with overhead power lines. It has consulted with a number of stakeholders who provide this training and have negotiated amendments to the training to include relevant information related to this matter. It is anticipated that amendments to training materials will be implemented by the end of 2005.

The Electrical Safety Office, in conjunction with the Strategic Communications Unit of DIR, developed and is in the process of implementing, a comprehensive education campaign. Work to date includes advertising in relevant industry journals, providing information to a range of key stakeholders who have provided this information to their members, and the provision of information on the Electrical Safety Office website.

Regular Consultation with Crane Industry Representatives

In conjunction with Workplace Health and Safety Queensland (WHSQ), the Electrical Safety Office regularly meets with representatives of two crane industry groups. These are the "Tower Crane" and "Mobile Crane" groups to discuss crane safety in general, as well as electrical safety.

7.2 Safety switches

A number of incidents in the WEP raised the use of safety switches[332]. Safety switches have been recognised as a major factor in the reduction of fatal electrocutions in both residences and workplaces.

The June 2004 DIR Issues Paper called "Safer Electrical Equipment" stated[333]:

> Safety switches, also known as Residual Current Devices or Ground Fault Circuit Interrupters, are capable of detecting very small leakages of current to earth and function by disconnecting the supply of electricity. They can protect a person from electric shock resulting from various incidents including faults in electrical appliances, circuit wiring or misuse of electrical equipment. Safety switches do not remove the need for safe practice in the use of electrical equipment but do provide continuing protection, unlike maintenance regimes which detect and repair fault only at particular times. Safety switches can mean the difference between life and death when a fault does occur.

7.2.1 Workplaces

Regulation of the use of safety switches differs[334] depending upon the type of work being performed. The installation of safety switches is not mandatory in many cases.

The current position is that workplaces where there is an inherently high electrical risk (for example, construction, assembly, fabrication, maintenance

332 There are thee basic types of safety switch, each with its own special features and application – standard safety switch, power outlet safety switch and portable safety switch.

333 Page 8.

334 Electrical Safety Regulation 2002 – Part 5, Division 4, Sections 77-81.

and manufacturing) must have a safety switch installed on the switch board or use a portable safety switch. Premises where office work or other work is carried out can either have a safety switch installed or have all electrical equipment tested and tagged.

A draft Code of Practice called “Electrical Safety In Workplaces - How to ensure safety and meet your obligations” has recently been prepared and is presently the subject of consultation.

It includes information on the use of safety switches.

7.2.2 Residential

Safety switches have been compulsory[335] in new homes in Queensland since 1992.

Since September 2002 a purchaser of residential property is required to install a safety switch within three months of settlement[336].

Otherwise, it is not compulsory to install a safety switch in a home constructed prior to 1992 until there is a change of ownership.

The Electric Safety Board strategic plan for 2003-2005 states[337] that “from 1991/92 to December 2000, an average of four domestic fatalities per year could have been prevented if a safety switch had been fitted to protect power circuits”.

One of the principal approaches of DIR has been to use an advertising campaign to raise awareness of the benefits of safety switches and to advocate higher levels of voluntary installation. A safety switch costs approximately $200 fully installed[338].

The question that needs to be asked is whether this approach has produced an adequate uptake of residential safety switch installation throughout the community.

Recent electrical fatality statistics supplied by DIR suggest that a safety switch “would have controlled the electrical safety risk” in six of the seven fatal electrical incidents that occurred in Queensland in the 2004-05 reporting year. Two of the fatalities occurred at separate residences where safety switches were not installed.

This issue, namely the adequacy of the voluntary take-up approach to safety switch installation for residential premises, was raised in the June 2004 DIR Issues Paper.

335 Electrical Safety Regulation 2002 – Part 5, Division 4, Sections 77-81.

336 Historically, it has been suggested that 50% of residential property in Queensland is transferred approximately every 7 years.

337 Page 8.

338 According to the ESO website.

I understand that DIR will shortly be in a position to review, and form a view on, whether or not the voluntary approach has been a success from an electrical safety perspective. I also understand that DIR intends to:

- review its strategies for encouraging owners of residential premises to install safety switches; and

- reconsider the case for amending the Regulation to require owners of residential premises to install safety switches over a nominated phase in period.

I will continue to monitor developments as they arise.

Chapter 8: Government Owned Corporations and Local Government Owned Corporations

8.1 Application of Ombudsman Act 2001

Section 184 of the *Government Owned Corporations Act 1993* (GOC Act) provides that:

> The *Ombudsman Act 2001* does not apply to a company GOC.

Section 728(1)(a) of the *Local Government Act 1993* (LG Act) provides that:

> The *Ombudsman Act 2001* does not apply to a corporatised corporation prescribed under a regulation.

Accordingly, I am unable to investigate, form opinions or make recommendations about the administrative actions of company GOCs and LGOCs.

8.1.1 Government Owned Corporations

A number of cases in the WEP concerned incidents which involved infrastructure controlled or operated by Energex.

Energex[339] is a government owned corporation (GOC) under s.6 of the GOC Act.

There are a number of other company GOCs involved in the generation, transmission, distribution and retail fields of the Queensland energy sector, namely:

- Tarong Energy Corporation Ltd
- CS Energy Ltd
- Stanwell Corporation Ltd
- Powerlink Queensland
- Ergon Energy Corporation Ltd and Ergon Energy Pty Ltd
- Energex Retail Pty Ltd.

8.1.2 Local Government Owned Corporations

There is one corporatised Local Government Owned Corporation, namely Wide Bay Water, but it has not been prescribed under a regulation so as to exclude it from the application of the *Ombudsman Act*.

339 Energex became a statutory GOC prescribed by regulation on 1 January 1995. It then became a company GOC pursuant to s.7(3) of the GOC Act on 1 July 1997 when it was incorporated or registered under the Corporations Law.

8.2 Part 4 of the Ombudsman Act 2001 – powers and procedures for conducting investigations

Section 24 of the *Ombudsman Act* provides that the Ombudsman may conduct an investigation either:

- informally; or
- by exercising powers under Part 4.

Part 4 of the *Ombudsman Act* sets out the Ombudsman's powers for conducting "formal" investigations. The relevant sections that provide the Ombudsman with coercive powers are ss.28 and 29(1). Those sections require persons who have received a formal notice from the Ombudsman to give an oral or written statement of information relevant to an investigation or produce documents containing information reasonably required for an investigation, and, if required, to attend before the Ombudsman to answer questions or provide documents relevant to an investigation.

Part 4 or "formal" powers would generally only be used where a matter raises a serious allegation of maladministration and for example where:

- an agency claims legal professional privilege; or
- an agency is unwilling to provide information other than in response to an investigation requirement; or
- there has been actual or suspected non-cooperation on the part of an agency or individual in response to a reasonable informal request for information or preliminary inquiry[340].

Section 30 introduces the concept of an "investigation requirement". Non-compliance with an investigation requirement can lead to prosecution under s.30 of the Act and other judicial sanction. It provides:

> **30 Compliance with investigation requirement**
>
> (1) A person who receives an investigation requirement must comply with the requirement, unless the person has a reasonable excuse.
>
> Maximum penalty—100 penalty units.
>
> (2) An excuse is a reasonable excuse for subsection (1) if—
>
> (a) within the time for compliance with the investigation requirement, the person gives the ombudsman a notice of the excuse in enough detail to allow the ombudsman to form an opinion on whether the excuse is reasonable; and

340 Section 22 of the *Ombudsman Act* allows the Ombudsman to make "reasonably necessary inquiries to decide whether a complaint should be investigated".

(b) the ombudsman advises the person that, in the ombudsman's opinion, the excuse is reasonable.

(3) Subsection (2) does not limit what is a reasonable excuse.

8.3 Level playing field

GOCs and LGOCs are intended to operate as corporate bodies on a commercial basis in a competitive environment.

Section 16 of the GOC Act provides:

> **"Corporatisation"** is a structural reform process for nominated government entities that—
>
> (a) changes the conditions and (where required) the structure under which the entities operate so that they operate, as far as practicable, on a commercial basis and in a competitive environment; and
>
> (b) …
>
> (c) …

The National Competition Policy[341] aims to ensure that private and public bodies are able to compete for business on a level playing field.

There are arguments both for and against the exclusion of GOCs and LGOCs from the Ombudsman's jurisdiction.

8.3.1 Argument for exclusion

The principal argument supporting the exclusion of GOCs and LGOCs from the operation of the *Ombudsman Act* relates to the creation of a "level playing field" for these corporatised entities with their private sector competitors. In other words, the argument is that GOCs and LGOCs should not be subject to the additional administrative and financial burdens that would be imposed if administrative decisions and actions of company GOCs could be the subject of complaint, investigation and review under the *Ombudsman Act*.

I do not express any opinion on this issue which is a matter for the Parliament to determine. My concern is with the terms of the provisions excluding GOCs and LGOCs from my jurisdiction.

341 In accordance with the National Competition Policy principles, GOCs are expected to operate on the basis that they do not experience significant advantages or disadvantages by virtue of their government ownership.

8.3.2 Need for refinement of the exclusion

In my opinion, the exclusion of GOCs and LGOCs from the Ombudsman's jurisdiction would be more appropriately achieved by excluding them from the definition of "agency" in the *Ombudsman Act*.

One of the principal functions of the Ombudsman is to investigate administrative actions of agencies, as defined – that is State government departments, public authorities and local governments. In my view, s.184 of the GOC Act, by removing company GOCs from the application of the *Ombudsman Act*, has produced some unintended and unjustifable consequences that are not in the public interest.

As illustrated in the example below, the broad exclusion may allow company GOCs to refuse to cooperate with Ombudsman investigations into the administrative actions of agencies that clearly are subject to the *Ombudsman Act*, by declining to provide relevant information in the GOC's sole possession.

Section 184 may also allow company GOCs to claim that they are exempt from the operation of the coercive powers given to the Ombudsman by Parliament to compel the production of information relevant to an investigation from any citizen or private sector corporation.

This would place company GOCs in a unique position. It is unlikely that Parliament was aware that s.184 would create this anomaly[342].

8.4 WEP example

There was one clear example in the WEP that neatly illustrates the jurisdictional problem confronted by my Office when investigating complaints involving infrastructure controlled or operated by a company GOC.

8.4.1 Cases 6 and 7

Cases 6 and 7[343] concerned the investigation of an incident involving a crane that became energised after making contact with live overhead power lines at a construction site. AB, the crane operator, and KC, a labourer, were fatally electrocuted at the site within minutes of each other.

Section 80(2) of the Workplace Health and Safety (Miscellaneous) Regulation 1995 required the employer at the construction site to:

(i) consult with Energex; and

(ii) ensure the safety precautions required by Energex were complied with.

342 The same argument applies to LGOCs and s.728(1)(a) of the Local Government Act 1993.

343 See summary at 4.6.1 of this Report.

The object of consultation between an employer and an electricity entity is to ensure, as far as reasonably possible, that steps are taken to make the construction site electrically safe as a workplace[344].

There was evidence that consultation took place between the employer and Energex. However, there was conflicting evidence from both parties as to what was discussed. I dealt with the issue as follows[345]:

> The WH&S inspector concluded that there was "consultation" and that Energex's requirements were met by the principal contractor. He was satisfied that s.80 had not been breached.
>
> However, the evidence I have gathered suggests that crucial evidence regarding the consultation with the electricity entity Energex, was not obtained. The Energex employee who met the principal contractor's representative on site and who provided the quotation for the tiger tails was not interviewed by the WH&S inspector, nor was the principal contractor's representative. Both of these persons have since been separately interviewed by my officers and each provided conflicting accounts regarding the initial consultation.
>
> The Energex employee stated that he informed the principal contractor's representative that it was possible to de-energise the HV power lines (for a price). The principal contractor's representative has denied receiving such advice.

This issue was not adequately investigated by either WH&S or the ESO.

In the course of my investigation of the adequacy of the inquiries made by WH&S and the ESO, I wrote[346] to Energex to ascertain what documentary evidence may have been available to the WH&S and ESO investigators had they pursued the consultation issue. My letter asked:

1. Did Energex at the relevant time keep records of the details of consultations held under s.80 of the Regulation? If so:

   (a) In what form were those records kept; and

   (b) On how many occasions, during the period August 1996 to August 1998, was Energex consulted by an employer or self-employed person in relation to working within 2 metres of elevated electric lines pursuant to the requirement for such consultation under s.80 of the WH&S (Miscellaneous) Reg 1995?

2. Is it normal practice for Energex to advise that HV overhead conductors can be de-energised at a price?

3. On how many occasions (say in the two years prior to this incident) did Energex de-energise HV conductors adjacent to construction sites … at the request of a builder?

344 Section 80 applies if certain persons or equipment are likely to come within two metres of an elevated electric line.

345 Page 54 of Cases 6 and 7 of the WEP.

346 By letter dated 19 November 2002.

In response, solicitors for Energex stated[347]:

> You have raised several questions for Energex in your correspondence of 19 November 2002. Some of these questions have by necessity been addressed in these submissions. However, **we are of the opinion that the questions that you have directed towards our client are in effect an investigation of the conduct of Energex (or SEQEB as it then was) and as such are ultra vires. It would be improper for our client to respond to matters that are ultra vires**. [emphasis added]

Energex provided a submission but it did not address any of the above questions about de-energising power lines other than to say, under the heading "Work site Powerline Safety", that its normal practice was to:

- require any application to be in writing, (as are all its responses); and
- for the responsible Energex officer to become familiar with the context in which the advice was sought.

The submission went on to discuss the usual procedure adopted in general terms and what had occurred on this occasion.

There are several points that I wish to make about this response, namely:

- My questions were directed to obtaining information about a specific issue and that was unavailable from any other source. These questions were relevant to my inquiry into the adequacy of investigations by WH&S and the ESO.
- The circumstances of this particular incident involved infrastructure controlled or operated by Energex, and the workplace and equipment of two private companies. Therefore, to properly investigate the agencies' actions, and form an opinion about the scope and qualities of their investigations, I had to take into account the interaction of departmental officers with these entities and assess relevant evidence given at the public Coronial Inquest.
- In the course of investigating Case 4, I informed Energex that my inquiries were not for the purpose of investigating its actions, as I had no jurisdiction to do so.
- I did not seek to use my statutory powers under the *Ombudsman Act* to compel Energex to produce the information.

The fact that Energex did not provide the specific requested information meant that I was unable to form an opinion about a matter that was a significant public safety issue and relevant to WH&S's investigation – namely,

347 By letter dated 10 January 2003.

the extent of industry compliance with s.80 of the WH&S (Miscellaneous) Regulation 1995.

8.5 Detailed Report of the Independent Panel

The Detailed Report of the Independent Panel[348] (commonly known as the Somerville Report) made a number of comments about vegetation management, cross-arm inspections and maintenance expenditure generally in relation to both Energex and Ergon Energy. Two of the major recommendations were that:

- Energex has not spent sufficient amounts in recent years on maintaining its system and, in particular, has not had an adequate focus on preventative maintenance, such as on vegetation management and cross-arm inspections. This has significantly contributed to the number and duration of outages across Energex's system. The Panel recommends that Energex ensure that sufficient amounts are spent to deliver an effective maintenance programme. In particular, attention needs to be given to its overhead network;

- Ergon Energy inherited six diverse asset management systems when it was established in 1999. The lack of reliable asset information available from these systems has significantly constrained the effectiveness of Ergon Energy's maintenance activities. The Panel believes that Ergon Energy has taken too long to address this problem and recommends that it expedite the up-grading of its systems to ensure it can implement a comprehensive and effective maintenance programme as soon as possible.

In WH&S's and the ESO's investigations of the incidents the subject of Cases 9 to 11, they should have investigated the adequacy of Energex's vegetation management practices. My focus was on the sufficiency of their investigations of the issue. Similarly, WH&S's investigation of the incident the subject of Case 4 should have considered the adequacy of Energex's maintenance program including its cross-arm inspection program. My focus was on the sufficiency of WH&S's investigation of the issue.

My inability to compel the electricity entities to disclose information of this nature while I am conducting investigations concerning infrastructure controlled or operated by them limits my Office's effectiveness. I would be able to obtain similar information from private corporations using the powers conferred by Part 4 of the *Ombudsman Act*.

I am unable to see the public benefit of the total exclusion of company GOCs from the operation of the *Ombudsman Act*.

348 Page 29 of Office of Energy, Department of Natural Resources, Mines and Energy, July 2004, *Detailed report of the independent panel – electricity distribution and service delivery for the 21st century*, Queensland Government, Brisbane, Queensland.

8.6 Possible legislative amendment

For the reasons stated in this chapter consideration should be given to:

8.6.1 Amending s.184 of the *Government Owned Corporations Act 1993* to read as follows:

> "A company GOC is not an agency within the meaning of the *Ombudsman Act* 2001".

8.6.2 Amending s.728(1)(a) of the *Local Government Act 1993* to read as follows:

> "A corporatised corporation prescribed under a regulation is not an agency within the meaning of the *Ombudsman Act 2001*".

8.6.3 Alternatively, the same outcome could be achieved by repealing ss.184 and 728(1)(a) and amending s.8 of the *Ombudsman Act* 2001 by inserting a new s.8(4) as follows:

> "(4) However, neither of the following is an agency –
>
> (a) a company GOC under the *Government Owned Corporations Act 1993*; and
> (b) a corporatised corporation under the *Local Government Act 1993* that has been prescribed by regulation".

In my opinion, the second alternative is preferable because it is good legislative drafting practice to insert all provisions relating to the operation of a specific legislative scheme (independent review) in the Act that provides for the scheme.

Chapter 9: Dangerous industrial conduct

9.1 Background

Several complainants in the WEP argued that criminal charges should have been brought against employers in relation to the incidents involving their relatives. They claimed that the imposition of fines was not, in itself, an appropriate penalty or deterrent for employers who may have recklessly breached legislative standards. These complaints pre-dated the enactment of the *Electrical Safety Act* and the recent amendments to the WH&S Act.

The Electrical Safety Taskforce prepared[349] an "Issues Paper and Call for Comment" in October 2000. One issue for consideration in that paper was "Industrial Manslaughter or Dangerous Industrial Conduct Causing Death or Serious Bodily Injury". The issue had previously been the subject of consideration by the Building and Construction Industry (Workplace Health and Safety) Taskforce.

At about this time[350], a separate Discussion Paper was prepared by the Department of Justice and Attorney-General called "Dangerous Industrial Conduct". The Discussion Paper stated that the then Attorney-General and Minister for Justice and Minister for the Arts was seeking public submissions "on a proposal for law reform in Queensland, specifically, the proposal of a new offence in the Queensland *Criminal Code*". The Discussion Paper went on to state[351]:

> This offence, tentatively called "Dangerous Industrial Conduct" is proposed to be an offence similar in concept to that of "Dangerous Driving" causing either death or grievous bodily harm (section 328A(4) of the *Criminal Code*).
>
> It is proposed that both individuals and corporations will be liable for the offence, with a maximum penalty of a fine of 6700 penalty units ($502,500.00) or 7 years imprisonment.

The Discussion Paper set out the case for a new offence in the following way:

> There have been recent calls for the introduction of a new offence of "corporate manslaughter" or similar offences by trade unions, academics, legal practitioners and the representatives and families of victims of industrial and workplace accidents.
>
> It has been argued that it is difficult to successfully prosecute persons with the offence of manslaughter when they create situations of dangerousness causing death or serious injury in a workplace to both employees and members of the public, even where there has been gross negligence. This difficulty has been compared to the difficulties inherent in prosecuting drivers

349 Department of Employment, Training and Industrial Relations, October 2000, "Issues Paper and Call for Comment", Queensland Government, Brisbane, Queensland.

350 October 2000.

351 Page 1.

> for manslaughter prior to the introduction of the offence that preceded the current section 328A of the *Criminal Code*.
>
> Further, penalties awarded so far for offences under the *Workplace Health and Safety Act 1995* have been considered inappropriate for cases where industrial negligence and breaches of legislation result in death or serious injury. To date, the highest penalty imposed by the courts where there has been a fatality has been $40,000.00.

The Issues Paper expressed[352] the case in favour of the creation of a new offence when it stated:

> Arguments for manslaughter again relate to deterrence and prevention principles. Hopkins (1995) argues that if individuals in society who cause death in a culpable manner can be charged with manslaughter why not companies in the context of workplace death. He goes on to say that a corporate manslaughter conviction carries more stigma and could capture more public interest than a conviction for failure to maintain a safe workplace. While these arguments are legitimate the realities of gaining a successful conviction within the present legal system is extremely problematic and highly unlikely.
>
> In contrast to general obligation offences under the Workplace Health and Safety Act 1995, successful prosecution for a crime such as manslaughter requires proof of guilty mind on the part of the defendant or mens rea. This is most problematic in relation to manslaughter charges as they pertain to a corporation. In order to gain a conviction the prosecution must prove a high degree of negligence. Negligence however is a state of mind and since a corporation does not have a state of mind it is almost impossible to describe a corporation's behaviour as negligent (Hopkins 1995).
>
> To address this problem the courts have held that a corporation will only be criminally liable for an offence if an officer of the corporation, senior enough to be a directing mind of the corporation, is negligent. This principle, commonly known as the 'Tesco Principle' has been criticised as unworkable in larger corporations as it fails to reflect the diffused nature of decision-making in medium and large organisations (Johnstone 1999).
>
> These difficulties become apparent when examining the Victorian experience. Since 1990 Victoria has maintained a policy of prosecuting individuals and corporations for manslaughter in cases of reckless or criminally negligent workplace deaths. Despite the existence of the provision since 1990 there has been only one successful prosecution. In R v Denbo Pty Ltd a company was found negligent and fined $120,000 for causing the death of one of its employees. Although the company pleaded guilty within one month of the trial the company went into liquidation and was therefore unable to meet the fine. In other cases the judiciary have attributed the negligence to personal failures of individuals and not company negligence (Creighton & Rozen, 1997). The solution to this problem may lie in the adoption of an entirely new corporate liability law that establishes new methods for determining corporation mens rea.

352 Pages 17 – 18 of Issues Paper.

Problems of prosecuting under general criminal law are significantly reduced in the context of personal liability matters. It is much easier to prove personal liability of individual managers compared to corporate liability. Cases however are still rare, with a few notable exceptions in the United Kingdom and United States of America. In addition most Australian jurisdictions have criminal provisions for reckless or negligent conduct leading to an injury. In Queensland any person who unlawfully does an act or omits to do any act (which it is the person's duty to do) that actually causes bodily harm can be charged under section 328 of the Criminal Code. If these offences are brought against corporations then the principles relating to mens rea must be proven. The decision as to whether criminal charges such as manslaughter should be laid rests with the police or investigating coroner (Johnstone, 1999). The bulk of union submissions received by the Taskforce acknowledged the difficulties of prosecuting corporations as outlined above and have sought support through the Attorney General's office to consider the introduction of new charges against individuals such as 'endangering peoples lives' or 'allowing dangerous activity'. The outcome of these negotiations or the likelihood of success are difficult to know or predict at this time.

9.2 Current position

The Final Report of the Electrical Safety Taskforce did not deal with the issue. The Final Reports of the Ministerial Review of WH&S and the ESO also did not address the topic.

Both the Issues Paper and the Discussion Paper are now some years old and pre-date the *Electrical Safety Act* and the amendments to the WH&S Act and the *Electricity Act*.

Recent advice[353] from the Department of Justice and Attorney-General is that "since the release of the Discussion Paper there have been no further legislative developments". A final public report was not prepared[354].

In relation to electrical safety, section 27 of the *Electrical Safety Act 2002* provides that a person on whom an electrical safety obligation is imposed must discharge the obligation. The section goes on to provide a range of maximum penalties dependent upon whether the breach of the obligation has led to multiple deaths, death or grievous bodily harm, bodily harm or another outcome. In each case, the penalty is expressed as either a fine or, in the alterantive, a term of imprisonment. Section 46 of the Act provides a defence for a person if they are able to "prove that the commission of the offence was due to causes over which the person had no control".

In relation to workplace health and safety, section 24 of the WH&S Act contains a similar provision.

353 23 March 2005.

354 Advice from Department of Justice & Attorney-General dated 17 June 2005.

9.3 Other jurisdictions

The issue of industrial manslaughter has been debated in a number of other jurisdictions. The Discussion Paper sets out a useful summary of the legal position, as it then was[355], in Victoria and the Commonwealth and some overseas jurisdictions such as Great Britain, the United States, France, Germany and Canada.

9.3.1 Australian Capital Territory

The ACT was the first jurisdiction in Australia to pass legislation[356] creating the offence of Industrial Manslaughter.

An employer in the ACT is guilty of this offence[357] if a court is satisfied[358] that the employer has been criminally negligent[359] or reckless[360] and that this negligent or reckless behaviour has caused the death of a worker. The death of the worker must occur in the course of the worker's employment.

A recent attempted prosecution for the new offence, involving an electrical fatality at a workplace, was unsuccessful. A media source reported[361] that the prosecution failed because the magistrate found it was unclear who should have been supervising the site. The magistrate ordered the matter not proceed to trial.

9.3.2 The Commonwealth

The Commonwealth has adopted a different approach.

In a recent legal article[362] considering some other legal models for the liability of corporations for the death and serious injury of their employees, the author summarised the Commonwealth position as follows:

> The *Criminal Code Act 1995* (Cth), effective 15 December 2001, was Australia's first attempt at a new legislative paradigm for corporate criminal liability. Under Part 2.5 of the Code, the physical element of an offence is attributed to a corporation if that element was committed by an employee, agent or officer of the body corporate, acting within the actual or apparent scope of his or her employment, or within his or her actual or apparent authority (s 12.2).
>
> The fault element of the offence makes the corporation liable if it has expressly, tacitly or impliedly authorised or permitted the offence (s 12.3(1)).

355 October 2000.

356 The Australian Capital Territory passed the Crimes (Industrial Manslaughter) Amendment Bill 2002 on 27 November 2003. Consequential amendments to the *Crimes Act 1900* took effect from 1 March 2004, and are included in Part 2A.

357 Section 49A of the *Crimes Act 1900* (ACT).

358 To the criminal standard, that is, beyond reasonable doubt.

359 Section 21 of the Criminal Code 2002 (ACT).

360 Section 20 of the Criminal *Code 2002* (ACT).

361 ABC Online – 8 December 2004.

362 Wheelwright, Karen, [2002] Deakin Law Review, "Corporate Liability for Workplace Deaths and Injuries – Reflecting on Victoria's Laws in the light of the Esso Longford Explosion".

> The corporation's intent is found in a corporate culture that fails to promote the compliance of its officers and employees with the criminal law, or encourages or tolerates non-compliance (s 12.3). Corporate culture is 'an attitude, policy, rule, course of conduct or practice existing within the body corporate generally' or in the relevant part of the body corporate (s 12.3(6)). In the words of one commentator, the Code takes a 'realist' rather than a 'nominalist' view of corporations. It conceptualises the corporation as a discrete and unique entity which can have a 'moral personhood' independent of its individual members and which can be criminally culpable in its own right. The concept of corporate culture 'takes cognisance of the complex nature of the corporate decision-making process and the diffusion of responsibility within corporations'.
>
> The Commonwealth approach is echoed to some extent in the recently-defeated Victorian proposals, which deal specifically with workplace deaths and injuries. Although not presently under active consideration, the proposals are worth considering for the alternative approach they present to this difficult problem.

9.3.3 Victoria

The Victorian government recently made an unsuccessful attempt to introduce amendments to the *Crimes Act 1958* (Vic) to provide for an offence of corporate manslaughter. One commentator[363] summarised what had occurred in the following way:

> On 22 November 2001, the Victorian government introduced the Crimes (Workplace Deaths and Injuries) Bill 2001 into the Victorian parliament. The bill passed the Legislative Assembly with amendments on 14 May 2002 but failed to pass the Legislative Council on 29 May 2002. The bill proposed to amend the *Crimes Act 1958* (Vic) to create new offences of corporate manslaughter and negligently causing serious injury by a body corporate, and to impose criminal liability on senior officers of a body corporate in certain circumstances. The bill's introduction was the culmination of a long period of policy development and consultation, beginning in October 2000, on proposals to strengthen the role of the criminal law in preventing deaths and serious injuries in the workplace.
>
> The bill introduced new offences of negligently killing by a body corporate (corporate manslaughter) and negligently causing serious injury by a body corporate. The injury or death had to be in respect of an employee in the course of his or her employment by the body corporate, or of a worker in providing services to, or relating to the body corporate.

9.4 Comment

There are a number of arguments for and against the creation of a new criminal offence as discussed. I do not intend to express a view one way or the other. Many of these were debated publicly prior to the enactment of the *Electrical Safety Act*[364] and the recent amendments to the WH&S Act[365], both

363 Wheelwright, Karen, [2002] Deakin Law Review, "Corporate Liability for Workplace Deaths and Injuries – Reflecting on Victoria's Laws in the light of the Esso Longford Explosion".

364 Section 27.

of which contain custodial penalties (as an alternative to a fine) for a breach of either an electrical safety obligation or a workplace health and safety obligation.

It is not the role of an Ombudsman to advocate to government about what policy position it should take in relation to the creation of a new criminal offence. I have raised the issue because complainants raised it with me during the WEP and the then[366] Attorney-General and Minister for Justice and Minister for the Arts thought the matter of sufficient importance to warrant the preparation of a Discussion Paper.

365 Section 24.

366 October 2000.

Appendix A: Recommendations made in the Electrical Safety Taskforce Final Report

Recommendation 1
That the functions of the electrical safety regulator be clearly outlined in legislation and assigned to an independent body to administer, reporting to the Minister for Industrial Relations.
Recommendation 2
That stand-alone electrical safety legislation be developed as a matter of urgency, based on the *Workplace Health and Safety Act 1995* and complementary to other safety legislation, to apply universally.
Recommendation 3
That a new system of notifications of electrical accidents and incidents together with investigations by the electrical safety regulator be introduced under the new electrical safety legislation (see R2), funded by a levy on electricity entities.
Recommendation 4
That all workplace electrical incident/accident investigations be conducted by a single body.
Recommendation 5
That "point of sale" electrical safety checks and the issue of an electrical safety compliance certificate be considered for domestic premises.
Recommendation 6
- That all domestic premises have at least power circuit safety switches fitted either at point of sale or within a phasing in period determined in consultation with stakeholders, whichever first occurs; and
- That workplaces as a minimum have electrical safety switches protecting all hand held or portable equipment supplied through electrical power outlets up to 20Amp, with a phasing in period determined in consultation with stakeholder.

Recommendation 7
That Government develop a strategic program of minimising the risk of contact with overhead lines, including undergrounding of existing lines.
Recommendation 8
That a mechanism be developed providing for comprehensive safety management plans for network operators to be monitored and enforced by the regulator.
Recommendation 9
That safety management plans include comprehensive asset management programs.
Recommendation 10
That a more strategic role, function and composition of the Electricity Health and Safety Council be subsumed into the corporate governance arrangements for the proposed electrical safety regulator.
Recommendation 11
That the current review of the role of workplace health and safety officers and representatives being undertaken by the Workplace Health and Safety Board take into account the needs of the electrical industry and that the workplace consultative arrangements contained in the *Workplace Health and Safety Act 1995* be enforced more stringently.
Recommendation 12
That the Government ensure adequate resourcing is made available to the proposed new electrical safety regulator. Consideration should be given to the following:
- the introduction of a levy on electrical entities;
- increased fines for breaches of the proposed new electrical safety legislation, including the awarding of investigation costs;
- the introduction of on-the-spot fines for lesser breaches;
- payment for service options (the Victorian model); and
- a review of electrical worker and contractor licence fees, including considering the introduction of application fees and re-inspection fees for errant contractors.

Appendix B: Recommendations made in the Final Report of the Ministerial Review of WH&S and the ESO

Recommendation 3.6(A)
That the Department becomes more intentional in identifying the appropriate level of service and advice that can be offered by front-line counter staff and the sharing of common resources without undermining the integrity and importance of specialist advice across the programs.
Recommendation 3.6(B)
That clear expectations regarding the scope and role of CSOs be firmly established in conjunction with a training regime designed to assist the understanding and performance of this role. Where possible, the model should seek to utilise the specialist skills of the CSO without compromising the integrated service delivery model.
Recommendation 3.10
That the next generation of resource agreements provide for "qualitative" outputs as well as "quantitative" outputs that genuinely reflect the needs of the stakeholders.
Recommendation 3.11
That Assistant Regional Directors (WHS) have direct-line management accountability with State Office.
Recommendation 3.13
That the single-line budget process that includes the four programs be abolished and replaced with a budget allocation for the express use of the health and safety program and managed centrally within State Office. That the key human resource policy issues of staffing levels, classification levels, recruitment and replacement, training and development be set by State Office and implemented in the regions after extensive consultation that balances the needs of the regions with those of State Office.

Recommendation 3.14
That a thorough analysis of the impact and effectiveness of Regional Support Units be undertaken to ensure resources are utilised equitably across the programs.
Recommendation 3.16(A)
That the current title Assistant Regional Director (Workplace Health and Safety) be renamed Regional Manager (Workplace Health and Safety).
Recommendation 3.16(B)
That the newly named Regional Manager (Workplace Health and Safety) has direct-line management accountability to the Director of Program Services.
Recommendation 3.16(C)
That the current function of the Regional Operations Unit be slightly amended to take responsibility for the day-to-day management issues associated with the Regional Managers (Workplace Health and Safety) and the Director of Program Services.
Recommendation 3.16(D)
That the General Manager, through the Business Manager, allocates and monitors a separate health and safety budget to each Regional Manager (WH&S) that reflects the strategic needs of the Division and the local needs of each Region.
Recommendation 3.16(E)
That an adjustment from the Regional Support Units be made to accommodate the shift in budget under this proposal.
Recommendation 4.3
That a full review of the existing Resource Allocation Model be undertaken that considers a robust funding and staffing model that more closely reflects the needs of each region.
Recommendation 4.4(A)
That the use of the “Challenge Test” be suspended pending a review of its role and effectiveness in ensuring the recruitment of a professional inspectorate.
Recommendation 4.4(B)
That more intentional consideration be given to the balance in recruiting from general industry and from academic institutions.
Recommendation 4.6
That merit-based processes be examined with a view to providing greater access to A06-level positions, provided skill levels commensurate with this level can be demonstrated.
Recommendation 4.7
That more effective processes be continually developed to assist the inspectorate perform their core duties in the field.
Recommendation 4.10(A)
That serious consideration be given to the establishment of a brand name (e.g. Worksafe QLD) that will clearly identify the Division and be used on all literature and contact points of the Division.
Recommendation 4.10(B)
That the Department strongly considers a name change that reflects the nature of the Workplace Health and Safety Program in its title.
Recommendation 5.4
That strategic resources are allocated to resolve the issues in relation to the IAS database to ensure a robust case management system is established in keeping with the long-term needs of the Division.
Recommendation 5.5
That a policy be developed and implemented that prevents any new inspectors from attending fatal investigations within the first 12 months of service on their own.
Recommendation 5.8
That the Division design an in-house incident investigation and report-writing course in line (wherever appropriate) with the “best practice” model being used in Tasmania and Victoria. (Need to discuss duration of course and content).
Recommendation 5.9(A)
That a Director of Prosecutions be recruited to head up the Legal Unit in Brisbane with a salary range no less than that currently provided to the Director of Program Services.
Recommendation 5.9(B)
That the positions of Regional Investigations Officer (RIO), Regional Prosecutions Officer (RPO) and Regional Investigations and Prosecutions Officer (RIPO) be amalgamated into a new title called the “Investigations and Prosecutions Case Manager”. The newly created position (to be classified at AO7) will report directly to the Director of Prosecutions and attract a salary range based on merit and in accordance with the role, knowledge and skills outlined.
Recommendation 5.9(C)
That an Investigations and Prosecutions Case Manager, reporting directly to the Director of Prosecutions in Brisbane, be recruited for the Cairns District to manage the Cairns and Innisfail districts.
Recommendation 5.9(D)
That the 3-stage investigation and prosecution process be established in accordance with the review guidelines.
Recommendation 5.9(E)
That approximately 10-12 positions located throughout the regions be created in the form of “specialist investigators” at level A06 to reflect the knowledge, skill and experience required to adequately perform in this role. Subsequent to the recruitment of the specialist investigators through a clean selection process, advanced training should be provided for the successful incumbents.
Recommendation 6.1(A)
That an analysis of the current expenditure be provided to the Workplace Health and Safety Board to ensure existing monies are utilised in accordance with the strategic objectives of the Division and the Board.

Recommendation 6.1(B)
That a benchmarking exercise be undertaken to determine a ratio of full-time field inspectors (warrant holders) to workers that meets the expectations of the major stakeholders. The results of such an exercise should then be used to set future goals upon which funding submissions can be made.
Recommendation 6.4(A)
That further work and analysis be undertaken in consideration of the introduction of a broad-based contribution from all employers to adequately fund the activities of the Division as set by the Board.
Recommendation 6.4(B)
That the Division explore cooperative arrangements with other entities before committing any resources for the exclusive domain of "public safety". That the funding for purely "public safety" matters be provided from consolidated revenue.
Recommendation 7.0
That the *Workplace Health and Safety Act 1995* be reviewed to reflect changes in the labour market and the modern needs associated with the role of regulator.
Recommendation 8.1(A)
That all "Priority One" incidents occurring at a workplace be managed through the Legal Unit of the Division of Workplace Health and Safety, in accordance with the recommendations outlined in chapter 5 of this report.
Recommendation 8.1(B)
That internal protocols and funding issues be negotiated within a policy framework between the Division of Workplace Health and Safety and the Electrical Safety Office.
Recommendation 8.2
That the new electrical inspectors for the Division of Workplace Health and Safety be "authorised" by the Electrical Safety Office to carry out investigations on domestic premises when a serious or fatal injury has resulted from an electrical incident, in order to assist the Electrical Safety Office. The details are to be negotiated between the two agencies as a matter of priority.

Appendix C: Recommendations made in the Final Report of the Ministerial Review of the ESO

Recommendation 3.1
That the government create a separate Electrical Safety Act to regulate the safety matters pertaining to the electrical industry. Such legislation must reflect modern enforcement methods and be consistent with the Workplace Health and Safety Act wherever possible.
Recommendation 3.2
That an independent electrical safety regulator be established with the status of a Statutory Officer, under the authority and control of the Minister for Industrial Relations. The role should have broad standard setting powers that regulates the electrical industry as well as offer future advise to the Minister on how to improve the health and safety performance of the electrical industry.
Recommendation 3.3
That the government establish an intentional process that seeks to engage with the key stakeholders over the systematic development of legislative standards that will introduce the requirement for "point of sale" electrical safety inspection reports for domestic premises.
Recommendation 3.4
That the Division of Workplace Health and Safety consult with the Electrical Safety Office and tidy up the existing workplace Regulation regarding the scope and use and application of safety switches as a matter of priority.
Recommendation 3.5
That the Division of Workplace Health and Safety in conjunction with the Electrical Safety Office begin an intentional consultation process with key industry stakeholders to develop legislative standards that will systematically broaden the scope, application and use of safety switches in workplaces.
Recommendation 3.6
That the existing Advisory Electrical Health and Safety Council be replaced by an Electrical Safety Board who shall make recommendations for improved safety performance to the Minister for Industrial Relations.
Recommendation 3.7
That the membership of the advisory Electrical Safety Board be appointed by the Minister for Industrial Relations and reflect the broad interests of the electrical industry.
Recommendation 3.8
That the proposed legislation apply to Queensland Rail other than to the requirements of height for the installation of overhead conductors associated with the rail traction system.
Recommendation 3.9
That the government establish an intentional process that seeks to engage with the "exempt parties" over the systematic development of legislative standards that will require the reporting of all electrical incidents to a central database established and maintained by the ESO.
Recommendation 4.1
That all incident investigation functions relating to Priority One incidents and undertaken by Authorised Persons cease immediately and be undertaken by the Division of Workplace Health and Safety.
Recommendation 4.2(a)
That a thorough evaluation of the Authorised Person be conducted in relation to the inspection of electrical installations, to identify the specific safety issues associated with this role.
Recommendation 4.2(b)
That if the safety issues identified in the evaluation proposal reveal significant safety breaches then special consideration must be given to transferring this role to the ESO. Transition and funding issues will need to be determined if any transfer of the role is deemed appropriate by the evaluation.

Recommendation 4.3
That the current system of key performance indicators used by the ESO be reviewed with consideration given to the adoption of a new system that reflects a baseline position of the electrical industries safety performance with a view to continuous improvement.
Recommendation 5.1
That further investigation and consideration be given to the establishment of a levy on electricity distributors to adequately resource the proposed regulatory requirements of the Electrical Safety Office.
Recommendation 6.1
That all Priority One incidents occurring at a workplace be managed through the legal unit of the Division of Workplace Health and Safety, in accordance with the recommendations outlined in chapter 5 of this report.
Recommendation 6.2
That internal protocols and funding issues be negotiated within a policy framework between the Division of Workplace Health and Safety and the Electrical Safety Office. Such protocols should include arranging for reciprocal powers between the inspectors in both agencies.
Recommendation 7.1
That the new electrical inspectors for the Division of Workplace Health and Safety be "authorised" by the Electrical Safety Office to carry out investigations on domestic premises when a serious or fatal injury has resulted from an electrical incident in order to assist the Electrical Safety Office. The details are to be negotiated between the two agencies as a matter of priority.

Appendix D: Opinions and Recommendations made in Case 1 of the WEP

Opinions - Division of Workplace Health & Safety
1. The standard of investigation of this matter by WH&S was severely inadequate.
2. The investigative process was fragmented and uncoordinated.
3. WH&S did not adequately investigate the circumstances surrounding [NS]'s death.
4. All reasonable and obvious avenues of inquiry were not explored.
5. Available witnesses were not questioned adequately or at all.
6. The investigation was poorly formulated and, for all practical purposes, was hastily concluded before all available lines of inquiry were exhausted.
7. Any conscientious review of the investigation by [position title deleted] should have recognised these failings at the time.
8. The [position title deleted] responsible for the case did not undertake the suggested additional investigations between the two sitting days of the Coronial inquest (27/07/99 and 07/12/99).
9. A workplace audit was not performed by WH&S at [the employer] until five months after [NS]'s death. This delay was unacceptable.
10. [The employer] management had advance warning that this audit was to be conducted and as such a true picture of the attitude of the directors of that company to safety was not obtained.
11. The [position title deleted] failed to ascertain the contents of the workplace audit and outline the details of the problems found at [the employer] to the Coroner on day two of the inquest;
12. The [position title deleted] public behaviour was inappropriate during and at the conclusion of day two of the inquest.
13. The $40,000 fine imposed on [the employer] is unlikely ever to be recovered.
14. The directors of [the employer] were not prosecuted personally, but this avenue should have been considered.
15. Overall, the investigative process was unacceptably inadequate.
16. The Coroner who conducted the inquest into [NS]'s death was not provided with all the relevant evidence because of the inadequacy of the WH&S investigation and the fact that the results of the workplace audit at [the employer] were not made available to him.
17. An apparent lack of coordination existed between WH&S and the ESO in relation to this investigation.
18. Putting to one side the important role of the Queensland Police Service, a single agency should be responsible for the investigation of electrical accidents in Queensland.

Recommendations - Division of Workplace Health & Safety
1. DETIR should apologise to [NS's parents] for the poor standard of its investigation.
2. DETIR should enter into meaningful negotiations with [NS's parents] to financially compensate them (a 50% contribution) for their legal expenses in having to arrange representation at the inquest.
3. A comprehensive management and strategic review of WH&S should be undertaken as soon as possible by a suitably qualified independent reviewer selected in consultation with myself. The review should address:
   - 3.1 the structure of WH&S, including the delegation and allocation of responsibility and the appropriateness of the current classifications of positions;
   - 3.2 the adequacy of staff and other resources within WH&S to enforce the WH&S Act and Regulations, including whether, specifically, matters developed and earmarked for prosecution have been or are being dropped because of resourcing difficulties;
   - 3.3 current investigation methodologies and processes, including the giving of warnings in relation to workplace audits;
   - 3.4 formal and informal staff training and guidance;
   - 3.5 management systems and processes used by WH&S, including internal and external performance indicators to monitor efficiency and effectiveness and internal communication and sharing of information on operations and performance, especially as between the audit and investigative teams;

3.6 the competency of existing staff employed in compliance / enforcement roles within WH&S, so as to determine whether all such officers possess the appropriate skills, knowledge and training to undertake investigations, with any identified deficiencies being addressed by specific training and professional development;
3.7 the lack of awareness of the quality system and the appropriate intervals at which compliance with it should be audited; and
3.8 any other matters which impact on the economy, efficiency and effectiveness of investigations, prosecutions and audits.

4. In the interim, a memorandum of understanding should be developed (if not already in place) between the ESO, WH&S and the Queensland Police Service concerning the conduct of investigations into electrical fatalities in the workplace that address the investigative duplication and overlap identified in this Report.
5. The concept of a single agency responsible for the investigation of electrical accidents in Queensland should be considered. This concept will need to be assessed within the context of the ongoing legislative review presently underway.
6. The giving of advance warnings of workplace audits should cease immediately in relation to all but essential cases.
7. Specialised training should be provided for investigative staff within WH&S as to how best to deal with the grieving family, friends and associates of persons who have died or been seriously injured in the workplace.

Opinions - Electrical Safety Office

1. The standard of investigation of this matter by the ESO was very poor.
2. The ESO did not adequately investigate the circumstances surrounding [NS]'s death.
3. All reasonable and obvious avenues of inquiry were not explored.
4. Available witnesses were not questioned at all.
5. DME and the ESO appear to be of the erroneous belief that the failure to investigate electrical accidents with a view to prosecuting offences is acceptable.
6. Current ESO staff may not possess the relevant skills and knowledge to conduct investigations.
7. The Coroner who conducted the inquest into the death of [NS] was not provided with all the relevant evidence, due to the ESO's failure to perform its statutory duties.
8. An apparent duplication of responsibility exists between WH&S and the ESO in relation to the conduct of electrical accidents in the workplace.
9. Putting to one side the important role of the Queensland Police Service, a single agency should be responsible for the investigation of electrical accidents in Queensland.

Recommendations - Electrical Safety Office

1. DME should apologise to [NS's parents] in relation to the ESO's failure to adequately investigate this matter.
2. DME should enter into meaningful negotiations with [NS's parents] to financially compensate them (a 50% contribution) for their legal expenses in having to arrange representation at the inquest.
3. A comprehensive management and strategic review of the ESO should be undertaken contemporaneously by the same reviewer referred to in [WH&S] Recommendation 3. The review should address:
   3.1 the structure of the ESO, including the delegation and allocation of responsibility and the appropriateness of current classification of positions;
   3.2 whether adequate staff and resources exist within the ESO to enforce the Electricity Act and Regulations;
   3.3 current investigation methodologies and processes;
   3.4 formal and informal staff training and guidance;
   3.5 management systems and processes used by the ESO, including internal and external performance indicators to monitor the efficiency and effectiveness of the ESO and internal communication and sharing of information on operations and performance;
   3.6 the competency of existing staff employed in compliance / enforcement roles within the ESO be assessed to determine whether all officers possess the appropriate skills, knowledge and abilities to perform electrical investigations and any identified deficiencies should be addressed by training and professional development; and
   3.7 any other matters that impact on the economy, efficiency and effectiveness of investigations, prosecutions and audits.
4. In the interim, a protocol or memorandum of understanding should be developed (if not already in place) between the ESO, WH&S and the Queensland Police Service in relation to the conduct of the investigation of electrical fatalities in the workplace and elsewhere that address the investigative duplication and overlap identified in this report.
5. The penalty provisions within the *Electricity Act 1994* and Regulation should be reviewed to determine their appropriateness.
6. Specialised training should be provided for investigation staff within the ESO on how to deal with the grieving family, friends and associates of electrocution victims.
7. The concept of a single agency responsible for the investigation of electrical accidents in Queensland should be considered. This concept will need to be assessed within the context of the ongoing legislative review presently underway.

Appendix E: Opinions and Recommendations made in Case 2 of the WEP

Opinions - Division of Workplace Health & Safety

1. The standard of investigation of this matter by WH&S was manifestly inadequate.
2. The investigative process lacked any direction whatsoever.
3. Only a superficial effort was made to investigate the circumstances surrounding [AK]'s death.
4. All reasonable and obvious avenues of inquiry were not explored.
5. Available witnesses were not questioned adequately or at all and interviews were not conducted with potential defendants.
6. The investigation was poorly formulated and wrongly concluded before all possible offences had been identified and considered and all available lines of inquiry were exhausted.
7. Any conscientious review of the investigation by [position title deleted] should have recognised these shortcomings at the time.
8. Overall, the investigative process was unacceptably inadequate.
9. The Coroner who conducted the inquest into [AK]'s death was not provided with all the relevant evidence because of the inadequacy of the WH&S investigation.
10. An apparent lack of coordination exists between WH&S and the ESO in relation to the investigation of electrical accidents.
11. Putting to one side the important role of the Queensland Police Service, the concept of a single agency responsible for the investigation of electrical accidents in Queensland should be considered.

Recommendations - Division of Workplace Health & Safety

1. DETIR should apologise to [AK's parents] for the poor standard of its investigation.
2. DETIR should enter into meaningful negotiations with [AK's parents] to financially compensate them (a 75% contribution) for their legal expenses in having to arrange representation at the inquest.
3. A comprehensive management and strategic review of WH&S should be undertaken as soon as possible by a suitably qualified independent reviewer. The review should address:
   - 3.1 the structure of WH&S, including the delegation and allocation of responsibility and the appropriateness of the current classifications of positions;
   - 3.2 the adequacy of staff and other resources within WH&S to enforce the WH&S Act and Regulations, including whether, specifically, matters developed and earmarked for prosecution have been or are being dropped because of resourcing difficulties;
   - 3.3 current investigation methodologies and processes;
   - 3.4 formal and informal staff training and guidance;
   - 3.5 management systems and processes used by WH&S, including internal and external performance indicators to monitor efficiency and effectiveness and internal communication and sharing of information on operations and performance, especially as between the audit and investigative teams;
   - 3.6 the competency of existing staff employed in compliance / enforcement roles within WH&S, so as to determine whether all such officers possess the appropriate skills, knowledge and training to undertake investigations, with any identified deficiencies being addressed by specific training and professional development;
   - 3.7 the lack of awareness of the quality system and the appropriate intervals at which compliance with it should be audited; and
   - 3.8 any other matters which impact on the economy, efficiency and effectiveness of investigations, prosecutions and audits.
4. In the interim, a memorandum of understanding should be developed (if not already in place) between the ESO, WH&S and the Queensland Police Service concerning the conduct of investigations into electrical fatalities in the workplace that address the investigative duplication and overlap identified in this Report.
5. The concept of a single agency responsible for the investigation of electrical accidents in Queensland should be considered.
6. Specialised training should be provided for investigative staff within WH&S as to how best to deal with the grieving family, friends and associates of persons who have died or have been seriously injured in the workplace.
7. Procedures should be developed to ensure verbal information gathered during the course of investigations is adequately recorded in writing.

Opinions - Electrical Safety Office

1. No independent investigation whatsoever was undertaken by the ESO into this matter. However, one was clearly required.
2. The ESO did not adequately investigate the circumstances surrounding [AK]'s death.
3. Obvious avenues of inquiry were not explored.
4. Available witnesses were not questioned at all.
5. DME and the ESO appear to be of the erroneous belief that the failure to investigate electrical accidents with a view to prosecuting offences is acceptable.
6. Current ESO staff may not possess the relevant skills and knowledge to conduct investigations.
7. The Coroner who conducted the inquest into the death of [AK] was not provided with all the relevant evidence, due in part to the ESO's failure to perform its statutory duties.
8. An apparent duplication of responsibility exists between WH&S and the ESO in relation to the conduct of electrical accidents in the workplace.
9. Putting to one side the important role of the Queensland Police Service, the concept of a single agency responsible for the investigation of electrical accidents in Queensland should be considered.
10. The ESO's reliance on "authorised persons" employed by electricity entities to conduct their quasi-criminal investigations should be reviewed and a better solution found.

Recommendations - Electrical Safety Office

1. DME should apologise to [AK's parents] in relation to the ESO's failure to adequately investigate this matter.
2. DME should enter into meaningful negotiations with [AK's parents] to financially compensate them (a 25% contribution) for their legal expenses in having to arrange representation at the inquest.
3. A comprehensive management and strategic review of the ESO should be undertaken contemporaneously by the same reviewer referred to in [WH&S] Recommendation 3. The review should address:
   - 3.1 the structure of the ESO, including the delegation and allocation of responsibility and the appropriateness of current classification of positions;
   - 3.2 whether adequate staff and resources exist within the ESO to enforce the Electricity Act and Regulations;
   - 3.3 current investigation methodologies and processes, including the present reliance placed upon "authorised persons";
   - 3.4 formal and informal staff training and guidance;
   - 3.5 management systems and processes used by the ESO, including internal and external performance indicators to monitor the efficiency and effectiveness of the ESO and internal communication and sharing of information on operations and performance;
   - 3.6 the competency of existing staff employed in compliance / enforcement roles within the ESO be assessed to determine whether all officers possess the appropriate skills, knowledge and abilities to perform electrical investigations and any identified deficiencies should be addressed by training and professional development; and
   - 3.7 any other matters that impact on the economy, efficiency and effectiveness of investigations, prosecutions and audits.
4. In the interim, a protocol or memorandum of understanding should be developed (if not already in place) between the ESO, WH&S and the Queensland Police Service in relation to the conduct of the investigation of electrical fatalities in the workplace and elsewhere that address the investigative duplication and overlap identified in this report.
5. The penalty provisions within the *Electricity Act 1994* and Reg should be reviewed to determine their appropriateness.
6. Specialised training should be provided for investigation staff within the ESO on how to deal with the grieving family, friends and associates of electrocution victims.
7. The concept of a single agency responsible for the investigation of electrical accidents in Queensland should be considered.
8. The role of "authorised persons" should be referred to the Joint Ministerial Taskforce and the reviewer referred to in [WH&S] Recommendation 3 for further analysis.
9. The Director-General of DME should issue an immediate directive to the [position title deleted] indicating that it is inappropriate for the ESO to rely solely on internal investigations undertaken by an electricity entity when an electrical accident involving that same electricity entity occurs.
10. The Director-General of DME should issue an immediate directive to the [position title deleted] indicating that the ESO must conduct independent investigations into all electrical fatalities, including examining and reporting on all electrical articles and equipment involved in any such incident.

Appendix F: Opinions and Recommendations made in Case 3 of the WEP

Opinions

My opinion, formed pursuant to section 49(2) of the *Ombudsman Act 2001*, is as follows:
The administrative actions to which this investigation relates were, at various times:

- **unreasonable** [section 49 (2) (b)],
- **based wholly or partly upon a mistake of fact** [section 49 (2) (f)] and
- **wrong** [section 49 (2) (g)].

The particulars of such maladministration are:

1. The ESO failed to document its decision that [TM] was not undertaking "electrical work" at the time of the incident. As a result, there is no record of a decision having been made and, if made, how the conclusion was reached. The decision lacked transparency.
2. The ESO failed during the initial stage of the analysis of the incident to seek a legal opinion as to the meaning of the phrase "electrical work" despite the fact that the matter involved a person's death by electrocution. The ESO justified not investigating the matter on the basis of its narrow interpretation of the term, thereby allowing the incident to become statute-barred under the *Elect Act* without the issue being properly resolved.
3. The initial stage of the WH&S investigation conducted by the [position title deleted] and supervised by [position title deleted] was inadequate because of its brevity and superficiality and led to a premature and unsustainable recommendation to take no further action.
4. The WH&S media policy allows the [position title deleted] an inappropriate level of autonomy in making media releases and an inappropriate level of access to non-delegated decision-makers for the purpose of preparing media briefings.
5. The release of information to the media was mismanaged by [position title deleted], who:
   - 5.1 sought comment from persons who were not delegated to make a final decision in relation to the future direction of the investigation; and
   - 5.2 provided the information to the media prior to any communication being made to [TM's parents]. Such information was contrary to WH&S's ultimate position in relation to the investigation, necessitating a "backflip".

6. The WH&S media policy fails to acknowledge the interests of the next of kin by ignoring their legitimate expectation that they would be informed about the outcome of an investigation before the information was released in a public forum.
7. The WH&S media policy fails to acknowledge the potentially serious implications of making a public statement about the health and safety aspects of a particular workplace environment prior to the expiration of the statutory limitation period for the commencement of court proceedings. An incorrect media report (as occurred in this matter) could result in an employer being given tacit approval by WH&S to continue using unsafe work practices.
8. The [position title deleted] failed to adequately document the investigation, with the result that superiors were unable to review investigative strategies.
9. The [position title deleted] claimed that he deliberately made a recommendation not to prosecute in order to "provoke the reaction that occurred". Although the evidence suggests his claim is incorrect, it was an inappropriate course of action if that was his motivation.
10. The [position title deleted] did not comply with the WH&S Event and Case Management Procedure that was in place at the time of the incident.
11. The [position title deleted] did not ensure that the [position title deleted] complied with the WH&S Event and Case Management Procedure.
12. WH&S and the ESO failed to respond to a letter from [TM's parents] dated 29 November 1999 in which they sought answers to various questions regarding the circumstances of their son's accident and his subsequent death. WH&S and/or the ESO were capable of answering the correspondence and jointly prepared a draft response. However, their failure to finalise the response left [TM's parents] uncertain about issues raised by them. It was inappropriate for [TM's parents] to have to rely upon prosecution proceedings and/or a Coronial Inquiry to obtain answers to their questions, which were reasonable in the circumstances.
13. Current audit practice, contained in the WH&S Investigations Manual, provides for an inappropriately low number of files marked "no further action" to be reviewed by senior officers.
14. It is unlikely that WH&S's initial investigation would ever have been reviewed had it not been for [TM's parents'] persistence and the efforts that they made for an adequate investigation to be undertaken.

Recommendations

I recommend, pursuant to section 50(1) of the *Ombudsman Act 2001*, that:

1.
   - 1.1 the ESO obtain a written legal opinion from either senior counsel or an academic with an acknowledged expertise in statutory interpretation, in respect of the meaning of "electrical work" to ensure that the term, as defined in the proposed new electrical safety legislation, covers the situations and addresses the problems highlighted in this Report; and
   - 1.2 this Office be consulted in relation to the briefing of such person and be provided with a copy of the opinion. The cost of obtaining such opinion is to be borne by the ESO.
2. WH&S unconditionally apologise to [TM's parents] for the inadequacy of the initial stage of the investigation.
3. WH&S unconditionally apologise to [TM's parents] for the premature and inappropriate release to the media of unsustainable conclusions concerning their son's death.
4. WH&S's current media policy and procedures be replaced with a media policy that addresses each of the issues raised in this Report, with this Office to be consulted on the contents of the new policy before it is published.
5. WH&S immediately enter into meaningful discussions with [TM's parents] with a view to making an ex gratia payment to assist them to meet their ongoing out of pocket medical and counselling expenses. A lump sum should be negotiated. This Office is prepared to provide guidance as to the terms and conditions of such settlement should [TM's parents] and DIR be unable to reach an agreement.
6. In future, all priority 1 files and at least 50% of priority 2 files marked for "no further action" should be reviewed by a senior manager (either a Regional Investigations Manager or a Regional Manager, depending on the priority of the matter) before any decision is made to cease investigative activity in relation to the subject matter of the file.
7. A senior officer or officers from WH&S State Office, chosen in consultation with this Office:
   - immediately undertake a comprehensive audit of investigation reports relating to all Priority 1 and Priority 2 files in the Cairns office of WH&S that have been marked for "no further action" and that relate to events that occurred between 1 July 2000 and the date of this Report;
   - report on the validity of such "NFA" recommendations; and
   - provide a copy of the report to me within 28 days of the finalisation of that audit.
8. DIR consider taking appropriate disciplinary action, pursuant to the provisions of Part 6 of the *Public Service Act 1996*, against:
   - 8.1 the [position title deleted], in respect of [the] handling of the initial stage of the [TM] investigation; and
   - 8.2 the [position title deleted], in respect of [the] management of the initial stage of the [TM] investigation.
9. DIR address the problems identified in this Report in relation to the regional model.
10. There should be a separate Electrical Safety Act to regulate safety matters pertaining to the electrical industry.
11. An independent safety regulator be established.
12. A single agency be responsible for the investigation of electrical accidents in Queensland.
13. There should be consistency in the amount of the penalties that may be imposed under the WH&S Act and the Electricity Act for like offences.

Appendix G: Opinions and Recommendations made in Case 4 of the WEP

Opinions

My opinions, formed pursuant to section 49(2) of the *Ombudsman Act 2001*, are as follows:

1. The failure of WH&S to ensure the Inspector was consulted about the use of the [position title deleted] as an expert was *wrong* within the terms of section 49(2)(g) of the *Ombudsman Act*.
2. The [position title deleted] opinion *was based wholly or partly on a mistake of law or fact* in terms of section 49(2)(f) of the *Ombudsman Act*. The [position title deleted] was not adequately briefed about all facets of the investigation.
3. The decision to ask the [position title deleted] to "review the file", without providing a specific set of questions that were known to be within his technical competence, was *wrong* within the terms of section 49(2)(g) of the *Ombudsman Act*.
4. The advice provided by the [position title deleted] to WH&S did not address the earthing system in place at the site and was significantly and materially incomplete and therefore unreasonable within the terms of section 49(2)(b) of the *Ombudsman Act* and *based wholly or partly on a mistake of law or fact* within the terms of section 49(2)(f) of the *Ombudsman Act*.
5. The matters referred to in Part 6.5 of this report [that is, the investigation report on Case 4] demonstrate that the investigative process was deficient in a number of significant respects and the administrative decisions relevant to those deficient processes were *wrong* within the terms of section 49(2)(g) of the *Ombudsman Act*.
6. The failure of WH&S to produce and record an investigative plan represented a departure from best practice for investigative activities and in that respect was *wrong* within the terms of section 49(2)(g) of the *Ombudsman Act*.
7. The failure of WH&S to undertake a conscientious internal review of its decision not to prosecute SEQEB, upon receipt of the complaints by [AM's parents] and GRAVES, was *wrong* within the terms of section 49(2)(g) of the *Ombudsman Act*.
8. The decision of WH&S not to prosecute *was an action for which reasons should have been given, but were not given* within the terms of section 49(2)(e) of the *Ombudsman Act*.
9. The matters referred to in Part 6.8 of this report [that is, the investigation report on Case 4] represent a departure from best practice for managing investigative activities and in that respect are *wrong* within the terms of section 49(2)(g) of the *Ombudsman Act*.
10. The decision of the ESO not to conduct an investigation into whether [AM]'s death involved any breaches of the Electricity Act and/or Electricity Reg by SEQEB *was based wholly or partly on a mistake of law or fact* within the terms of section 49(2)(f) of the *Ombudsman Act*.
11. The decision of the ESO not to investigate possible breaches of the Electricity Act and Reg by SEQEB was consistent with its general policy that the investigation and prosecution of such breaches were the responsibility of the QPS and WHS. The decision and the policy were both *wrong* within the terms of section 49(2)(g) of the *Ombudsman Act*.
12. The holding of a Coronial Inquest into the cause of death where electricity appears to be a factor does not relieve the ESO of its duty to competently investigate and prosecute any breach of the Electricity Act and Reg established by the circumstances of the death.

13A. The present penalties applying to breaches of the WH&S and Electricity Acts resulting in a fatal electrocution are inadequate. No recommendation is necessary as this issue is currently being reviewed by the Ministerial Review implementation.

13B. The inadequacy of those penalties did not justify ESO's decision not to investigate and prosecute possible breaches of the Electricity Act and Reg relating to the circumstances of [AM]'s death. The ESO's decision in that regard was *wrong* within the terms of section 49(2)(g) of the *Ombudsman Act*.

14. The decision of the ESO to inform the Commissioner of Police and Coroner that the SEQEB Inspector would be an appropriate witness to be called in any inquest into the accident was *wrong* within the terms of section 49(2)(g) of the *Ombudsman Act*.
15. ESO's decision to rely on investigations carried out by SEQEB ignored SEQEB's conflict of interests and was *wrong* within the terms of section 49(2)(g) of the *Ombudsman Act*. No recommendation is necessary as this issue is being addressed by the Ministerial Review implementation.
16. The failure of the ESO to take steps to identify whether the SEQEB Inspector was qualified to investigate the incident and give expert evidence to the Coronial Inquiry was *wrong* within the terms of section 49(2)(g) of the *Ombudsman Act*.
17. DIR has some moral obligation to make an ex gratia payment to the [AM's parents] for legal expenses incurred in retaining legal representation at the Coronial Inquest.

Recommendations

My recommendations to address the identified maladministration made pursuant to section 50(1) of the *Ombudsman Act 2001*, are as follows:

1. WH&S legal/prosecution unit prepare and maintain a central register of all internal persons with a level of technical knowledge that qualifies them to give expert evidence in a particular field. The register should also record similar details of any experts external to WH&S that have been used in any proceedings.
2. All persons employed by DIR who may be called upon to provide expert advice or opinion be trained in the drafting of statements for court purposes and the presentation of evidence in court.
3. WH&S develop a policy/procedure in relation to the use of experts. The policy should require officers to formulate a list of specific questions to be put to experts where their advice is sought. It should also require the experts to describe their specific qualifications and/or experience in the field to which the questions relate.
4. DIR should address the administrative deficiencies identified in Part 6.5 of this report [that is, the investigation report on Case 4] including by providing inspectors with further training in good investigative practice. It may be that they can be addressed by the Ministerial Review implementation.

5. In consultation with the Ombudsman's Office, DIR establish an effective internal review process to deal with complaints that cannot be dealt with under Part 11 of the *Workplace Health & Safety Act 1995*, including complaints about the quality of WH&S investigations.
6. Where a complaint relates to a decision by DIR not to commence a prosecution following a WH&S investigation, the internal review process require that advice be given to the complainant, in reasonable detail, of the critical factors taken into account by DIR in reaching the decision not to prosecute, subject to the complainant having a sufficient direct interest in the matter.
7. DIR formally apologise to the [AM's parents] for the decision of the ESO not to conduct an investigation into whether [AM]'s death involved any breaches of the Electricity Act and Electricity Reg by SEQEB.
8. Training be provided to DIR investigative staff on the scope and purpose of the *Coroners Act 1958* and the compilation and presentation of evidence in Coronial Inquests.
9. DIR should enter into meaningful negotiations with [AM's parents] with a view to compensating them for the out of pocket legal expenses incurred by them in obtaining legal representation at the Coronial Inquest.

Appendix H: Opinions and Recommendations made in Case 5 of the WEP

Opinions

My opinions, formed in accordance with s.49(2) of the *Ombudsman Act* 2001, are as follows:

1. The failure of WH&S to prepare an investigation plan represented a departure from best practice for investigative activities and in that respect was *wrong* within the terms of s.49(2)(g) of the *Ombudsman Act*.
2. The failure of the [position title deleted] to record the reasons for his decision that there was insufficient evidence to establish a breach of the obligation imposed by s.28(2) of the WH&S Act was *wrong* within the terms of s.49(2)(g) of the *Ombudsman Act*.
3. The failure of the [position title deleted] to record the reasons for [the] acceptance of the [position title deleted] decision that there was insufficient evidence to establish a breach of the obligation imposed by s.28(2) of the WH&S Act, was *wrong* within the terms of s.49(2)(g) of the *Ombudsman Act*.
4. The failure of the [position title deleted] to record [the] reasons for the acceptance of the [position title deleted] decision that there was insufficient evidence to establish a breach of the obligation imposed by s.28(2) of the WH&S Act was *wrong* within the terms of s.49(2)(g) of the *Ombudsman Act*.
5. The failure of the [position title deleted] to make any record of the oral advice given by the Crown Law officer and the APO was *wrong* within the terms of s.49(2)(g) of the *Ombudsman Act*.
6. The failure of the [position title deleted] to communicate the oral advice given by Crown Law and the [position title deleted] to the [position title deleted] and [position title deleted] was *unreasonable* within the terms of s.49(2)(b) of the *Ombudsman Act*.
7. The failure of the [position title deleted] to inquire as to the progress of the prosecution brief prior to the matter becoming statute barred was *unreasonable* within the terms of s.49(2)(b) of the *Ombudsman Act*.
8. The failure of WH&S to retain the [position title deleted] memorandum on the file was *unreasonable* within the terms of s.49(2)(b) of the *Ombudsman Act*.
9. The decision to defer the commencement of prosecution action for possible breaches of the WHS legislation until QPS had finalised its investigation was *wrong* within the terms of s.49(2)(g) of the *Ombudsman Act*.
10. The [position title deleted] should have questioned [the current caravan park owner] about:
    - any safety checks [the current caravan park owner] had caused to be carried out on the security lighting during the period he had owned the caravan park;
    - [Caretaker and caravan park resident]'s statement about the security lights that "occasionally they would flicker. It normally happened in damp weather";
    - [Caretaker and caravan park resident]'s statement about the malfunctioning of the light on the pole the subject of the incident; and
    - whether he had taken any steps to have the light checked or repaired.

    His failure to do so was *wrong* within the terms of s.49(2)(g) of the *Ombudsman Act*.
11. If, as the [position title deleted] suggests, the failure of WH&S to initiate prosecution action was based on the view that an employer's knowledge of non-compliance of an electrical installation under s.81 was an element of the offence, the decision was *based wholly or partly on a mistake of law* and was *wrong* within the terms of s.49(2)(f) and (g) of the *Ombudsman Act*.
12. If the [position title deleted] approached the same lawyer from the Crown Law Office to review an investigation the lawyer had previously given legal advice about, the [position title deleted] actions were *unreasonable* within the terms of s.49(2)(b) of the *Ombudsman Act*.
13. The internal review of the WH&S investigation into the death of [DD], co-ordinated by the [position title deleted], was deficient in its depth of inquiry. The acceptance of its conclusions by the [position title deleted] was *wrong* within the terms of s.49(2)(g) of the *Ombudsman Act*.
14. The failure of the ESO to initiate an investigation into possible breaches of the Electricity Act and Reg in relation to the incident was *wrong* within the terms of s.49(2)(g) of the *Ombudsman Act*.
15. The failure of the [position title deleted] to obtain legal advice on the evidentiary value of the statement by a former FNQEB employee to the ESO's show cause inquiries was *unreasonable* within the terms of s.49(2)(b) of the *Ombudsman Act*.
16. Following the numerous complaints by [DD's father], GRAVES and approaches by the CJC, a meaningful internal review of the failure by the ESO to conduct an investigation should have been undertaken. The failure to do so was *unreasonable* within the terms of s.49(2)(b) of the *Ombudsman Act*.
17. The advice conveyed to various parties by the [position title deleted], in which he attributes certain comments to [DD's father], was *wrong* within the terms of s.49(2)(g) of the *Ombudsman Act*.

Recommendations

My recommendations to address the maladministration I identified, made in accordance with s.50(1) of the *Ombudsman Act 2001*, are as follows:

1. That WH&S and the QPS develop a Memorandum of Understanding (MOU) about their respective investigative responsibilities in relation to incidents involving potential breaches of WH&S legislation and potential offences under the criminal law.
   The MOU should recognise the statutory limitation for the commencement of prosecutions under the WH&S legislation and provide, in appropriate circumstances, for offences under that legislation to be commenced and, at the request of QPS, adjourned until the QPS investigation has been finalised.
2. That the MOU be communicated to all relevant persons within DIR and QPS.
3. In [Case 4 of the WEP] I recommended that DIR establish a formal and credible internal review process that seriously considers complaints by members of the public about the quality of its investigations. I would add to that recommendation the specific points that all persons performing such review functions should be:
   - of at least the same seniority as the original inspector/decision maker; and
   - have had no substantial involvement in the investigation subject to review.
4. That the Director of DIR Investigations and Prosecutions Unit conduct the further internal inquiries into the WH&S investigation into the death of [DD] that I have detailed above, with a view to providing relevant evidence to the Coroner. A report on the results of those further inquiries should be provided to my Office as soon as they have been completed.
5. If [former caravan park owner] again seeks to be licensed as an electrical fitter, DIR conduct inquiries into whether he is a suitable person to hold a licence under the Electricity Act.
6. DIR assess the competence of staff within the ESO to conduct and/or manage future show cause investigations into licence holders under the electrical legislation and provide training as appropriate.
7. That the Director of DIR Investigations and Prosecutions Unit conduct the further internal inquiries into the ESO investigation into the death of [DD] that I have detailed above with a view to providing relevant evidence to the Coroner. A report on the results of those further inquiries should be provided to my Office as soon as they have been completed.
8. DIR should write to [DD's father] and apologise for wrongly attributing these comments to him.
9. DIR should formally apologise to [DD's father] for the failure of both WH&S and the ESO to competently perform their statutory duties in relation to the investigation of the incident on 13 January 1997 that claimed the life of his son.

Appendix I: Opinions and Recommendations made in Cases 6 and 7 of the WEP

Opinions

My opinion, formed pursuant to s.49(2) of the *Ombudsman Act 2001*, is as follows:

1. The failure of the [position title deleted] to assess whether:
   - it was the dogger's role to secure (or back-hook) the chains; and
   - if so, whether this apparent failure constituted a breach of the WH&S legislation,

   was wrong within the meaning of s.49(2)(g) of the *Ombudsman Act*.
2. The failure of the [position title deleted] to contact Energex to verify the accuracy of the principal contractor's statement that:
   > at no stage did Energex advise us that there was an alternative solution relating to the high voltage lines, namely that they could be de-energised,

   was wrong within the meaning of s.49(2)(g) of the *Ombudsman Act*.
3. The WH&S Event & Case Management Procedure was flawed in not requiring that Workplace Incident Reports on critical incidents, such as this one, be referred to the [position title deleted] for review.
4. WH&S failed to carry out relevant inquiries in relation to whether or not the respective employers of the deceased had complied with s.80 of the WH&S (Miscellaneous) Regulation 1995 and, therefore, its administrative actions were wrong within the meaning of s.49(2)(g) of the *Ombudsman Act*.
5. WH&S failed to carry out relevant inquiries in relation to whether or not the principal contractor had complied with s.57 of the WH&S Regulation 1997 and, therefore, its administrative actions were wrong within the meaning of s.49(2)(g) of the *Ombudsman Act*.
6. WH&S failed to carry out relevant inquiries in relation to whether or not the employer of [AB] had complied with s.61 of the WH&S Regulation 1997 and, therefore, its administrative actions were wrong within the meaning of s.49(2)(g) of the *Ombudsman Act*.
7. WH&S failed to adequately investigate whether or not:
   - [KC's employer] had discharged its obligations under the WH&S Act, under s.28 (as the employer of KC), under s.30 (as the person in control of the workplace) and under s.31 (as the principal contractor);
   - [AB's employer] had discharged its obligations under the WH&S Act, under s.28 (as the employer of AB).
8. The *Workplace Health and Safety Act 1995* and the Workplace Health & Safety Regulation 1997 (in particular, section 149) did not adequately protect workers performing work (other than "electrical work") from the dangers of working underneath or near overhead power lines.
9. The failure of the ESO to conduct an independent investigation of the incident was wrong within the meaning of s.49(2)(g) of the *Ombudsman Act*.

Recommendations

In my provisional report I recommended that:

> the reviewers of the WH&S legislation and/or the taskforce preparing the new Electrical Safety legislation assess the WH&S issues raised in Part 6 of this Report with a view to addressing those issues, where appropriate, in the legislation.

Since that time, some of the issues raised in Part 6 have been addressed in the new *Electrical Safety Act 2002* and Electrical Safety Regulation 2002 that commenced on 1 October 2002. Other issues are dealt with in the Workplace Health and Safety Act and Another Act Amendment Bill 2002.

The *Electrical Safety Act 2002* established new consultative arrangements for electrical safety including the appointment of a statutory officer with the title Commissioner for Electrical Safety. One of the Commissioner's functions is to advise the Minister on electrical safety matters generally. Accordingly, the following recommendation refers to the Commissioner.

Pursuant to s.50(1) of the *Ombudsman Act 2001*, I recommend that:

1. The Commissioner for Electrical Safety consider the safety issues raised in Part 6 of this report with a view to recommending to the Minister that measures be prescribed to address those issues in relevant Codes of Practice under the *Electrical Safety Act 2002*.

Appendix J: Opinions and Recommendations made in Case 8 of the WEP

Opinions

My opinion, formed pursuant to s.49(2) of the *Ombudsman Act 2001*, is as follows:

1. The failure of WH&S to obtain formal written legal advice about the application of the WH&S Act to the incident was wrong within the meaning of s.49(2)(g) of the *Ombudsman Act*.
2. At the time [JC] was electrocuted, the site around the fallen power line was a "workplace" within the meaning of s.9 of the WH&S Act and therefore WH&S had a statutory obligation to investigate whether or not FNQEB had discharged its safety obligations under s.28(2) of the WH&S Act.
3. The information contained in the [position title deleted] briefing of 10 September 1998, which related to the level of investigative activity undertaken by WH&S into the incident, was false. The information was relied on by the [position title deleted] in preparing a response to GRAVES by the Minister. This had the effect of misleading the Minister and subsequently GRAVES. The decision by the [position title deleted] to provide a briefing in those terms was based wholly or partly on a mistake of fact and was wrong within the meaning of s.49(2)(f) and (g) of the *Ombudsman Act*.
4. The incident was not investigated by the ESO because of the Office's policy at the time that it did not independently investigate electrical incidents. This policy meant that the ESO failed to discharge its obligation under the Electricity Act to ensure the safety requirements of the Act were complied with and to investigate possible breaches of the Act. This investigative inaction was unreasonable within the meaning of s.49(2)(b) of the *Ombudsman Act*.
5. The ESO's decisions:
   - not to independently investigate whether or not the FNQEB had discharged its obligations under the Electricity Act and Reg; and
   - to rely almost exclusively on the investigations undertaken by the FNQEB investigator

   were wrong within the meaning of s.49(2)(g) of the *Ombudsman Act*.
6. Having regard to the evidence given at the inquest, the ESO's failure to review its decision not to independently investigate whether or not FNQEB discharged its safety obligations under the Electricity Act and Reg. was unreasonable within the meaning of s.49(2)(b) of the *Ombudsman Act*.
7. The decision of the ESO to advise the Coroner, without qualification, that the FNQEB investigator would be "an appropriate witness to be called to any inquest into this accident" was wrong within the meaning of s.49(2)(g) of the *Ombudsman Act*.
8. DIR has a moral obligation to make an ex gratia payment to [JC's parents] to compensate them for legal expenses incurred in retaining legal representation at the Coronial Inquest.

Recommendations

My recommendations to address the identified maladministration made pursuant to section 50(1) of the *Ombudsman Act 2001*, are as follows:

1. DIR should undertake relevant independent research into the various types of splice joins used by electricity supply entities with a view to determining whether any of those joins are unsuitable to bear the static and dynamic loadings likely to be encountered in the geographic region in which any such entity operates.
2. DIR write to [JC's parents] and apologise for the deficiencies in the WH&S and the ESO investigative processes and explain the reforms that have been implemented to address these inadequacies.
3. DIR write to the coordinator of GRAVES, and acknowledge that the former Minister was provided with misleading advice in a briefing prepared by the [position title deleted] in relation to [the coordinator of GRAVES] complaint about the level and quality of the WH&S investigation into the incident. DIR should also apologise to [the coordinator of GRAVES] for the provision of the misleading advice. A copy of this correspondence should be sent to [JC's parents] and the present Minister responsible for DIR, the Honourable Gordon Nuttall MP. DIR should also advise the former Minister, Mr Paul Braddy, of the circumstances relating to the provision of the misleading advice.
4. DIR should enter into meaningful negotiations with [JC's parents] with a view to compensating them for the out of pocket legal expenses incurred by them in obtaining legal representation at the Coronial Inquest.

Appendix K: Opinions and Recommendations made in Cases 9, 10 and 11 of the WEP

Opinions

My opinion, formed pursuant to s.49(2) of the *Ombudsman Act 2001*, is as follows:

1. The failure of WH&S to obtain formal written legal advice about the application of the WH&S Act to the incident was wrong within the meaning of s.49(2)(g) of the *Ombudsman Act*.
2. At the time [JS, ES and KB] were electrocuted, the site around the fallen powerline was a "workplace" within the meaning of s.9 of the WH&S Act and therefore WH&S had a statutory obligation to investigate whether or not Energex had discharged its safety obligations under s.28(2) of the WH&S Act.
3. The failure of the ESO to consider whether or not Energex had complied with its obligation under s.173 of the Electricity Act was wrong within the meaning of s.49(2)(g) of the *Ombudsman Act*.
4. The decision of the ESO to advise the Coroner, without qualification, that the Energex investigator would be "an appropriate witness to be called to any inquest into this accident" was wrong within the meaning of s.49(2)(g) of the *Ombudsman Act*.
5. The action of the [position title deleted] in not advising the then Minister of evidence given at the inquest which contradicted Energex's investigation report, was wrong within the meaning of s.49(2)(g) of the *Ombudsman Act*.
6. DIR has a moral obligation to make an ex gratia payment to the families of the deceased for legal expenses incurred in retaining legal representation at the Coronial Inquest.

Recommendations

My recommendations to address the identified maladministration made pursuant to section 50(1) of the *Ombudsman Act 2001*, are as follows:

1. DIR should undertake relevant independent research into the vegetation management policies and practices of the electricity supply entities and determine whether these are appropriate.

2. DIR review action taken by the ESO in response to the Coroner's eight riders. If appropriate action has not been taken in respect of any issue, DIR should address any rider not actioned.
3. DIR write to [JS's father-in-law] and apologise for the deficiencies in the WH&S and ESO investigative processes and explain the reforms that have been implemented to address these inadequacies.
4. DIR should enter into meaningful negotiations with the families of the deceased with a view to compensating them for the out of pocket legal expenses incurred by them in obtaining legal representation at the Coronial Inquest.
5. DIR should consider whether electricity supply entities should be required as a matter of law to immediately de-energise supply upon receiving notification of a fallen power line so that a specific safety procedure is followed before the electricity supply can be re-energised to ensure the risk to health and safety has been completely removed.
6. DIR:
   - undertake independent research into the regulatory approaches of other State and (relevant) international jurisdictions to LV fault protection; and
   - consult widely with relevant academic and industry bodies on any existing, new or emerging technology that would enable the risks presented by fallen LV power lines to be removed or minimised.

Appendix L: Opinions and Recommendations made in Case 12 of the WEP

Opinions - Electrical Safety Office

My opinion, formed pursuant to s.49(2) of the *Ombudsman Act 2001*, is as follows:

1. The ESO did not properly investigate whether the employer had an obligation under s.126 of the Elect Reg to ensure that the work [SG] was undertaking just before the incident could be performed safely and, if so, whether the employer discharged that obligation with particular reference to the issues listed in Parts 7.4.2.1 to 7.4.2.9 of this Report.
2. The ESO did not properly investigate whether the employer had an obligation under s.127 of the Elect Reg to provide a competent assistant and, if so, whether the co-worker discharged the obligations of the competent assistant.
3. The ESO did not properly investigate whether the employer had an obligation under s.135 of the Elect Reg to provide a safety observer and, if so, whether the co-worker discharged the obligations of the safety observer.
4. The ESO investigation placed too much emphasis on whether [SG] had met his responsibilities for his own safety and insufficient emphasis on the employer's responsibilities for [SG]'s safety.
5. The ESO should not have involved the [position title deleted] in the investigation because his association with Energex could reasonably have given rise to the perception that the ESO investigation was not conducted impartially.
6. The investigation by the ESO was not coordinated with the investigation by WH&S.
7. The ESO took no immediate steps, despite a strong recommendation by the Acting Crown Solicitor to do so, to initiate action to amend the legislation to clarify the relationship between the various categories of licence-holders so that the interpretation favoured by the ESO was expressed in unequivocal language.
8. The ESO should have ensured that the Coroner was made aware of the substance of the opinion of the Acting Crown Solicitor.

9. The ESO failed to provide a copy of the first Crown Law advice to my Office in response to the former Ombudsman's request for relevant files, including legal opinions, although it received the advice before it forwarded the files to my Office.

Opinions – Division of Workplace Health and Safety

My opinion, formed pursuant to s.49(2) of the *Ombudsman Act 2001*, is as follows:

10. WH&S was the lead investigating agency in relation to possible breaches of the WH&S Act.
11. WH&S did not properly investigate whether the employer discharged its workplace health and safety obligation under s.28(1) of the WH&S Act. In particular, the investigation did not properly address the principal issues for investigation identified in Part 6 of this report.
12. The recommendation to take no further action, and the decision to accept the recommendation, were inappropriate because relevant lines of inquiry had not been pursued.
13. An investigative plan should have been prepared but was not.
14. The WH&S records do not disclose a sound evidentiary basis for the [position title deleted] conclusion that the use of insulating mats was not necessary.
15. The WH&S investigation uncritically adopted the "findings" of other entities and failed to adequately consider potential offences from a workplace health and safety perspective.
16. The WH&S investigation placed too much emphasis on whether [SG] had met his responsibilities for his own safety and insufficient emphasis on the employer's responsibilities for [SG]'s safety.
17. Legal advice in relation to possible prosecution action regarding the incident was not obtained when it should have been.

Opinions – Breach of duty and official misconduct

My opinion, formed pursuant to s.49(2) of the *Ombudsman Act 2001*, is as follows:

18. DIR has not adequately addressed the issues raised by the complainant in his letter to the former Director-General of DME dated 21 November 1999.
19. The Director-General of DETIR and the Minister for DETIR were provided with incorrect information in a memorandum dated 6 August 1999.

Recommendations

My recommendations to address the identified maladministration made pursuant to section 50(1) of the *Ombudsman Act 2001*, are as follows:

1. DIR investigate why the Crown Law legal opinions were not disclosed to my Office, the Coroner and the complainant and advise me of the results of its investigation.
2. DIR immediately provide copies of the three Crown Law opinions to:
   - the complainant; and
   - the Coroner, by providing them to the QPS officer assisting the Coroner.
3. DIR review the investigations of the incident conducted by WH&S and the ESO and form an opinion as to whether the findings made were correct.
4. In conducting the review, DIR have regard to the opinions I have expressed and the issues for investigation I have identified in this Report.
5. DIR advise me of the outcome of its review and provide reasons.
6. If DIR concludes from the review that the original findings were not soundly based, DIR advise the complainant and the Coroner (by providing a copy to the QPS officer assisting the Coroner) and provide reasons.
7. DIR establish procedures to ensure officers involved in investigations do not have potential or actual conflicts of interest in matters being investigated.
8. DIR request the Commissioner for Electrical Safety to review:
   - 8.1 whether the issues of concern expressed in the Electrical Safety Alert relating to the design and operation of EWPs and their suitability for undertaking work in proximity to overhead electric lines are still valid and, if so, what action should be taken to ensure the health and safety of electrical workers using EWPs for overhead line work;
   - 8.2 the adequacy of current training programs for electrical workers in the operation of EWPs;
   - 8.3 any inconsistencies, ambiguities and duplication in the various Guidelines and Manuals discussed in this Report; and
   - 8.4 whether the Electrical Safety Act, the Electrical Safety Reg or any of the Codes of Practice issued under the Electrical Safety Act require amendment in light of the opinions I have expressed and the issues for investigation I have identified in this report.
9. DIR assess and if necessary investigate, the matters raised by the complainant in his letter of 21 November 1999 relating specifically to the incident and provide a written response to the complainant.
10. DIR investigate how incorrect information about the use of insulating mats contained in a memorandum dated 6 August 1999 was provided to both the Director-General of DETIR and the Minister for DETIR and advise me of the outcome of the investigation.
11. DIR seek legal advice from the Solicitor-General:
    - about the issues I have raised in Part 7.5.6 of this report; and
    - liaise with my Office in relation to the preparation of the brief.

Appendix M: DIR's response to the WEP

1.0 Preamble

While the Workplace Electrocution Project largely relates to incidents that occurred in the period from 1995 to 1999, the reports have provided the opportunity for the Department of Industrial Relations to critically review all aspects of the regulation of workplace health and safety and electrical safety in Queensland. The Department has acted decisively in responding to the recommendations. The outcomes of this response provide a platform for establishing best practice enforcement of electrical safety and workplace health and safety in Queensland. The benefits from the change in approach have been demonstrated through the increased efficiency and effectiveness of the inspectorates and in the conduct and completion of investigations.

2.0 Background

In January 2000 the Parliamentary Commissioner for Administrative Investigations, the Queensland Ombudsman, commenced an investigation project into a series of electrocutions in Queensland during the period 1995 to 1999. The complaints encompassed 12 fatalities arising from nine separate incidents. In essence, the complaints were about how those fatalities were investigated and dealt with by the Division of Workplace Health and Safety and the Electrical Safety Office. Due to the number of complaints and their seriousness, the Ombudsman set up the Workplace Electrocution Project.

At the time of the Ombudsman's investigations, the Government had acted to improve workplace health and safety and electrical safety through:

- the launch of a new Workplace Health and Safety Enforcement Framework in August 1999 by the then Minister for Employment, Training and Industrial Relations signalling a new approach to investigations and prosecutions;
- additional funding to enhance workplace health and safety prosecution activities through the establishment of the Legal and Prosecutions Unit in February 2000, and the recruitment of six regional investigations / prosecutions officers and necessary administrative support in 2000-01;
- the establishment of an Electrical Safety Taskforce (in May 2000) to make recommendations on improving safety standards in industry. The Taskforce reported in April 2001;
- the relocation of the Electrical Safety Office to the Department of Industrial Relations;
- an election commitment to appoint at least an additional 12 workplace health and safety inspectors with electrical expertise to enhance incident investigation and industry audits; and
- the appointment of 22 electrical safety inspectors.

All recommendations from the Workplace Electrocution Project were considered by the Minister for Industrial Relations, the Honourable Gordon Nuttall MP. Subsequently, in April 2001 the Minister commissioned an independent review of the Division of Workplace Health and Safety and the Electrical Safety Office. Mr John Crittall and Mr Ray Dempsey were commissioned to conduct the reviews.

Senior staff from the Ombudsman office, including the Assistant Commissioner, were included on the reference group to the Review, as were other key stakeholders.

The final report of the Review was considered in August 2001. A total of 48 recommendations relating to both agencies were made. The key recommendations included:

- the development of stand-alone electrical safety legislation;
- the creation of an electrical safety regulator and an electrical safety advisory board accountable to the Minister, as part of the legislative process;
- improvements to investigation processes to ensure a single approach to the investigation of all electrical fatalities and serious incidents;
- the establishment of a dedicated legal and prosecutions unit to ensure early intervention by legal officers into complex investigations; and
- a review of the *Workplace Health and Safety Act 1995* to ensure that it reflects changes in the labour market and contemporary regulatory needs.

The recommendations from the Ombudsman's reports, the Ministerial Reviews and the Electrical Safety Taskforce have resulted in the following initiatives.

3.0 Policy framework

3.1 Stand-alone electrical safety legislation

The Ombudsman's Reports, the Electrical Safety Taskforce Report and the Ministerial Review into the Electrical Safety Office identified the need for stand-alone electrical safety legislation to cater for the specific needs of the electricity industry. The need was realised as The *Electrical Safety Act 2002* and the Electrical Safety Regulation 2002 which commenced on 1 October 2002. The objective of the Act is to eliminate the human cost to individuals, families and the community of death, injury and destruction that can be caused by electricity.

The stand-alone electrical safety legislation introduced a range of reforms aimed at improving electrical safety, including:

- clearly defined obligations on a wide range of persons for electrical safety;
- the appointment of an independent Commissioner and an Electrical Safety Board to advise the Minister on ways to improve electrical safety;
- the continuing regime for business and occupational licensing of contractors and the licensing of electrical workers;
- standards for networks, underground and overhead power lines;
- standards for safe working distances around live lines and electrical parts, such as cranes working around power lines;
- standards for electrical installations and equipment;

- a new definition of “electrical work” that addressed concerns raised by the Ombudsman;
- increased penalties for breaches of the electrical safety legislation that are consistent with the *Workplace Health and Safety Act 1995* for like offences;
- establishing an enforcement framework to ensure compliance with the Act, including a statewide electrical safety inspectorate with enforcement tools, powers and a prosecutions process consistent with the *Workplace Health and Safety Act 1995*;
- establishing funding support for the Department to ensure compliance with the *Electrical Safety Act 2002* and promote electrical safety in the community through annual contributions by distribution entities; and
- the introduction of a requirement for safety management plans to be prepared by prescribed electricity entities. The plans will be approved, monitored and enforceable, covering issues such as vegetation (around power lines) and asset management such as maintenance at sub-stations.

Some of the more significant reforms arising from the new electrical safety legislation are explained in greater detail in the following sections.

3.1.1 Live work

Live work is electrical work that is carried out on electrical circuits where the equipment is not isolated from the electricity supply. Between 1990 and 2000, nine fatalities (external to the supply industry) have involved live work. There has been a culture in the electrical industry that electrical work must be performed live to minimise inconvenience to customers and other workers.

The Electrical Safety Regulation 2002 imposed an obligation on employers and self-employed persons to ensure that all electrical work is performed using a safe system of work and not performed while electrical equipment is live. However, a person is permitted to work live where it is not practicable to perform the electrical work other than by live work because:

- a supply of electricity is necessary for the proper performance of the electrical work; or
- there is no reasonable alternative to performing the electrical work by live work; or
- it is necessary in the interests of safety, whether or not electrical safety, that the electrical work be performed while the electrical equipment is energised.

3.1.2 Exclusion zones

Between 1990 and 2000, 39 fatalities have involved electrical workers working on or near exposed live parts. This is an issue highlighted in a number of the Ombudsman’s reports.

Safe working around electrical parts, such as overhead power lines, has been addressed by introducing “exclusion zones” into the Electrical Safety Regulation 2002. Exclusion zones are the safe approach distances for work involving people, machinery (operating plant) and vehicles. The exclusion zone model adopted mirrors the “National Guidelines for Safe Approach Distances to Electrical Apparatus” (produced by the Electricity Supply Association of Australia). The principle is that the more safety controls in place, the closer you can go to the electrical part. That is, as the system of work becomes safer, the exclusion zone becomes smaller. These exclusion zones seek to reduce the number of electrocutions and injuries resulting from contact with live electrical parts.

3.1.3 Electrical safety switches

Safety switches in Queensland homes are a key element to improving electrical safety. From 1991 to 2001 Queensland had an average of three fatalities per year due to consumer related electrocutions. A further 2,185 injuries were reported during this period as a result of electrical incidents in homes. The majority of these fatalities and injuries could have been prevented had domestic residences been fitted with a safety switch to protect power circuits.

In 1992 the Australian Standard that prescribes mandatory requirements for electrical work performed in Queensland, AS/NZS 3000 Electrical Installations (the Wiring Rules), was amended to require that all new houses have a safety switch installed on power circuits. There is no requirement in the Wiring Rules for houses built prior to 1992. A new requirement has been introduced through the Electrical Safety Regulation 2002 mandating the installation of a safety switch at the point of sale of a domestic residence. The regulation, which is an Australian first, will apply to the estimated 500,000 houses built before 1992 that do not have an electrical safety switch. It is estimated that it will take, on average, up to 15 years to install safety switches in the majority of homes built prior to 1992. This regulation will reduce the potential for electrocutions and shocks in homes. This new requirement was promoted widely through a comprehensive communication strategy.

3.1.4 Codes of practice

In addition to the *Electrical Safety Act 2002* and Electrical Safety Regulation 2002, three codes of practice have been approved. Codes provide practical guidance on how a person can meet their obligations under the Act. The three codes of practice are:

1. **Working near exposed live parts -** This code provides practical advice on ways to manage electrical risk when working near exposed live electrical parts. The code will apply to persons such as plant operators, painters, scaffolders, sign makers and people working with irrigation pipes when they are working near exposed live parts.
2. **Works -** This code sets criteria for design and maintenance standards for lines and earthing for electricity entity networks.
3. **Electrical work -** This code provides practical advice to electrical workers and contractors performing electrical work.

3.1.5 Fallen power lines

In response to the Ombudsman recommendations in the Fallen Power Lines report the Electrical Safety Office has:

- initiated a Splice Joint Investigation Project as a means of developing recommendations designed to reduce or eliminate the risk of failure of connections between conductors made by helical splices. Key deliverables are recommendations that may include improvements to helical splice standards,

specifications, installation methods, monitoring and maintenance methods, and possible alternative technologies; and
- sought independent legal advice regarding whether electricity supply entities should be required as a matter of law to immediately de-energise supply upon receiving notification of a fallen power line so that specific safety procedures are followed before the electricity supply can be re-energised to ensure the risk to health and safety has been completely removed.

3.2 Commissioner for Electrical Safety

On 10 October 2002, the Governor in Council approved the appointment of Mr Jack Camp as the inaugural Commissioner for Electrical Safety. Mr Camp holds the electrical qualifications required by the legislation, and has extensive professional experience in electrical safety, serving on many electricity related boards including Chair of the precedent Electrical Workers and Contractors Board.

The Commissioner's functions include advising the Minister on electrical safety matters generally and managing the activities of the Electrical Safety Board and three Board Committees which are specifically concerned with licensing and disciplinary matters, electrical safety promotion and standards for electrical equipment. These new consultative arrangements allow industry and the community to participate in developing strategies for improving electrical safety.

One of the Commissioner's priorities is to review issues raised by the Ombudsman regarding mobile cranes and high voltage overhead power lines. The Commissioner will provide recommendations to the Minister regarding measures that may be prescribed to address these issues in the appropriate Code of Practice. The Commissioner has written to industry and other stakeholders inviting membership to a working party to progress this review.

As required by the *Electrical Safety Act 2002*, the Commissioner and the Electrical Safety Board have developed a five-year strategic plan for improving electrical safety. Extensive industry and community consultation informed the development of the plan with respect to its contents and direction. This plan provides a blueprint to ensure the continuous improvement of electrical safety in Queensland homes and workplaces.

3.3 Workplace Health and Safety amendments

A key recommendation of the Review of the Division of Workplace Health and Safety 2001 was to review the *Workplace Health and Safety Act 1995* (the WH&S Act) to ensure it reflects changes in the labour market and meets contemporary regulatory needs, and to consider the adequacy of current enforcement mechanisms and penalties.

Changes in the labour market and, more particularly, the growth of "contingent" workers, have dramatically affected the nature of the key relationships at work and have placed considerable pressure on the definitions and responsibilities of obligation holders under the WH&S Act. The anticipated growth in "contingent" workers and the complexity of new work arrangements required an examination of the current legislative framework.

In addition, while the key focus for workplace health and safety must always be on prevention, enforcement activity has a direct link with the level of compliance with workplace health and safety standards and the incidence of injury and illness at work. Designing an appropriate regime that secures optimum compliance requires consideration of penalties, incentives and the tools available to the Inspectorate to adequately perform its role.

As a consequence, the *Workplace Health and Safety Act 1995* was updated to:
- clarify the application of the existing obligation of employers and self-employed persons and introduce an obligation on persons who conduct a business or undertaking;
- enhance existing obligations on suppliers of plant and substances for use at a workplace;
- introduce obligations on designers of buildings and persons in control of relevant workplace areas;
- enhance the existing consultative provisions;
- enhance enforcement mechanisms and investigation powers; and
- clarify the definitions relating to "event notification" and "building and construction work".

The *Electrical Safety Act 2002* was also amended to ensure that this legislation was consistent with the *Workplace Health and Safety Act 1995*.

4.0 Organisational restructure

DIR has undergone significant organisational restructure in response to the recommendations arising from the Ministerial Review including a change of name for WHS to Workplace Health and Safety Queensland (WHSQ). The Department has instituted changes which have resulted in:
- simplified reporting relationships;
- greater accountability for each level of management;
- greater emphasis on the delivery of services by introducing "direct line" management responsibilities between State Office and the Regions;
- provision to of discrete budget allocations and controls; and
- the establishment of the Legal and Prosecutions Services Unit that provides legal services and support to both WHSQ and the Electrical Safety Office on investigations and prosecutions and has direct line reporting to the General Manager of WHSQ.

This organisational restructure has bridged the gap between strategy formation and implementation roles. This enables DIR to provide a more consistent regulatory regime across the State. This new structure has also helped considerably in the implementation of the new electrical safety legislation and workplace health and safety reforms.

5.0 Statewide inspectorate

5.1 New structure and management systems

A new structure and management systems have been put in place for the Electrical Safety Office, including systems to ensure effective internal communication and information sharing throughout the Department. For example, all

Regional Managers from ESO, WHSQ and IR participate in regular conferences to discuss current issues impacting on the Department.

5.2 Authorised persons

The management and strategic review also proposed a thorough evaluation of the functions of Authorised Persons. Authorised Persons who were employed by the electricity distributors to undertake inspections of electrical contractors' installations, auditing to ensure compliance with the safety aspects of the *Electricity Act 1994* and investigate electrical incidents, no longer undertake this role.

5.3 Increased inspectorate resources

Prior to the introduction of the *Electrical Safety Act 2002*, the enforcement of the regulatory regime for electrical safety was undertaken by authorised persons. Authorised persons were employed by the electricity distributors to undertake inspections of electrical contractors' installations, conduct auditing to ensure compliance with the safety aspects of the *Electricity Act 1994* and to investigate electrical incidents. The introduction of the *Electrical Safety Act 2002* resulted in these roles being transferred to the Department. This was done to reduce the potential for conflicts of interest where distributors were investigating their own incidents or those of their competitors, and to provide an effective mechanism for increasing and improving enforcement and compliance strategies.

A new electrical safety inspectorate was established within the Electrical Safety Office and consists of 32 staff, 22 inspectors to undertake the investigations, 3 principal advisors, 3 supervisors, 3 administrative staff and 1 licensing officer. These staff are in addition to the 16 electrical inspectors and specialist advisors that were appointed following the Government's election commitment. The electrical safety inspectorate's primary focus is to ensure safe electrical installations, equipment and work practices.

In addition, over 170 Workplace Health and Safety Inspectors have been authorised to investigate and exercise powers under the *Electrical Safety Act 2002*. This includes a number of inspectors with an electrical background and focus.

5.4 New investigation protocol

An Investigation Protocol has been developed given that both Electrical Safety Office (ESO) and WHSQ inspectors are authorised under the *Electrical Safety Act 2002* to ensure compliance with the legislation. The operational policy relates to internal notification procedures and investigation decision-making procedures for electrical incidents reported to the Department of Industrial Relations. Its objective is to streamline investigation functions, minimise duplication and overlap, and build greater accountabilities by:

- clarifying which agency assumes carriage of the investigation of different types of electrical events;
- broadly outlining the investigation process and the various levels of responsibility and accountability for the conduct of prosecutions; and
- ensuring effective communication between both agencies at the time of notification and during the investigation, so that electrical incidents are investigated and managed effectively.

5.5 Improved enforcement framework

A key priority of the Electrical Safety Office is the development of an Enforcement Framework to ensure a comprehensive, consistent and transparent enforcement strategy. It consists of three parts:

1. *Part One – Enforcement Options* examines the enforcement tools available to electrical safety inspectors to enforce compliance.
2. *Part Two – Investigations* examines the principles and priorities for investigations into electrical incidents and seeks to make the most efficient use of resources to ensure electrical incidents are investigated in a consistent, transparent and proportional way to determine their cause.
3. *Part Three - Prosecution and Disciplinary Action* examines the decision-making process for determining whether it is appropriate to prosecute persons who may have contravened the Act and/or initiate disciplinary action against the holders of electrical licences.

The Enforcement Framework is informed by WHSQ's Enforcement Framework and therefore establishes a consistent departmental enforcement policy.

5.6 Improved investigation skills training

One of the major findings of the Ombudsman's reports and the Management Reviews was the reduced capacity of WHSQ and ESO to conduct comprehensive investigations and inspectors' lack of confidence to investigate complex and high profile cases. In response, DIR developed a competency development regime in the discipline of conducting investigations, aimed at achieving credibility through professional, accountable and effective investigations. This regime consists of three weeks of intensive investigation skills training.

Two-week investigations course

A two-week Investigation Skills course has been developed for Inspectors across the State. Participation in this course is mandatory for both new and existing inspectors, irrespective of their previous training.

The aim of the course is for Inspectors to develop the competencies required to investigate cases. The course supplements inspectors' technical knowledge and concentrates on the practical and process skills relating to incident investigation and auditing. The competencies developed in the course articulate with the Diploma in Government (Workplace Inspection).

All inspectors from WHSQ and ESO have successfully completed the course. This course is recognised within Queensland and other Australian occupational health and safety jurisdictions as an excellent, high quality, investigations course.

Advanced investigations skills course

This course builds upon the initial two-week training block. It is targeted at Investigators and other staff expected to conduct more complex investigations. This one-week program focuses primarily on the development of competencies required for magistrate's court and coronial court involvement.

In November 2000, investigative staff within WHSQ received specialised training regarding interpersonal communication with grieving families, friends and associates of persons who have died or been seriously injured in the workplace. This training now forms an integral component of the advanced investigations training developed by WHSQ.

Auditing course

In 2002 ESO inspectors completed an International Standards Organisation (ISO) 9001 auditing course. This provided the inspectorate with the necessary skills and knowledge to conduct audits on the target areas of high voltage and hazardous areas as well as electrical contractor systems. The ISO training also qualifies ESO inspectors to assess accredited auditors of these target areas against specified performance criteria to ascertain levels of compliance and effectiveness.

5.7 New internal review of operational policies and procedures in regions

During the transition to the new investigation processes in 2002 a team of auditors, one of whom was a legal officer, monitored the implementation of the processes. The audits took place in each region during May and June 2002.

The team reported directly to the Director, Program Services. Documentation was reviewed for all incidents involving a fatality or grievous bodily harm and for ten other incidents in each region. Regional Managers implemented changes to their management systems where non-compliance was identified.

During 2002, the then Planning and Monitoring Unit of the Division of Workplace Health and Safety, developed an internal review process to audit the implementation of operation policies and procedures in the regions. This program was developed in consultation with the Internal Audit Unit of DIR.

From 2002 until end of 2003 procedures and policies with the strongest links to WHSQ's core business activities were audited by Central office staff. These included the conduct of investigation and prosecution process, the classification of type one events and selection of type 2 events for comprehensive investigation.

Discrepancies were reported and rectified within agreed timeframes. A self-auditing process is presently being implemented so that Regional Managers can monitor compliance with policies and procedures. This amended process includes spot checks of the self-audit process by Central office staff.

In addition to WHSQ activities in relation to the *Electrical Safety Act 2002*, the ESO inspectorate has conducted several proactive safety blitzes on electrical equipment sold at retail outlets and carnivals resulting in the issuing of electrical safety protection notices and fines for unapproved electrical equipment being offered for sale. Other industry targeted audits include energy efficiency labelling, electric scooters, battery charges and fish tank lights.

The Electrical Safety Inspectors also conduct ongoing assessments including:

- *Target* – Auditing the checking of safety switches being installed following transfer of title.
- *Process* – Initiated in September 2003, these are full in-depth systems audits on an electrical contractor and can include product checks. Process audits are now largely replacing stand-alone product audits.

5.8 DIR compliance activity

Compliance activities of the Workplace Health and Safety inspectorate for the two years 1998/99 and 2003/04 are summarised in the following table:

Improvement Notices	Prohibition & Electrical Safety Protection Notices	On-the-Spot Fines	Incidents Investigated	Complaints Investigated	Workplace visits
1998/99					
6720	619	116	1151	2314	8784
1999/00					
9491	1918	169	1370	3068	11358
2000/01					
7290	1416	141	1494	3558	10001
2001/02					
6196	1168	101	1429	2643	8974
2002/03					
11136	1409	289	2379	3374	11134
2003/04					
16200	1848	485	4953	3411	13251

Compliance activities specific to the Electrical Safety Office inspectorate for the two periods 1/10/02-30/6/03 and 1/07/03-30/06/04 are summarised in the following tables:

Improvement Notices	Electrical Safety Protection Notices	Infringement Notices (On-the-Spot Fines)	Investigations
1/10/02-30/6/03			
1082	185	0*	924
1/07/03- 30/06/04			
1896	314	126*	1236

* On-the-spot fines came into effect as of 1 July 2003

Assessments

Product	Target (Safety Switches)	Process
1/10/02-30/6/03		
1358	395	8*
1/07/03- 30/06/04		
186	1055	762*

* Focus of audits moving from product to process

5.9 DIR's audit program 2003 & 2004

A copy of the WHSQ audit programs for 2003 and 2004 is attached in Appendix 2.

ESO completion targets for 2003/04 were, product audits 500, targeted assessments 1000, and process audits 1500.

Completion target have been revised due to the increased workload associated with investigations. The 2004-2005 targets are 1000 for process audits, and 1000 for targeted assessments.

5.10 DIR protocol for compliance audits

Each year WHSQ Central office negotiates with each region the extent of the year's compliance audit program. The agreed WHSQ program is formalised in a Regional Performance Agreement that is signed off by the Regional Manager and the General Manager.

For each state-wide compliance audit campaign that is to be undertaken, a proposal is prepared and approved by WHSQ Central Office. A copy of the protocol is attached in Appendix 3.

5.11 Significant issues from 2003 compliance audits

During the compliance audit program, WHSQ inspectors issued more than 1800 prohibition notices to stop activities where there was an immediate risk to workers.

Inspectors also issued nearly 500 infringement notices (on-the-spot fines) for breaches of the WHS and electrical safety legislation. The use of infringement notices is a simple, effective and efficient alternative to prosecution action.

5.12 Actions currently undertaken by DIR that were not performed before 2000

The *Workplace Health and Safety Act 1995* was amended in 2003 to enable the use of enforceable undertakings as an alternative to prosecution. *The Electrical Safety Act* introduced enforceable undertakings in 2002. Currently the sanctions that can be imposed for breaches of the law do not extend beyond needing correction of the problem through improvement or prohibition notices, the imposition of on-the-spot fines and prosecution.

Enforceable undertakings have the potential to create long term improvements in workplace health and safety which will benefit the entire community. Enforceable undertakings are legally binding commitments made by persons who are considered to have breached their legal obligations. A "workplace health and safety undertaking" or an "electrical safety undertaking" is a written undertaking made by a person that:

- recognises that the chief executive alleges that the person has breached the Act; and
- identifies the facts and circumstances of the alleged breach; and
- includes an assurance from the person about the person's future behaviour.

Enforceable undertakings do not replace current enforcement mechanisms, such as improvement or prohibition notices, but they are an alternative to prosecution where appropriate. The decision to accept or reject an enforceable safety undertaking will be made by the Chief Executive Officer of the Department of Industrial Relations in accordance with protocols forming part of the Enforcement Framework.

If the workplace health and safety undertaking is breached, the Chief Executive Officer of the Department of Industrial Relations may apply to the Industrial Court for an order. The maximum penalty for failing to comply with a workplace health and safety undertaking is 1000 penalty units.

Enforceable undertakings can be made to:

a. cease certain behaviour;
b. take specific action to redress parties adversely affected by a contravention of the legislation;
c. implement specified actions or programs to prevent future breaches; and

d. implement other publicity or educative programs to assist other obligation holders improve safety performance.

The advantages of enforceable undertakings are that:

a. they can be publicised in the community and used to improve the safety performance of other obligation holders; and
b. outcomes of undertakings can be practical and broader in range than monetary penalties. For example, outcomes can include requirements to:
    - review the company's workplace health and safety performance,
    - develop and implement an appropriate safety management system,
    - conduct or fund research into a workplace health and safety issue relevant to the industry,
    - produce information products for distribution throughout the industry or sector
    - arrange independent externally valid evaluations or audits of the safety management system,
    - implement specific projects, such as special training programs to address specific needs for workers, supervisors and management.

Workplace Health and Safety Queensland and the ESO commenced implementing this enforcement option during 2003/04.

6.0 Investigations and prosecutions

The Ministerial Review has been a catalyst to implement reforms to WHSQ and ESO's investigations and prosecutions function to ensure high quality, consistent investigation and prosecution outcomes. A set of broad principles were developed based on the recommendations of the Ministerial Review, the Ombudsman's reports and the experiences of other jurisdictions. These principles, outlined below, have formed the basis of the new investigations and prosecutions framework:

- Recruitment and selection of highly competent investigators;
- Appointment of investigators based on the demonstration of certain defined competencies;
- Adoption of an on-going, structured case management approach to investigations;
- Early involvement of legal officers to:
    - provide early advice on 'case to answer';
    - provide advice on applicability of evidence being gathered with a view to streamlining the investigation;
    - explore the range of possible breaches and guide evidence collection accordingly;
    - assist in standardised report requirements;
    - develop knowledge of case in the event of court proceedings.

6.1 Inspectorate powers

Inspectors have been given authorisation under both the *Workplace Health and Safety Act 1995* and the *Electrical Safety Act 2002* to enter, inspect and enforce compliance in both domestic residences and workplaces. Immediate effect was given to the investigation of high priority electrical incidents, with the Department assuming primary investigation functions for all fatal and serious electrical events, regardless of whether the incident occurred at domestic premises, workplace, public place or any other place.

6.2 Implementation of formal investigation protocols

DIR Regions and Investigation teams have also implemented formal protocols for the investigation of complex cases. These protocols address issues such as accountabilities, achievement of milestones, and involve internal auditing checks. Auditors independent to the Regions also audit WHSQ's investigative practices. The introduction of such protocols and audits ensures investigative robustness and consistency.

6.3 Memorandum of Understanding

The existing memorandum of understanding (MOU) between ESO, WHS and the Queensland Police Service concerning the conduct of investigations into serious industrial incidents has been reviewed and redrafted. This new MOU addresses the issues raised by the Ombudsman, and it ensures that there exists no investigative duplication or overlap.

6.4 Complaints management policy

A complaints management policy has been drafted and will reflect the whole of government review of this issue. This policy will help achieve consistency and impartiality in respect to complaint handling.

6.5 New investigations structure

The Review recommended three new functions to the investigations and prosecutions function of the Division of WHS and the Electrical Safety Office. These new roles have allowed the Division of WHS and the ESO to address all the areas of concern and to move toward a new approach to conducting investigations. The new roles consist of:

- a Director to lead and manage the Legal and Prosecution Services Unit
- an Investigations Manager in each DIR Region to lead the investigative function in the Regions; and
- regionally-based investigators to conduct serious and complex investigations. An investigator will lead and case manage each investigation.

6.6 Legal and Prosecution Services Branch

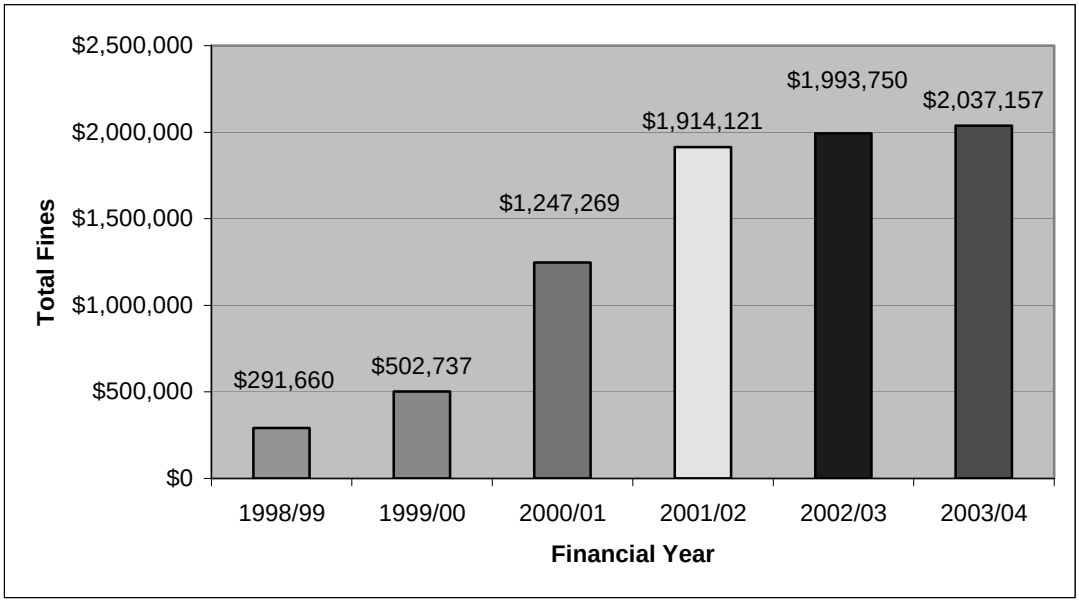
At the beginning of 2000, a Legal and Prosecution Services Unit was established by the Division of WHS. The improved enforcement and investigations framework has resulted in a fairly consistent increase in the quantum of fines and successful prosecutions as demonstrated in Table 1 and 2.

Table 1. Total number of WHSQ & ESO prosecutions for 1998/99 to 2003/04

Financial Year	Total Prosecutions
1998 – 1999	43
1999 – 2000	55
2000 – 2001	129
2001 – 2002	135
2002 – 2003	105
2003 – 2004	138

Figures relate to information available to the Legal and Prosecution Services Unit at the time of calculation. The Legal and Prosecution Services Unit may not be aware of previous Regional Prosecutions.

Table 2. Total fines imposed for the financial years 1998/99 – 2003/04



6.7 New approach to prosecutions

The establishment of the Legal and Prosecutions Services Branch has led to the development of a new approach to prosecutions to:

- ensure prosecution activity is strategically focused and targeted for maximum impact (a focus on cases that are high value, high profile and high impact);
- give the delegated authority of decision to prosecute to a single senior officer so that these decisions are not being made in isolation and are applied consistently throughout Queensland;
- significantly reduce the average length of investigations;
- ensure the provision and retention of high quality professional investigators through targeted recruitment and selection processes, appropriate remuneration and high level training and professional development opportunities; and
- ensure legal expertise available from the outset of the investigation process.

The Legal and Prosecution Services Branch consists of a number of legal officers, both solicitors and barristers. They are located in Brisbane and have regional portfolios.

WHSQ and ESO have implemented a number of reforms aimed at improving the profile and success of prosecutions, including:

1. the broad publicity of prosecution results;
2. finding opportunities (and establishing processes) to undertake “risk-based prosecutions” – prosecution of situations where there may have been no injury or illness, but where a clear obligation has not been met;
3. the development of a formalised “conduct of prosecutions” protocol to streamline the prosecutions process;
4. development of a regimented case management and early intervention approach to investigations where investigation milestones are carefully monitored, processes are streamlined and appropriate legal input is obtained at an early stage.

On seven separate occasions the Legal and Prosecution Services Unit successfully appealed the fine imposed by the magistrate. Table 3 provides details of the cases.

Table 3: Details of appeals that resulted in a substantial fine increase 2002/03 -2003/04

Financial Year	Name	Details
2002 – 2003	JBL Quality Applicators Pty Ltd	• Fine increased from $5,000 to $27,500. • Worker fell 4.15m from scaffolding. No handrails, guardrails or other devices in place to prevent his fall. • Worker sustained cracked femur cap, broken pelvis, broken arm, lacerations to ankle and bruised ribs.
	Andgra Pty Ltd	• Fine increased from $3,000 to $20,000. • Young worker employed as trolley boy received injury to foot when he fell from trailer on trolley collecting tractor. Foot passed under wheel of vehicle.
2003 – 2004	Bow Park	• Fine increased from $30,000 to $60,000. • Worker died when gearbox fell on his head while dismantling a windmill.
	Friendly Sofa Design	• Fine increased from $8,000 to $25,000. • Worker (18 yrs) received laceration to hand when contacted moving saw blade on mitre saw. Blade was guarded but not adequately.
	NQ Blasting & Coating Pty Ltd	• Fine increased from $15,000 to $25,000. • Worker suffered fractures to both legs when run over by front wheel of a 10 tonne crane.
	RGB Winton Pty Ltd	• Fine increased from $22,500 to $40,000. • Worker fatally crushed by falling pre-cast tilt-up panel.
	S Lowe & Sons Pty Ltd	• Fine increased from $3,000 to $10,000. • Fall from height potential.

The Branch received an Australia Day Award in January 2001 from the Director-General of DIR for “Achievement of Excellence”, further testimony to the effectiveness of the new investigations and prosecutions framework.

7.0 Electrical Safety Projects

7.1 Network safety

As previously advised, ESO has conducted research into several areas related to electricity entities and distribution systems, specifically into the suitability of splice joints for power lines in order to identify any shortcomings.

Research is ongoing into best practice in the management of vegetation near power lines through the ESO’s involvement in the development of ‘National Guidelines for Safe Vegetation Management Work Near Power Lines’. ESO has also initiated the Vegetation Management Best Practice Project as a means of improving electrical safety outcomes through the identification of improvement opportunities, and development of recommendations designed to address these matters. The recommendations arising from this project may involve matters such as vegetation clearing profiles, clearing frequency, recording methods, data management, and modelling tools that serve a predictive function, thus enhancing vegetation management planning and effectiveness.

Another important initiative related to vegetation management is the ESO’s role in the development of ‘Guidelines for use in Developing an Agreement on Vegetation Management under Power lines between an Electricity Entity and a Local Government’. Such agreements are a useful means of developing cooperative arrangements between electricity entities and local government that benefit the reliability and safety of the electricity distribution system.

As outlined in section 3.1 of this paper, part of the framework for delivering the objectives of the Electrical Safety Act 2002 is the requirement for prescribed electricity entities to implement safety management systems for entity ‘works’. As a means of providing electricity entities with practical guidance for meeting these legislative requirements, ESO has developed a Guide to Safety Management Systems for Prescribed Electricity Entities.

An important aspect of the safety management system regime for prescribed electricity entities is the establishment of accredited auditors. The role of accredited auditors is to assess and verify electricity entities’ safety management systems in accordance with legislated requirements and report to the electrical safety regulator. The Department of Industrial Relations has advertised for accredited auditors, and to date two have been approved and are currently in discussions with prescribed entities. Applications for the position of accredited auditor continue to be assessed.

7.2 Coroners’ Recommendation Project

In response to Coroners’ recommendations relating to safety switches and electrical equipment the ESO has instigated the Coroners’ Recommendation Project in order to consider the recommendations and develop appropriate responses that contribute to the minimisation of electrical risk.

As a result of the Coroners’ Recommendation Project regulation amendments are being developed as is a Code of Practice for electrical equipment. Work is well advanced on this project with the development and distribution of an issues paper, the approaching finalisation of a regulatory impact statement, and the development of a Code of Practice for electrical equipment. These measures are designed to effectively respond to the Coroners’ recommendations and deliver improved electrical safety outcomes in the workplace.

A strategy has been developed involving a range of advertising mediums designed to improve electrical safety awareness in the community and highlight the protection offered by electrical safety switches

The ESO has developed a proposal and strategies intended to influence the development of Australian Standards with the goal of a wider adoption of safety switches for fixed wiring and electrical equipment.

7.3 Communications

The recent Queensland Household Survey identified gaps between the public's perceived and actual knowledge about safety switches. An analysis of survey results has enabled ESO to identify target groups for future communications and further increase public awareness about the benefits and legislative requirements for safety switches.

ESO is also promoting the Code of Conduct for the retail sale of electrical installation products to the public, which provides guidance on practical ways for industries, businesses and individuals to comply with legal requirements.

7.4 Electrical licensing

An extensive licensing policy has been developed and extensive work carried out with the Department of Employment and Training (DET) and Registered Training Organisations "RTOs" to achieve quality training outcomes in the electrical industry. Under an ongoing audit program 15 RTOs have been audited to ensure that electrical licence applicants possess the necessary skills and knowledge required under the electrical licensing system. As recommended by the Electrical Licensing Committee, skills maintenance requirements for electrical worker licence renewal have been updated in order to contribute to the maintenance of essential skills and knowledge pertaining to legislated requirements, safe work practices and electrical testing. These changes have been implemented as a means of ensuring the ongoing contribution of the licensing system to positive electrical safety outcomes.

8.0 Conclusion

The Workplace Electrocution Project has highlighted the need for substantial improvement in the legislative framework and in ensuring accountable and responsible enforcement of that framework. The recommendations resulting from the Ombudsman's investigations and the Reviews of the Division of Workplace Health and Safety and the Electrical Safety Office have provided a blueprint or road map for the Department to critically review its business and go forward. It is essential that the Department continue to build on the successes achieved in previous years if we are to have the confidence of the community and Government.

I would again like to thank the Ombudsman and his staff for the positive and constructive manner in which they have dealt with the Department, and also for their contribution to the initiatives implemented to date.

9.0 APPENDIX 1

AVERAGE PENALTIES IMPOSED

PROSECUTION - COMPANY (s.28 (1)&(2), s.30 (1), s.31)

Financial Year	CIRCUMSTANCE OF AGGRAVATION s. 24 - WHS Act 1995	Average Penalty Imposed	Maximum Penalty Imposable
1998 - 1999	Death / Grievous Bodily Harm	$15,000	
	Bodily Harm	$6,000	
	Simpliciter	$1,000	
1999 - 2000	Death / Grievous Bodily Harm	$19,400	
	Bodily Harm	$8,500	
	Simpliciter	$1,000	
2000 - 2001	Death / Grievous Bodily Harm	$22,000	
	Bodily Harm	$8,000	
	Simpliciter	$1,500	
2001 - 2002	Death / Grievous Bodily Harm	$28,830	$300,000
	Bodily Harm	$13,000	$187,500
	Simpliciter	$3,000	$150,000
2002 - 2003	Death / Grievous Bodily Harm	$24,286	$300,000
	Bodily Harm	$15,454	$187,500
	Simpliciter	$5,670	$150,000
2003 - 2004	Multiple Death	-	$750,000
	Death / Grievous Bodily Harm	$23,527	$300,000
	Bodily Harm	$17,141	$187,500
	Simpliciter	$ 9,800	$150,000

PROSECUTION - INDIVIDUAL (s. 29)

Financial Year	CIRCUMSTANCE OF AGGRAVATION s. 24 WHS Act 1995	Average Penalty Imposed	Maximum Penalty Imposable
1998 - 1999	Death / Grievous Bodily Harm	-	-
	Bodily Harm	-	-
	Simpliciter	-	-
1999 - 2000	Death / Grievous Bodily Harm	-	
	Bodily Harm	$3,000	
	Simpliciter	-	
2000 - 2001	Death / Grievous Bodily Harm	$3,000	
	Bodily Harm	$1,485	
	Simpliciter	$1,200	
2001 - 2002	Death / Grievous Bodily Harm	$2 000	
	Bodily Harm	-	
	Simpliciter	-	
2002 - 2003	Death / Grievous Bodily Harm	-	$60,000
	Bodily Harm	-	$37,500
	Simpliciter	$3,500	$30,000
2003 - 2004	Multiple Death	-	$150,000
	Death / Grievous Bodily Harm	$4,667	$75,000
	Bodily Harm	$3,000	$56,250
	Simpliciter	$2,833	$37,500

PROSECUTION - EXECUTIVE OFFICER (s. 167)

Financial Year	CIRCUMSTANCE OF AGGRAVATION s. 24 WHS Act 1995	Average Penalty Imposed	Maximum Penalty Imposable
1998 - 1999	Death / Grievous Bodily Harm	$500	$60,000
	Bodily Harm	$3,000	$30,000
	Simpliciter	-	-
1999 - 2000	Death / Grievous Bodily Harm	$7,500	$60,000
	Bodily Harm	$2,000	$30,000
	Simpliciter	$525	
2000 - 2001	Death / Grievous Bodily Harm	$2,350	
	Bodily Harm	$1,050	
	Simpliciter	$2,400	
2001 - 2002	Death / Grievous Bodily Harm	$2,000	
	Bodily Harm	$750	
	Simpliciter	-	
2002 - 2003	Death / Grievous Bodily Harm	$10,000	$60,000
	Bodily Harm	-	$37,500
	Simpliciter	-	$30,000
2003 - 2004	Multiple Death	--	$150,000
	Death / Grievous Bodily Harm		$75,000
	Bodily Harm	$2,500	$56,250
	Simpliciter	$300	$37,500

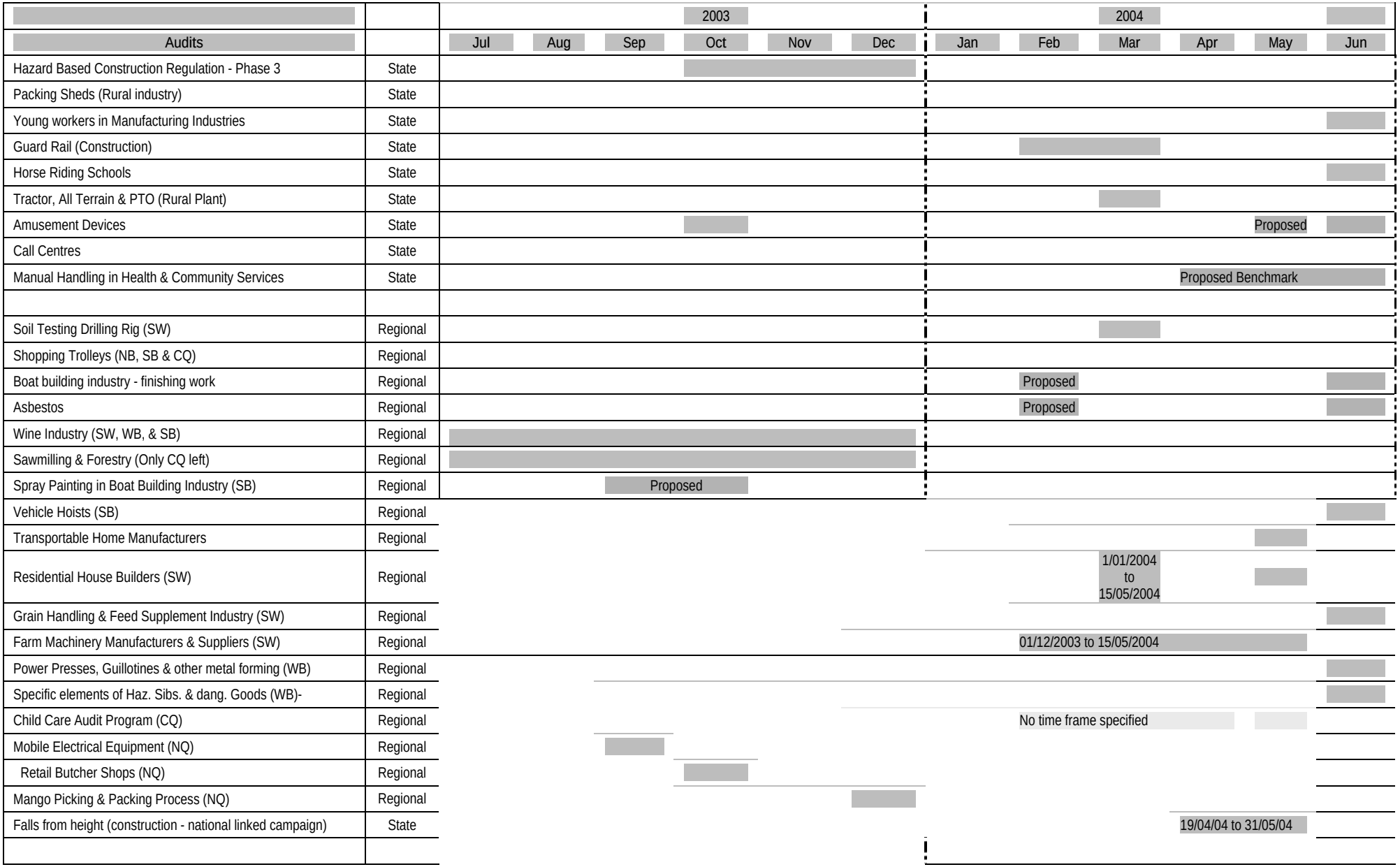
APPEAL MATTERS

Year	Total No. of Appeals	No. Brought by WHS	No. Brought by Defendant	No. Successful Appeals
1998 - 1999	1	0	1	0
1999 - 2000	2	2	0	1
2000 - 2001	8	6	2	7
2001 - 2002	16	13	3	16
2002 - 2003	6	4	2	3
2003 - 2004	16	12	4	8
Total to date	49	37	12	35

Note: There are currently one (1) appeal to be heard

* Figures relate to information available to the Legal and Prosecution Services Unit at the time of calculation. The Legal and Prosecution Services Unit may not be aware of previous Regional Prosecutions.

9.1 APPENDIX 2



Regional Workshops 2003-2004		2003											
	Type	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Meat	Regional												
Amusement devices	Regional												
Sawmilling	Regional												
Spray painting boat building	Regional												
Lead in radiator workshops	Regional												

9.2 APPENDIX 3

Workplace Health and Safety Procedure	DWHS/PROC/00/16
Title: Industry Audit/Blitz Proposal	Date Effective: 10/5/01

Change Control		
Version 2	Description of Changes: Revision of terminology	Date Effective: 22/08/2002

Scope

This procedure relates to the protocols to be used when a Region, Operations Unit or any other person identifies the need to conduct an industry audit or blitz project.

Purpose

To provide guidance to persons wishing to put forward a proposal for an industry audit or blitz project.

Procedure

- The proponent develops a detailed project proposal (Section A of Industry Audit/Blitz Proposal) containing:
  - a clear statement of objectives, timeframes, resources required
  - the need for and composition of any working party
  - a sector profile (where appropriate)
  - a summary of the problem/issue which the project is addressing (see the proforma located in the Templates folder in Linkworks – select Templates; IAS; Objects Create; "Industry Audit/Blitz Proposal") once proforma is completed, it should be submitted.
- For Statewide proposals, the project is forwarded to the Manager, Planning and Monitoring Unit for consideration. The Planning and Monitoring Unit will complete Section B of the Industry Audit/Blitz Proposal. Planning and Monitoring will allocate a priority to the proposal and may make recommendations in respect of the Project.
- For Regional initiatives, a project proposal should be completed by the relevant officers and then approved by the Regional Manager. A copy of the proposal should be forwarded to the Manager, Planning and Monitoring Unit and the Director, Program Services, Workplace Health and Safety for noting.

Proposals originating from Operations units should be endorsed by the Manager of the Unit and approved by the Manager, Operations. A copy should be forwarded to the Director, Program Services. If regional resources are required, the Manager, Planning and Monitoring Unit must liaise with the Regional Manager regarding any resource implications and approve the proposal.

Signed (Manager) P&M	Distributed to:
Date	
Signed (Director) Program Services	RMs & DMs
Date	

INDUSTRY AUDIT/BLITZ PROJECT PROPOSAL	
SECTION A:	*To be completed by Proponent*
PROPOSED PROJECT	
Regional specific OR State-wide proposal	
Applicable Strategic Goals[367]	
Project Background	
Project Objectives	
Problem/Issue project intends to address: Document: Extent of injury/illness; Existing advice on the issue; If yes to 2, why isn't it working, e.g. not communicated/not complied with/not relevant; What needs to be done to address 3.	
Project Deliverables: For example: Enforcement strategy; Communication strategy; or New information product.	
Sector profile: Industry demographics relevant to project, eg, no of workers per ANZIC code, no of workplaces	
Anticipated human resources required: (and other resources for project – time commitment of staff and specialty, if any)	
Proposed Project Timeframe:	
Consultation that has occurred or will need to occur	
Endorsed: e.g. RM, Manager Operations Unit	

367 Refer to the Workplace Health and Safety in Queensland, Strategic Directions and Framework, 2000 – 2005

SECTION B:	***To be completed by the relevant business unit/s impacted for consideration of Planning and Monitoring Unit.*** ***A separate Section B to be completed by each relevant business unit.***
Comment on proposal: eg, supported/not supported, additional information required for scope, alternative strategies already in place.	
Anticipated human and/or physical resources for the Division of Workplace Health and Safety: e.g. Industry Awareness Unit, Planning and Monitoring Unit, Inspectorate, Operations Unit	
Allocated Priority: (High, Medium, Low)	
Anticipated commencement: To be established in consideration of current projects.	
Endorsed: Manager, Planning and Monitoring Unit	……. / /2002
Approved: Director, Program Services	……. / /2002

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