



**eHealth Services Research Group (eHSRG)
University of Tasmania**



WorkSafe Tasmania Coronial Findings Review

Synthesis of Research Findings

Final Report

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Executive Summary

WorkSafe Tasmania (WST), Tasmania's safety regulator, has a responsibility to advise and investigate workplace safety in a number of industries, as well as in general workplace activities. As part of that responsibility, Worksafe Tasmania (WST) commissioned a research based project to study the way in which coroners' recommendations regarding deaths in the workplace have been reviewed and responded to by WST, and by Tasmanian industry more generally. The study also provides a review of the management and impact of coroners' recommendations in other states and territories, noting implications for Tasmania.

The project involved four streams of activity:

- A structured **evidence-based literature review**, designed to provide up-to-date evidence about the impact of coronial findings on the regulation of workplace safety. With literature categorised and structured based on the level of evidence they provided about the key issues being investigated;
- A **review of Coroners Acts** from each Australian State and Territory to clarify the coroner's powers in each jurisdiction, and to clarify the legislated basis of coroners' recommendations and responses;
- **Analysis of Coronal Findings and Recommendations** based on data retrieved from the National Coronal Information System and state coroners' websites, about coronial findings, recommendations, and responses; and,
- **Semi-structured interviews** with coroners and key personnel in Tasmania and elsewhere in Australia, to identify issues and challenges, and to discuss potential improvements in responses to coroners' recommendations.

The findings from each of these four streams of activity are described in Chapter 4, and Chapter 5 provides a synthesis of those findings.

A clear picture has emerged of a therapeutic public health focus that underpins the actions of coroners in investigating deaths and making recommendations. This preventative responsibility is embodied to a greater or lesser extent in each of the Coroners Acts. The sequence of fatal incident, investigation (by police, work safety inspectors and the coroner), recommendation, and response can be viewed as a cycle which has the overall intent of reducing the risk of death. The implementation of an appropriate response to a carefully crafted recommendation from the coroner will have the effect of reducing the likelihood of a subsequent death in similar circumstances. This pattern of activity is seen as an Incident–Investigation–Recommendation–Response (IIRR) cycle. For the cycle to operate effectively, and to provide the desired outcome, it is necessary that each step operates with optimum effectiveness. This means that thorough investigations are required, that recommendations must properly target the causative factors underlying the fatal incident, that recommendations are promptly communicated to the individual or organisation who is able to respond, and that an appropriate response is implemented without undue delay.

There is some evidence to suggest that a requirement for government organisations to provide a response to the coroner within a reasonable time, and for those responses to be published alongside the coroner's recommendations (as is the case in Queensland, New

South Wales, and Victoria) is likely to have a positive effect on the operation of the IIRR cycle.

Regardless of how effective the operation of this cycle is, there will still be circumstances in which 'rogue' employers in the private sector will deny or avoid their responsibility to provide a safe workplace. In such circumstances the process of prosecution can reinforce the need to maintain a safe workplace.

The consequences of a workplace death can have a severe impact on small firms, as well as on the families and work colleagues of the deceased. There appear to be opportunities for positive intervention by WorkSafe Tasmania to moderate these impacts.

Recommended actions:

Based on this research, the eHealth Services Research Group (eHSRG), University of Tasmania present eight evidence-based recommendations intended to enhance the effectiveness with which Worksafe Tasmania and industry more broadly respond to coroners' recommendations in the future.

Recommendation 1: It is recommended that WorkSafe Tasmania develop a Memorandum of Understanding with the Coroners Office, to ensure effective and timely communication between the two organisations.

The beneficial impact of responses to coroners' recommendations can be improved by ensuring effective collaboration between coroners and work safety regulators. A Memorandum of Understanding between the Coroners Office and WorkSafe Tasmania, supported by an identified primary contact within each organisation, is likely to provide the most effective approach.

Recommendation 2: It is recommended that WorkSafe Tasmania consider establishing a disciplined internal process, as if Section 72 of the Victorian Act applied in Tasmania.

The therapeutic effect of responses to coroners' recommendations is enhanced when those responses are formulated without undue delay, and reported to the coroner. The impact of this feedback is further enhanced when responses, along with recommendations, are made publicly available, and particularly so when recommendations and responses are provided in a format which is clear and easily understood.

In the absence of a legislated or mandated requirement for a response to the coroner WorkSafe Tasmania should set internal benchmark times for these processes. This will ensure that:

- Receipt of a recommendation is acknowledged in writing;
- A response is provided to the coroner within a defined period (for example three or six months);
- The format used for the response includes a brief de-identified summary of the case acceptable to the coroner's office, the recommendation, and response.

Recommendation 3: It is recommended that WorkSafe Tasmania approach the Coroners Office to request that recommendations made within the findings of investigations into work-related deaths be published, as standalone documents, in an accessible format, with identifying details redacted if necessary.

The published documents could include responses to those recommendations if and when they are received. When a Tasmanian coroner makes a recommendation following a workplace death, that recommendation is only recorded within the findings of the coroner's investigation, and may be published on the Coroners Court website as a PDF document.

Publication of coroners' recommendations could provide a valuable workplace safety resource, particularly if they were made available in an accessible format, and indexed by industry type and hazard category. There are currently no circumstances in which responses to recommendations by Tasmanian coroners will be published.

Recommendation 4: It is recommended that WorkSafe Tasmania discuss with the Coroners Office the possibility of ensuring that WorkSafe receives a copy of all coronial findings about workplace deaths which include a recommendation, and that WorkSafe contact recipient organisations about the recommendations to which they have been asked to respond.

Coroners' recommendations following a workplace death are intended to enhance workplace safety, and prevent another fatality in similar circumstances. This outcome depends on an appropriately framed recommendation, and also on appropriate responses. WorkSafe's expertise could contribute to ensuring that both the recommendation and the response have an effective impact on workplace safety, not just in the organisation to which the recommendation has been made, but for industry more generally.

This will require WorkSafe being aware of recommendations to other organisations, and communication with organisations about coroners' recommendations and their intended response.

Recommendation 5: It is recommended that WorkSafe Tasmania review its capacity to support small businesses following a fatality, and consider whether a support and advisory role might promote the development of a safety culture in such organisations.

Small firms face particular problems following a workplace death which are not experienced by larger companies. Some small firms may avoid any acknowledgement of responsibility for the death; in extreme cases the company may be placed into liquidation. At the other extreme, the managers and owners of the company may accept a significant degree of responsibility, and engage an external consultant to rectify any safety deficiencies. This approach is less likely to promote a safety culture than could be the case with an internal response.

There is an opportunity for WorkSafe Tasmania to provide support for small organisations to assist them in the development of internal policies and procedures, at a scale appropriate for the organisation, as a way of avoiding the likely "overkill" that could result from the use of external consultants. This approach is also more likely to encourage a safety culture within the organisation.

Recommendation 6: It is recommended that WorkSafe Tasmania consider whether additional opportunities exist for it to foster and support a safety culture in workplaces (particularly in large organisations) over and above the maintenance and application of documented safety management systems.

There is a risk that safety management will be addressed through “managerialism”, relying on formal bureaucratic processes, and the mere appearance of an effective documented safety framework. This activity may not engender a healthy ‘safety culture’.

An opportunity exists for WorkSafe to ensure that the importance of its efforts to introduce and support a ‘safety culture’ in organisations, particularly in high risk industries, is not underestimated or undervalued.

Recommendation 7: It is recommended that WorkSafe Tasmania undertake a review of the pastoral support that is made available, by WorkSafe and others, for the families and work colleagues of deceased employees following a fatality.

Ensuring that appropriate pastoral care is provided for families and colleagues of deceased workers emerged as an important issue in the literature. The consequences of a death at work can include a devastating impact on families and workers, and is made worse by the ensuing investigations, limited access to information, and by legal processes and procedures.

Suitable arrangements may already be in place, but if WorkSafe Tasmania does not have a clear understanding of the pastoral care which is made available, it should investigate further. It would be beneficial for WorkSafe Tasmania, police, and the coroner's office to have an agreed roster of sources of pastoral care to be referred to in the event of a fatality.

Recommendation 8: It is recommended that WorkSafe Tasmania discuss with the Coroners Office the possibility of the *Coroners Act* (1995) being amended to require responses from government organisations, with publication of those responses.

A model for these changes is provided by Clause 72 of the Victorian *Coroners Act* (2008).

The therapeutic effect of responses to coroners’ recommendations is enhanced when those responses are formulated without undue delay, and reported to the coroner, and both recommendations and responses are published.

An amendment to the Tasmanian *Coroners Act* requiring responses from government organisations to recommendations made by the coroner would result in coroners receiving feedback about their recommendations, and a public record of the responses. This would encourage government organisations to respond promptly, and in a way that the community finds acceptable.

The impact of these changes is likely to be enhanced if the recommendations and responses are published in an integrated, accessible format.

The report concludes with a number of suggestions for further research, designed to:

- Evaluate options for professional development to support and enhance existing investigation skills;
- Review mechanisms available for the prompt distribution of safety advice;
- Explore mechanisms for supporting safety in small firms;
- Evaluate mechanisms for managing safety documentation;
- Investigate the feasibility of legislating for mandated responses to coroners' recommendations, with publication;
- Enhance the usability of recommendations made by coroners;
- Validate the impact of coroners' recommendations and responses on workplace safety and on fatality rates; and
- Evaluate available options for providing pastoral care.

This research, conducted during the second half of 2016, has located responses to coronial recommendations within a therapeutic public health context, as part of broader efforts to improve workplace safety. The research has also identified significant variations within Australia in coroners' investigations and recommendations, and responses to those recommendations. With deaths in the workplace, some examples of those activities (such as the mandated requirement for responses in the Victorian Coroners Act, and the template used in Queensland for responses) provide options which are clearly of benefit. The overall process in Tasmania could be appreciably improved by adopting those best practice examples. WorkSafe Tasmania could strengthen its internal processes by adopting those elements in advance of any formal implementation.

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Abbreviations used

CSV	Comma separated values file format
IIRR	The cycle of: "Incident - Investigation - Recommendation – Response" that occurs as a result of a workplace death
NCIS	Australia's National Coronial Information System
PCBU	Person conducting a business or undertaking
PDF	Adobe portable document format
RACS	Royal Australasian College of Surgeons
WST	Workplace Standards Tasmania

1. Introduction

There has always been some degree of risk associated with work, and some occupations are more dangerous than others. During the course of the last 100 years there have been significant efforts in Western societies directed towards improving safety in the workplace. At its most extreme, failure to effectively manage safety in the workplace can result in the deaths of workers or bystanders

Safe Work Australia's *Notifiable Fatalities Monthly Report* for December 2014 (Safe Work Australia, 2015) reported 233 workplace fatalities (of workers and bystanders). Five industry sectors accounted for 184 of those deaths: Transport, Postal & Warehousing (88 deaths); Agriculture, Forestry & Fishing (39); Construction (32); Mining (14); and Manufacturing (11 deaths).

The aftermath of a workplace death usually involves an investigation by a coroner; this may include a formal inquest, and coroners may include one or more recommendations regarding the management of safety within their findings. These recommendations are intended to improve safety and reduce the likelihood of a subsequent death in similar circumstances.

This document presents the key findings from a research project commissioned by WorkSafe Tasmania to investigate, in a Tasmanian setting, the way in which WorkSafe and industry more generally have responded to coroners' recommendations, and what changes if any might enhance the benefit derived from those recommendations and responses.

The research project has included four streams of research activity and was supported by a steering committee comprised of industry representatives from key Tasmanian industry sectors. The four streams of research activity were:

- A structured **evidence-based literature review**, designed to provide up-to-date evidence about the impact of coronial findings on the regulation of workplace safety. With literature categorised and structured based on the level of evidence they provided about the key issues being investigated;
- A **review of Coroners Acts** from each Australian State and Territory to clarify the coroner's powers in each jurisdiction, and to clarify the legislated basis of coroners' recommendations and responses;
- **Analysis of Coronial Findings and Recommendations** based on data retrieved from the National Coronial Information System and state coroners' websites, about coronial findings, recommendations, and responses; and,
- **Semi-structured interviews** with coroners and key personnel in Tasmania and elsewhere in Australia, to identify issues and challenges, and to discuss potential improvements in responses to coroners' recommendations.

The report provides evidence-based recommendations to Worksafe Tasmania on potential changes directed towards enhancing the effectiveness of Tasmania's responses to coroners' recommendations. The eHealth Services Research Group (eHSRG) has endeavoured to align these recommendations with existing frameworks within Worksafe Tasmania and relevant industry sectors.

This report, the final component of the project, is structured as follows:

Chapter 2: provides a background to the project, and to issues associated with workplace fatalities, the role of the coroner, including the making of recommendations, and responses to those recommendations.

Chapter 3: describes the methodology which was applied during each of the four streams of research.

Chapter 4: presents the findings from the research undertaken.

Chapter 5: provides a synthesis of the findings, and a discussion of the issues raised

Chapter 6: provides recommendations to WorkSafe Tasmania for possible future action, with advice about appropriateness and effectiveness.

Chapter 7: identifies areas where further research might be of benefit.

The results of the literature review are described in detail in a separate document (Showell, Roehrer, & Turner, 2016).

2. Background

WorkSafe Tasmania (WST), Tasmania's safety regulator, has a responsibility to advise and investigate workplace safety in a number of industries, as well as in general workplace activities. As part of that responsibility, Worksafe Tasmania (WST) commissioned a research based project to study the way in which coroners' recommendations regarding deaths in the workplace have been reviewed and responded to by WST and by Tasmanian industry more generally. The study also aimed to provide a review of the management and impact of coroners' recommendations in other states and territories, noting implications for Tasmania.

Coroners' recommendations and workplace safety

Part of the role of the coroner is to conduct an investigation, which may include an inquest, into unexpected deaths. In the case of work related deaths, the coroner may make a specific recommendation to any organisation whose role includes the oversight of issues related to public safety, as well as broader recommendations to industry more generally. The intention of such recommendations is to encourage changes designed to protect individuals and the community.

This research is primarily focused on responses to recommendations which have been made by a coroner following an investigation into a workplace death. However, evaluating those responses inevitably requires some attention to the recommendations themselves, and to the overall process within which those recommendations and responses are situated. At the broadest level these processes can be viewed as an example of a public health activity (Bugeja, Ibrahim, Ozanne-Smith, Brodie, & McClure, 2012; Sleet, Hopkins, & Olson, 2003), and this perspective has been adopted in this report.

The public health process involves a cycle of activity: a fatal incident in the workplace is followed by an investigation by work safety inspectors and the police. The reports of these investigations are given to the coroner, who will then decide whether there are grounds for a full public inquest, or whether an investigation based on the evidence provided will give sufficient detail to allow the matter to be concluded.

The findings from the coroner's investigation, with or without inquest, may include recommendations to one or more individuals or organisations deemed to have a role or capability in the reduction of the likelihood of another death in similar circumstances. Individuals and organisations are expected to consider the recommendations made by the coroner, and to determine an appropriate response. If the coroner's recommendations are seen to be appropriate, the response should include actions that implement those recommendations.

The process of making recommendations and responding to them sits within a cycle which includes the original *incident*, one or more *investigations*, a *recommendation* by the coroner, and a *response*. This Incident-Investigation-Recommendation-Response (IIRR) cycle is shown in Figure 1. The intention of this cycle is to prevent a recurrence of the originating incident by improving the management of safety in the workplace.

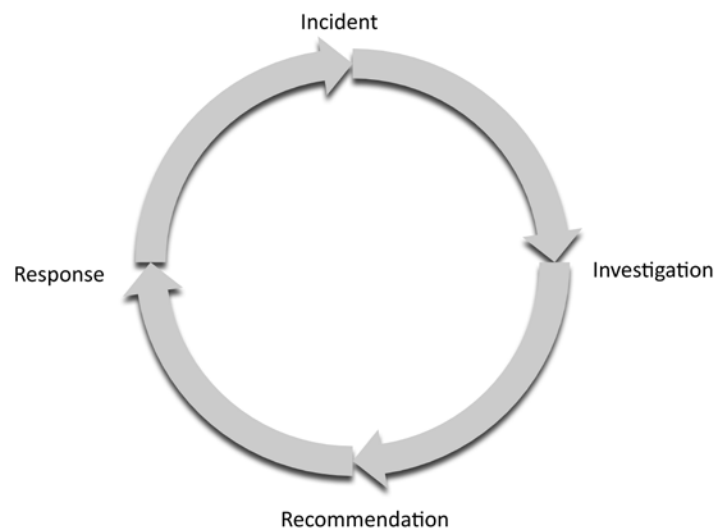


Figure 1: The Incident-Investigation-Recommendation-Response (IIRR) cycle

The intention of this cycle of incident, investigation, recommendation and response is to progressively reduce the risk of death in the workplace. However, for these benefits to be realised, the IIRR cycle must function effectively: at each stage, between stages, and as an overarching system.

This report is focused on ensuring that responses made to coroners' recommendations about workplace fatalities in Tasmania will provide an optimal or 'best possible' benefit in terms of overall workplace safety.

About the project

The research commissioned by WorkSafe Tasmania has included a literature review, a review of state Coroners Acts, stakeholder interviews, and an analysis of records about coroners' recommendations held within the National Coronial Information System and state coroners' websites. More specifically, the research has focused on issues associated with the following key issues:

- 1. The management of safety in the workplace**
- 2. The making of recommendations by a coroner**
- 3. Responses to coroners' recommendations, by organisations and employers**
- 4. The impact of recommendations and responses on workplace safety**

These issues have been extrapolated to a number of more specific questions that have been addressed by this research project including:

- What factors shape a recommendation by a coroner?
- What is the overall quality of coroners' recommendations, and how appropriate are they?
- How do employers and government organisations respond to recommendations?
- How effective are the individual responses?
- How effective is the overall process?
- What other issues affect the relevance and effectiveness of the process?
- What are the mechanisms by which coroners' recommendations could have an enhanced impact on workplace safety?

3. Methodology

The research which has been undertaken to investigate responses to coroners' findings has incorporated four streams of activity:

- A structured **evidence-based literature review**, designed to provide up-to-date evidence about the impact of coronial findings on the regulation of workplace safety. Literature was categorised and structured based on the level of evidence they provided about the key issues being investigated;
- A **review of Coroners Acts** from each Australian State and Territory to clarify the coroner's powers in each jurisdiction, and to clarify the legislated basis of coroners' recommendations and responses;
- **Analysis of Coronial Findings and Recommendations** based on data retrieved from the National Coronial Information System and state coroners' websites, about coronial findings, recommendations, and responses; and,
- **Semi-structured interviews** with coroners and key personnel in Tasmania and elsewhere in Australia, to identify issues and challenges, and to discuss potential improvements in responses to coroners' recommendations.

The methodology techniques applied in each of these four streams of research are described in the sections that follow.

3.1 Literature review

The literature review applied a methodological approach designed to provide an up-to-date review of relevant literature about the impact of coronial findings on the regulation of workplace safety, including the effective management of the processes of making and responding to recommendations, and the role of recommendations in the improvement of workplace safety.

The review sought literature which was primarily focused on coroners' recommendations following a non-intentional externally caused workplace fatality; the responses to those recommendations; and, related issues pertaining to coronial processes and workplace safety.

A series of selection criteria were used to focus on both peer-reviewed and non-peer reviewed material published in the English language in Australia and internationally since 2005. Some literature on accident causation has been included where assessed as providing relevant context for the review. The search strategy involved the interrogation of a wide array of electronic databases, using search terms including:

(workplace [AND] (death [OR] fatality) [AND] ((coroner [OR] coroner's [OR] coronial) [AND] (inquiry [OR] investigation [OR] inquest [OR] recommendation)

The search included full text databases; citation databases and sources; web-based search engines; and direct analysis of output from government agencies and centres of research excellence, as well as using web-based resources and common search engines to identify non-peer reviewed materials of relevance including government reports.

The materials retrieved were analysed, categorised and structured based on the level of evidence which they provided about the key issues being investigated, using a framework

developed by the eHSRG for the conduct of evidence-based reviews. Materials were rated from Category 1: Comprehensive intervention based studies providing high quality evidence transferable to other settings, through to Category 4: Published Opinions or Reviews, and Category 5: Published Reports.

This approach ensured a broad coverage of relevant literature, as well as identifying potential gaps or limits to the current evidence, as well as providing insights into current Australian practice.

Results of the literature review are summarised in Section 4.1, and presented in full in a separate document that has already been presented to WorkSafe Tasmania as part of this research project (Showell et al., 2016).

3.2 Legislation

The power of a coroner to investigate and report on the circumstances of a death, and to make recommendations, is granted through legislation. Each state and territory in Australia grants this power through its own *Coroners Act*.

eHSRG staff undertook a brief desktop review of Australia's coroners acts in order to understand the extent of coronial powers in each jurisdiction, and to clarify the legislated basis of coroners' recommendations and responses, and publication of those findings and responses.

The results of this review are provided in Section 4.2

3.3 Analysis of Coronial Findings and Recommendations

3.3.1. Sources of data

The two principal sources of data about coroners' recommendations in Australia are: the National Coronial Information System (NCIS), and the websites maintained by most state coroners. It is important to note that 'responses to coroners' recommendations' are also published in Queensland, New South Wales and Victoria.

National Coronial Information System

The National Coronial Information System (NCIS) is an internet connected database providing a comprehensive source of data about coroners' investigations and recommendations in Australia and New Zealand. The system was implemented following a review in 1994 by the National Injury Surveillance Unit of the Australian Institute of Health and Welfare. The NCIS holds coronial information from all Australian states since July 2000 (January 2001 for Queensland).

Researchers are able to access the NCIS subject to approval from the Victorian Justice Human Research Ethics Committee. Access to NCIS data is provided at two levels. With appropriate ('minimal risk') ethics approval researchers are granted Level 2 access to non-identifiable information about closed cases (completed coroners investigations) including basic coded data. This data provides an overview of the frequency of coroners' investigations and recommendations following a workplace death, by year, by state, and by industry type. With more stringent ('high risk') ethics approvals researchers can be provided

with Level 1 access to all records related to a case, including details that the coroner has marked as confidential and not for public disclosure.

Data from state coroners' offices

In most states published findings are made available on the internet, although, not all coroners' findings are made available publicly. Queensland, New South Wales and Victoria also publish responses to coroners' recommendations on a publicly accessible website. Details of responses to coroners' recommendations are not stored within the NCIS. Additional data about workplace fatalities in Tasmania was sought from Worksafe Tasmania directly.

3.3.2. Analysis

Statistical overview

Selected data was extracted from the NCIS as a comma separated value (CSV) file, search parameters were set to select data about identified workplace deaths by state or territory, including details of Industry and Industry sector, and the presence of a recommendation from the coroner. Data was analysed using Microsoft Excel.

The results of the statistical analysis of Level 2 data are provided in Section 4.3.1.

Coroners' recommendations

The methodological approach for the analysis of coroners' recommendations included three components: extraction and analysis of data from the National Coroners Information System (NCIS); a review of published responses to coroners' recommendations in Queensland, New South Wales and Victoria; and, a comprehensive evaluation of recommendations and responses in Tasmania.

Relevant cases were identified by reviewing summary data retrieved using Level 2 access. The identifying characteristics that were used to search for these cases included those cases that were:

- From a particular state;
- For a range of dates of death or case closure;
- Marked as 'Closed' (NCIS access was not sought for 'Open cases');
- Marked as 'Work related'; and
- Marked as having 'Recommendations included'

The NCIS was accessed to retrieve PDF files of all available findings by Tasmanian coroners regarding workplace deaths including a brief case summary, the recommendations and the recipients. Each identified case was loaded in turn from the NCIS database, and the pdf file of the case findings downloaded for secure storage. A screen snapshot of the case details was also captured.

The retrieved records were cross-referenced with a list provided by WST of reported workplace fatalities in Tasmania during the same period to decrease the likelihood that a workplace fatality had been overlooked.

Coroners' recommendations and responses - other states

Most states and territories publish coroners' findings on the internet, although there are variations in the proportion of cases that are published, and the ease with which particular

types of cases can be located. In Tasmania, recently published cases are now accompanied by some basic keyword indexing. In three states – Queensland, New South Wales and Victoria – responses are published alongside the coroners’ findings and recommendations. All available data about coroners’ recommendations and responses for work related cases in the latter three states were downloaded and analysed to provide some indication of their potential to improve workplace safety.

The coroners’ recommendations from these cases were evaluated by identifying whether each recommendation identified:

- The organisation that should respond or act;
- The action that was expected;
- The immediate result of the action; and,
- The longer term outcomes that were anticipated .

Published responses were categorised as being:

- **Already completed:** Including recommendations that were addressed by measures that were in place at the time of the incident, or implemented prior to the coroner’s recommendation (including recommendations or actions by others that the coroner adopted or endorsed);
- **Accepted:** Measures which were accepted and implemented;
- **Alternatives:** Measures which were implemented as a preferable means to achieving the desired outcome, or recommendations which were adopted ‘in part’;
- **Rejected:** Recommendations which were not supported or that were rejected with no alternative implemented; or
- **Missing:** Recommendations for which there was either: no response; a response not published; a response was published, but not identified by the search; or for which the identified organisation decided not to respond, or responded, but did not act.

Responses

Responses provided on the Queensland, New South Wales and Victoria coroners’ websites were matched with the recommendations made within published findings where available.

It should be noted that it was not always possible to easily identify work related cases

The results of the analysis of NCIS Level 1 data and findings, recommendations and responses retrieved from state coroners’ websites are provided in Section 4.3.3.

The analysis of recommendations and responses from Queensland, New South Wales and Victoria, and the analysis of Tasmanian recommendations are provided in Sections 4.3.2 and 4.3.3

3.4 Interviews

The research included a number of semi-structured interviews with key participants in Tasmania and elsewhere in Australia, including coroners and key personnel within relevant industry sectors. These interviews were undertaken in order to generate additional data on issues and challenges and to discuss potential approaches to improve current responses to coroner recommendations. Interviews were conducted with:

- a) staff from the Tasmanian Coroners Office (including coroners);
- b) staff from mainland stakeholder groups;
- c) WorkSafe staff; and
- d) representatives of other Tasmanian organisations.

In Tasmania, semi-structured interviews were conducted face-to-face where possible, and audio recorded (with the interviewee's prior consent). Recordings were transcribed for subsequent analysis. Where face-to-face interviews were not possible, interviews were conducted by telephone, with comprehensive notes taken during the call. Interview data were analysed and coded drawing on the principles of grounded theory (Glaser & Strauss, 1967) with key insights interpreted in the context of all other data generated from data analysis, and in conjunction with conclusions from the literature review.

Interviews with participants outside Tasmania were conducted by telephone, in order to collect information on coronial investigation processes, recommendations and their associated stakeholder responses in relation to workplace deaths. Discussions and interviews were conducted with stakeholders in Victoria, Queensland, New South Wales, South Australia and Western Australia.

The proportion of coronial cases which investigate workplace deaths is relatively small, and many of the interviews also included a discussion of health related examples of coronial practice. Again, semi-structured interview techniques were applied, using open-ended questions, encouraging respondents to raise any points about coronial processes which they considered relevant to findings and recommendations about workplace deaths, to response mechanisms, or the preventative health function.

Key findings from the interviews are presented in section 4.4.

4. Findings

4.1 Literature review

The evidence-based review of relevant literature about the impact of coronial findings on the regulation of workplace safety provided contemporary evidence about the role of coroners' recommendations in the improvement of workplace safety, and the effective management of the process of making and responding to recommendations.

4.1.1 What causes workplace 'accidents'?

Models of accident causation make an important contribution to the understanding of workplace accidents, including fatalities. These models have developed significantly over time, and may provide a view of causation which is person-centred, system-centred, or both.

Models have also evolved to account for a significant increase in complexity in the design and operation of work over the last 80 years, and vary in the degree of complexity which they incorporate (describing a simple linear path, a complex linear path, or complex non-linear factors contributing to an accident). Less complex models may still be appropriate in understanding less complex work environments

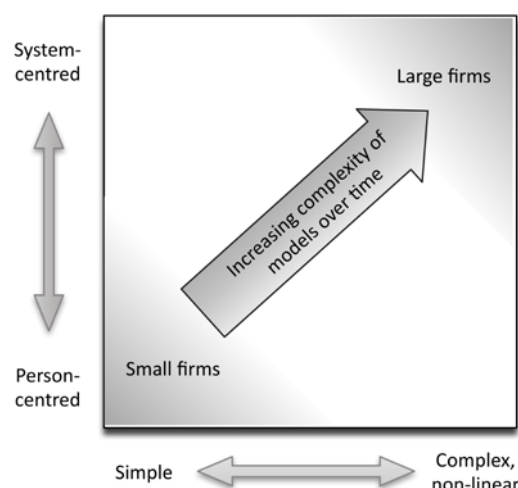


Figure 2: Types of accident causation model

The variation in the explanatory power of accident causation models means that the model which is applied in a particular case may need to be tailored to the circumstances being investigated – no single model is able to explain accidents, injuries or fatalities in all situations.

4.1.2 How can workplace fatalities be minimised or avoided?

Safety in the workplace, like safety in most other settings, is a curious phenomenon. While the concept of safety is well accepted and understood in the abstract, most attempts to quantify safety depend on measures of its inverse – the number of deaths or lost time injuries; the time between serious accidents; or the cost of compensating injured workers. Many experienced safety practitioners have developed an almost instinctive ability to categorise a workplace as either safe or unsafe – an unsafe site might be described as “an

accident waiting to happen”. However, formal evaluation of the factors which contribute to a safe workplace are less common.

There are both philosophical and practical questions about the extent of preventative measures that should be applied in addressing the risk of a workplace death (or serious injury). Are workplace deaths an inevitable (and by inference acceptable) consequence of ‘normal accidents’, or are work related deaths to be avoided at all costs?

The evidence shows that there are differing opinions about whether fatalities must be an inevitable part of the contemporary workplace. Although safety management is commonly limited to ‘reasonably practicable’ interventions, it is ethically challenging to agree to a workplace fatality target of more than zero. The evidence highlights that sometimes an ‘implicit acceptance of fatality risk’ permeates some work environments to the detriment of the overall workplace safety culture. There are examples, such as Sweden’s ‘Vision Zero’ policy, of communities that have decided that deaths and serious injuries are unacceptable.

There can be no simple resolution of these diverse views, but differing perspectives are likely to have an influence on how an investigation into a death will be conducted, how the findings are presented to the coroner, and how the coroner develops and documents any recommendations.

4.1.3 Aftermath of a workplace death

Investigations

A workplace death will be followed by a complex web of interrelated investigations – by police, safety regulators and coroners – and these investigations may lead to changes in the work environment or work practice. There may also be a prosecution initiated by police or the regulator, or a civil suit for damages. The investigations frequently have different time-frames and goals, and the evidence shows that both the investigations and the interventions that follow are best understood through the lens of a preventative public health framework.

The models of accident causation discussed previously can have a significant effect on the findings of investigations into a workplace death, and hence into the nature of recommendations that might be made. The model applied by an investigator will largely determine what causative factors are identified (and hence, these may influence the coroner’s approach to the generation of findings and recommendations).

The evidence shows that the use of a person-centred causation model will favour findings which identify failings by individuals as the most likely cause of an accident, while the use of a system-centred model will encourage the consideration of systemic causes. Coroners’ findings may be guided by the results they are given by police and safety investigators, particularly in the absence of an inquest.

Importantly, there are also significant variations in the nature of the coronial role between jurisdictions, including within Australia. The power of coroners to make recommendations differs, and the nature, quality, extent and frequency of recommendations will vary, depending on both the circumstances of the case, and on the coroner who is conducting the investigation. The evidence shows that many countries do not have a coroner role as it is understood in Australia, and that not all jurisdictions expect or allow coroners to make recommendations within their findings. The evidence also shows that over recent years Australian coroners have come to exhibit a strong preventative focus in their deliberations.

Responses

Employers may demonstrate a 'virtuous' or a 'blinkered' response, depending on how they view their responsibility for any workplace accident. The evidence shows that some employers will establish or maintain a sense of remoteness from the incident, and locate responsibility for the death elsewhere. This attitude is likely to be associated with a 'blinkered' response that will tend to avoid addressing core safety issues.

The evidence also highlights that company size can affect the precursor conditions, impact and aftermath of a workplace death. Small organisations in particular may struggle to establish and maintain effective safety management systems, and tend to respond differently to a fatality, and to coroners' recommendations than larger companies. Small companies may also find the aftermath of a workplace death particularly difficult, and may seek the services of an outside consultant to implement the necessary safety management processes.

There is evidence of a number of other differences between large and small organisations in the way that they manage safety; in rates of fatality; and in the way that they respond to an incident and its consequences, as well as in attitudes to actions by the coroner and the work safety regulator. These differences may be of particular relevance in Tasmania.

Pastoral care

A lengthy period between a workplace death and the conclusion of the coroner's investigation can reduce the effectiveness of any recommendations made. In Australia, coroners' investigations do not commence until all work safety actions are complete.

The evidence shows that recommendations made after an extended period (years) are more likely to be seen as being inappropriate or irrelevant. In some jurisdictions, such as the United Kingdom, the coroner's investigation precedes any legal action by the regulator, and in most cases is completed within 6 months.

The investigation process after a workplace death can have a devastating impact on those affected, particularly on the family of the deceased. This impact is much worse when the investigation process seems to be unnecessarily protracted.

The evidence shows that the impact on a bereaved family is likely to be much worse if the investigation process, including coronial proceedings, occur over an extended period. This impact can be more severe if investigators are unable or unwilling to advise the family of any interim findings.

4.1.4 Impact of the overall process

One focus of this structured review was to identify research literature providing evidence of the positive impact of coronial investigations and coronial recommendations on workplace deaths. There was some evidence to suggest that coronial *investigations* could have a positive (although geographically limited) impact, but there was no evidence about any impact from coronial *recommendations*. This is partly because these issues do not appear to have been investigated, and is clearly different from stating that recommendations *do not* have a positive impact.

The potential beneficial impact of coroners' recommendations can be limited by a number of factors, including:

- Ineffective communication of recommendations to the intended recipients;

- Recommendations arriving too late to be of use; and
- Recommendations which are not accepted or not responded to.

These findings suggest that there are a number of opportunities to improve the overall process.

If the IIRR cycle is to operate at its most effective (accepting that evidence of effectiveness is currently limited or absent) then each step of the cycle will need to be managed and conducted appropriately. It should be noted that there is evidence that a failure to effectively complete this cycle can lead to subsequent fatalities in similar circumstances.

The evidence shows that the promptness, effectiveness and frequency of responses to coroners' recommendations can be improved by ensuring that any responses made are provided directly to the coroner's office. The evidence also shows that the effectiveness of investigations, recommendations and responses can be enhanced through greater collaboration between the coroner, the safety regulator and the employer.

4.2 Legislation

Part of the role of the coroner is to conduct an investigation, which may include an inquest, into unexpected deaths. Within their findings, coroners may make specific recommendations to any organisation whose role includes the oversight of issues related to public safety, as well as broader recommendations to identified groups. The intention of such recommendations is to encourage changes designed to protect individuals and the community. In Australia, the system of recommendations and responses is structured differently in each state and territory. The process may be supported by provisions in legislation, by administrative instruction, or as a matter of practice. The *Coroners Act* in each Australian state and territory include provisions for a coroner to make recommendations (also described as 'comments' in the Queensland Act) following an investigation into a death. However, there are some differences between the various Acts.

Making recommendations

In each of the mainland states, the relevant legislation provides that a coroner "**may**" make a recommendation.

Uniquely, Section 28 of the Tasmanian *Coroners Act 1995* (Findings, &c., of coroner investigating a death) provides that:

- (2) A coroner **must**, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate.
- (3) A coroner **may** comment on any matter connected with the death including public health or safety or the administration of justice.

(*Coroners Act (Tas)*, 1995, sec. 28 (2))
[Emphasis added]

To whom are recommendations made?

In South Australia (SA), Western Australia (WA), the Australian Capital Territory (ACT) and the Northern Territory (NT), coroners recommendations are primarily made to the Attorney General (AG). In the ACT, the coroner must also provide those recommendations to the relevant minister, while in WA and NT it is the responsibility of the AG to give a copy of the

recommendation to relevant heads of agencies. The SA *Coroners Act* has no specific requirement for the AG to pass on recommendations other than for deaths in custody.

In other mainland jurisdictions, each *Act* requires recommendations to be sent variously to the relevant Minister (Vic, NSW, Qld) or public statutory authority or entity (Vic, Qld). Queensland's *Act* also requires the report to be provided to any person with a sufficient interest who appeared at the inquest. Only the NSW *Coroners Act* requires recommendations to be sent to individuals and bodies outside government to which recommendations are directed.

In Tasmania, although the *Act* states that coroners must make recommendations where appropriate, it does not currently specify that a recommendation should be directed to an individual or organisation, and neither is there any suggestion that a response is required, other than provisions that a coroner *may* report to the AG on a death, and *may* make recommendations to the AG on any matter connected with a death. No legislated or administrative processes are evident in Tasmania requiring a government organisation to provide the coroner with a response to their recommendations.

Publication

There is a clear dichotomy in the legislated requirements for publication of findings and recommendations.

Findings and recommendations from inquests in Victoria and Queensland *must* be published on the website unless the coroner directs otherwise, and in Queensland *may* be published following an investigation without inquest. (*Coroners Act (Qld)*, 2003, *Coroners Act (Vic)*, 2008) *Acts* in the other states and in the territories do not specify publication, although in Tasmania the accompanying Rules (*Coroners Rules (Tas)*, 2006, sec. 25) do require findings to be given to the senior next of kin. As a matter of practice, findings from most jurisdictions are published on the relevant coroners' websites.

Responses to recommendations

In three jurisdictions, responses including details of actions taken or planned are provided to parliament. In SA and the ACT, responses to recommendations must be tabled in parliament by the relevant Minister within six months. In the NT, the AG tables a response from the relevant head of agency within 3 months.

In Victoria, responses from public statutory authorities and entities are to be provided to the coroner within 3 months and published on the Internet. Coroners Acts in Qld, NSW, WA and Tas do not include a requirement for any response to a coroner's recommendation.

However, in NSW, *Premier's Memorandum M2009-12 – Responding to Coronial Recommendations* specifies that Ministers or NSW government agencies must acknowledge the receipt of any coronial recommendation within 21 days, and provide a written response to the Attorney General within six months, either outlining the action being taken, or giving reasons why no action is to be taken.

It should be noted that Tasmania has a unique legislated requirement, not included in Coroners Acts other states or territories, requiring a coroner to conduct an inquest when investigating the work-related death of a worker (but not a bystander):

“24. Jurisdiction of coroner to hold inquest into a death

- (1) Subject to section 25, a coroner who has jurisdiction to investigate a death must hold an inquest if the body is in Tasmania or it appears to the coroner that the

death, or the cause of death, occurred in Tasmania or that the deceased ordinarily resided in Tasmania at the time of death and –
[...]

(ea) the deceased died at, or as a result of an accident or injury that occurred at, his or her place of work and the coroner is not satisfied that the death was due to natural causes...”

(*Coroners Act (Tas)*, 1995, sec. 24)

The coroner may conduct an investigation without inquest if so requested by the worker’s senior next of kin.

4.3 Analysis of Coronial Findings and Recommendations

4.3.1 Statistical summaries

Investigations, inquests and recommendations

Data for all coroners’ cases involving external caused workplace fatalities that were closed during the period from 1 January 2006 to 30 June 2016 were retrieved from the National Coronial Information System. In all tables below, annual data for 2016 is for a half-year only.

There were 3,159 cases closed during the period evaluated, with 12.3% of cases overall proceeding to inquest.

Table 1: Inquests and Investigations following a workplace death, by State (2006-mid 2016)

	NSW	VIC	QLD	SA	TAS	ACT	NT	Total
With inquest	137	90	100	<5	27	12	14	387
Without inquest	807	1,027	522	204	121	15	73	2,769
Not stated	>5		>5					>5
Total	946	1,117	623	211	148	27	87	3,159
Inquests	14.5%	8.1%	16.1%	3.3%	18.2%	44.4%	16.1%	12.3%

The results show a wide variability in decisions by coroners to proceed to a full inquest in the investigation of a workplace death. An inquest is least likely in South Australia (3.3% of cases) and Victoria (8.1%) and most likely in the Australian Capital Territory (44.4% of cases), although with a relatively low number of investigations into workplace deaths (27 cases in 11 years).

Recommendations made (from inquests and investigations)

As shown in Table 2, recommendations were far more likely within findings from inquests than for investigations without inquest (48.3% overall, compared to 3.7%). Tasmanian coroners were by far the most likely to make recommendations, which accompanied 81.5% of inquests, and 34.8% on investigations without inquest.

Table 2: Coroners' recommendations from Inquests and Investigations

	NSW	VIC	QLD	SA	TAS	ACT	NT	Total
With inquest								
Recommendation made	59	43	45	<5	22	<5	11	187
No recommendation	60	47	55	<5	5	9	<5	181
Not stated	18			<5				19
Total	137	90	100	7	27	12	14	387
% with recommendation	43.1%	47.8%	45.0%	57.1%	81.5%	25.0%	78.6%	48.3%
Without inquest								
Recommendation made	>5	47	<5	<5	44		<5	102
No recommendation	243	977	511	166	76	15	70	2,058
Not stated	560	<5	8	37	<5			609
Total	807	1,027	522	204	121	15	73	2,769
% with recommendation	0.5%	4.6%	0.6%	0.5%	36.4%	0.0%	4.1%	3.7%
Grand Total	944	1117	622	211	148	27	87	3,156

Time between the workplace incident and closure of the coroner's case

A separate analysis was undertaken of the time between incident and the coroner's findings for work-related deaths in Tasmania. The results are summarised in Table 3, which shows the time between the incident and the closure of cases, by year of closure.

Table 3: Time (in years) between incident and case closure for work related deaths in Tasmania

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	All
All											
Number of cases	17	10	21	12	16	26	6	13	9	12	142
Minimum	0.3	0.4	0.3	0.2	0.3	0.5	0.9	1.0	0.7	1.0	0.2
Maximum	3.0	2.7	7.0	7.0	35.6	45.3	3.1	4.9	49.2	13.0	49.2
Median	0.7	0.9	1.3	1.3	1.1	2.1	1.1	2.3	1.9	2.3	1.5
Average	1.1	1.1	2.3	2.1	3.4	8.8	1.5	2.3	7.3	4.7	3.6
With inquest											
Number of cases	3	4	6	4	1	3	-	2	2	2	27
Minimum	0.5	0.6	1.3	2.9	2.3	1.1		2.1	1.9	3.7	0.5
Maximum	2.4	2.7	7.0	7.0	2.3	2.9		3.2	4.8	3.8	7.0
Median	1.7	0.9	2.5	3.9	2.3	2.9		2.6	3.4	3.7	2.7
Average	1.5	1.3	4.1	4.4	2.3	2.3		2.6	3.4	3.7	2.9
Without inquest											
Number of cases	14	6	15	8	15	23	6	11	7	10	115
Minimum	0.4	0.4	0.3	0.2	0.3	0.5	0.9	1.0	0.7	0.2	0.2
Maximum	3.0	1.8	7.0	2.0	35.6	45.3	3.1	4.9	49.2	7.1	49.2
Median	0.6	0.8	1.0	0.6	1.1	2.1	1.1	2.3	1.9	1.4	1.3
Average	1.0	0.9	1.6	0.9	3.5	9.7	1.5	2.3	7.6	2.1	3.5

As would be expected, investigations which included an inquest took longer than those without inquest (0.5–7.0 years, median 2.7 vs 0.2–49.2 years, median 1.3). There is also a discernible trend for cases without inquest to take longer in recent years (median 0.6 – 1.04 years between 2006 and 2009, and 1.1 – 2.3 years between 2010 and 2015). No cases took longer than a year prior to 2010, and no cases after 2010 took less than a year.

Data for 2010, 2011 and 2014 show extended maximum closure times due to a small number of cases from the 1960s, 70s and 80s which were closed after protracted delays, although median case durations are not significantly raised. These protracted cases do not appear to represent usual coronial practice.

4.3.2 Responses to coroners' recommendations

Government organisations in Queensland, New South Wales, and Victoria are required to provide the coroner with a response to recommendations made within the findings of coronial investigations, and these responses are published on the respective coroners' websites. These published records provide a valuable resource for reviewing coroners' recommendations and the responses which they elicit.

All publicly available responses to coroners recommendations involving workplace deaths from all three states were retrieved for analysis, and reviewed for appropriateness.

Queensland

In Queensland, a single web page provides a short case summary, including the decedent's name, a link to the findings and a link to the response provided, or a note that a Queensland government response is not required.

Published responses are provided as a single PDF document, using a standardised template which is logically structured and easy to read. Nine cases were identified, covering the period 2013 to 2015. The report is progressively updated as additional elements of the response are provided by government departments. This approach would appear to be a **good model to adopt for Tasmanian reporting** of responses to coroners' recommendations.

New South Wales

In New South Wales, responses to coroners' recommendations are published as a series of MS Word documents. The search identified 12 work related cases with published recommendations, between 2010 and 2015. Published findings are provided on the coroner's website with a separate website operated by the Justice Department providing MS Word documents containing case summaries, recommendations and responses, in table format. It appears that some table cells which contain extensive content truncate a portion of the text, making it unreadable.

This method of documenting responses fails to provide context for progress reports about actions in response to a recommendation. On occasion, a deferred response appears to have been omitted.

There does not appear to be a logical link between published findings and responses some published cases with responses on the Justice website do not appear to be matched by an accessible version of the coroner's findings for that case. Documents contain details of responses received over successive six-month periods up until 2013, and annually thereafter.

Victoria

In Victoria the Coroners Court website lists published findings including an indication of whether associated responses are also published. Links are provided to PDF documents of the findings, and of any responses received by the coroner. In a few cases findings or responses were not provided on the website, even though they were noted as being "published in full".

The PDF files provide scanned versions of printed documents, but with no optical character recognition applied; this means that text within those files is neither searchable nor selectable.

Responses are provided verbatim, as submitted to the Coroner's Office and are not always easy to interpret without referring to the coroner's original finding. The website provides the findings for 20 workplace investigations by a coroner (with one of these being a fire which did not involve a death). Of the 19 investigations into workplace fatalities, 11 involved an inquest, with three of the inquests reporting on investigations into the same incident. Publication dates of the findings ranged from April 2010 to June 2016.

This method for publishing responses provides less context than the single document format that is used in Queensland.

Other

In South Australia coroners' recommendations are included in the coroner's annual report which is tabled in Parliament. Government organisations may provide responses to some coroners' recommendations and in some cases these may be included in the State Coroner's annual report. Alternatively these responses may be published on the website of an individual government department. However there does not appear to be a practicable way of retrieving all responses.

The Coroners Acts in Queensland, New South Wales and Victoria do not require non-government organisations to provide a response to the coroner. However some non-government organisations do provide a response. In one Victorian case the company to whom a recommendation had been directed responded as follows:

"[The company] has carefully considered the recommendations which (as noted by the coroner) apply to the current operator of [government service]."

This was the entire content of their response to the coroner's recommendations.

In a case in New South Wales the response to a coroner's recommendation is recorded as follows:

"[the company] is not a government agency and is not required to respond to the recommendations of the New South Wales coroner under PM 2009 – 12."

Analysis

All available responses to coroners' recommendations following a workplace death were retrieved from the respective coronial websites, together with the recommendations themselves. The number of responses in each state by year is shown in Table 4.

Table 4: Published responses to recommendations by mainland coroners regarding workplace deaths

	2010	2011	2012	2013	2014	2015	2016
Queensland				3	5	1	
New South Wales	4	1	3		2	1	
Victoria	2	2	3	2	1	5	2

The number of recommendations made in each finding varied between states. Queensland coroners usually made only one recommendation, and never more than four, while it was unusual for coroners in New South Wales and Victoria to make only a single recommendation. Table 5 shows the number of recommendations made per case.

Table 5: Number of coroners' recommendations per case (where responses were published)

	Number of	Number of	Recommendations per case
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	cases	recommendations	1	2	3	4	5	6	7	8	9	10
Queensland	10	15	8		1	1						
New South Wales	12	46	2	2	2	1	1	1		1	1	
Victoria	16	55	3	2	2	2	2	2				1

The coroners' recommendations from these cases were evaluated by identifying whether each recommendation identified:

- The organisation which should respond or act;
- The action that was expected;
- The immediate result of the action; and
- The longer term outcome that was anticipated.

All recommendations with published responses clearly identified the individual or organisation who was expected to respond, and all but four clearly described the action which was recommended. Victorian coroners were more likely to describe the immediate result that the recommended action was intended to provide (34/55), while two recommendations from Queensland detailed the anticipated long-term outcome that was expected. Table 6 summarises the components that were included in each recommendation

Table 6: Identified components of coroners' recommendations

	Responsible individual or organisation	Recommended action	Expected result	Desired outcome
Queensland	15	15	3	2
New South Wales	45	45	4	0
Victoria	55	52	34	0

Actions described in the published responses were categorised as being:

- **Already completed:** Including recommendations which were addressed by measures which were in place at the time of the incident, or implemented prior to the coroner's recommendation (including recommendations or actions by others which the coroner adopted or endorsed);
- **Accepted:** Measures which were accepted and implemented;
- **Alternatives:** Measures which were implemented as a preferable means to achieving the desired outcome, or recommendations which were adopted 'in part';
- **Rejected:** Recommendations that were not supported or were rejected with no alternative implemented;
- **Missing:** Recommendations for which there was either: no response; a response was not published; a response was published, but not identified by the search; or for which the identified organisation decided not to respond, or responded, but did not act.

The nature of responses to coroners' recommendations was variable between states. Responses in Victoria were more likely to report that the therapeutic action had already been undertaken, while published responses were more likely to be absent in New South Wales. Table 7 summarises the nature of the responses provided in each state.

Table 7: Reported actions in response to coroners' recommendations

	Already undertaken	Accepted	Accepted in part, or alternative action	Rejected	No response identified
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Queensland	0	12	3	0	0
New South Wales	5	22	3	4	14
Victoria	16	21	12	3	3

It should be noted that some published responses were found to include multiple categories (for example, part of a recommendation already in place, and another part rejected as being impractical). As a result, the **totals in the table above** may exceed the number of recommendations made.

4.3.3 Recommendations by Tasmanian coroners

There is no convenient way to review responses to recommendations made by Tasmanian coroners, comparable to the published material made available in Queensland, New South Wales and Victoria. However, it was possible to analyse all coroners' recommendations made in the findings of investigations into workplace deaths.

Coroners' recommendations in Tasmania

Level 2 data was extracted from the NCIS to provide a list of all Tasmanian coroners' cases, from 2002 to the September 2016 which were flagged as work related. These records were cross-referenced with data from WorkSafe Tasmania about notifications of workplace fatalities which had been reported by a 'person conducting a business or undertaking' (PCBU).

Not all recommendations made by Tasmanian coroners are available publicly. As a matter of routine, coronial findings are distributed to interested parties, including those organisations to which recommendations have been made. However, if the coroner decides that the findings of the investigation are to remain confidential, they are not published on the coroners office website.

For each record, the PDF of findings was downloaded from the NCIS, and reviewed to identify those which included recommendations.

Recommendations were made to a wide range of organisations and groups.

These are shown in Table 8 for the period between 2007 and 2016.

Table 8: Intended recipients for recommendations by Tasmanian coroners regarding workplace deaths

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	Total
Government entities											
Worksafe/Work Standards Tasmania:			1					4			5
State Government:			1								1
Rail Safety Regulator				1							1
Secretary Human Services					1						1
TFITB						1					1
Minister for Workplace Safety, Director of Industrial Safety				1							1
Police				1					1		2
"Relevant Authorities"											
Non-government											
Specific employers and associations				1	1			4			6

Employer groups	1		1	1	1	1	1		1		7
Employers and PCBUs in general	1		3					1			5
Workers and worker groups					1			1	1		3
Communities	1		1				1				3
Total	3	0	8	5	4	2	2	10	3	0	36

The number of recommendations per case was tabulated; recommendations were grouped into three time periods – 2002 to 2006, 2007 to 2011, and 2012 to 2016.

Table 9 shows the number of recommendations made per case.

Table 9: Number of recommendations per case by Tasmanian coroners

	Number of cases	Number of recommendations	Recommendations per case									
			1	2	3	4	5	6	7	8	9	10
2002-2006	16	45	9		1	1	2	2	1			
2007-2011	17	45	7	4	3	1		1				1
2012-2016	9	23	6		1			1		1		

Recommendations were transcribed and categorised using the same method applied for those from Queensland, New South Wales, and Victoria. Table 10 shows the categorisation of those recommendations.

Table 10: Identified components of recommendations by Tasmanian coroners

	Number of recommendations	Responsible individual or organisation	Recommended action	Expected result	Desired outcome
2002-2006	45	43	44	14	0
2007-2011	45	41	45	13	2
2012-2016	23	20	21	5	0

Because all recommendations were analysed, rather than just those with published responses, there were several which were less clear-cut than those from mainland states. A number of recommendations were made which did not clearly identify any specific organisation that was expected to respond, and/or did not provide anything other than a very general indication of the intended respondent (for example, such as 'the relevant public authorities').

On rare occasions findings are finalised without recommendations being made when the circumstances of the case might suggest that recommendations might be warranted. One example is provided by the findings of an investigation without inquest finalised in 2010. The deceased was working at height from an unsafe platform; this dislodged, and the worker fell around 3.8 m to his death. No recommendations were made. The coroner found that the deceased was a "...supervisor who was capable of managing the daily workshop planning and tasking. Regrettably on this occasion, his decision to perform an unsafe work tasks resulted in his tragic death."

There may have been particular circumstances in this incident or in this investigation that led the coroner to a person-centred rather than a system-centred view of the accident, and/or that led the coroner to avoid making recommendations. However, the circumstances of the

incident do suggest that unsafe work systems were likely to have contributed to this accident to a significant extent.

Response example - Quad bikes/ATVs

The Tasmanian coroner is currently conducting an inquest into seven quad bike deaths. A submission to the inquest by the Royal Australasian College of Surgeons (RACS) on 7 April 2016 provided a summary of five key recommendations.

"SUMMARY OF KEY RECOMMENDATIONS

"The Royal Australasian College of Surgeons requests that the Tasmanian Coroner consider the following recommendations.

- "1. **Helmets:** compulsory helmet wearing all quad bike riders (whether an operator or passenger) at all times, on all roads, together with adoption/development of a suitable standard for quad bike helmets designed for the requirements for off-road riding.
- "2. **Children:** all available strategies to prevent children under 16 years from riding quad bikes, including prohibiting use of adult- and child-sized quad bikes alike, restricting sale of child- sized quad bikes, and mandating child-resistant starting mechanisms.
- "3. **Training and licencing:** compulsory quad bike handling training mandatory for all new owners, and all employees whose work involves quad bikes.
- "4. **Safety rating system:** there is a need for improved stability, dynamic handling and rollover crashworthiness safety for both workplace and recreational quad bikes. The College recommends implementing an Australasian New Quad Bike Assessment Program, along similar lines to the ANCAP safety rating system, noting the differences in proposed rating methodologies.
- "5. **Standards and design:** industry-partnered development and implementation of an Australian standard for quad bikes, which incorporates the design advances and safety features identified in the TARS report and allied engineering and road safety research. Separate and more demanding safety requirements may be appropriate for quad bikes intended for use in the workplace, or for which conditional registration may be sought for limited on-road use."

("Submission to Inquest into the Death of 7 Riders of Quad Bikes in Tasmania," 2016, p. 3)

These recommendations are not new. The findings of an inquest in Tasmania in 2004 included a similar recommendation about the wearing of helmets by quad bike riders. This recommendation has subsequently been repeated and the findings of an inquest in Tasmania in 2009 made recommendations similar to those of the RACS regarding training for quad bike riders.

The findings of subsequent inquests in Queensland and New South Wales in 2015 into multiple quad bike fatalities have resulted in recommendations which replicate the entire list provided by the RACS. It appears that repeated recommendations dating back as far as 2004 (and possibly even earlier) have as yet had no appreciable impact on quad bike safety.

This highlights the issue that industry intransigence may derail attempts by coroners and safety practitioners to implement sensible precautions against fatal accidents.

In an editorial in the *Australian and New Zealand Journal of Public Health*, Tony Lower (2013) raises concerns about attempts to prevent or delay safety improvements for 'quad bikes' (sometimes inappropriately referred to as 'all terrain vehicles' – ATVs), which are

classified as 'plant' when used on a farm. He describes the attitudes to safety concerns which are displayed by relevant industry lobby groups – the Speciality Vehicle Institute of America in the US, and the Federal Chamber of Automotive Industries (FCAI) in Australia. These organisations claim that research which they fund into quad bike safety issues is “ongoing”, that they are committed to the safety of the product that they represent, that the evidence so far is not clear, and that the product is inherently safe in the hands of careful users. Lower draws parallels between this stance and that of the US Tobacco Institute in delaying action to address the health risks associated with smoking.

4.4 Interviews

4.4.1 Tasmanian coroners

Interviews with the manager of the Coroners Office focused on the processes which are involved in the investigation of a workplace death, and the potential for enhancing the beneficial outcomes of those processes. Interviews with coroners focused on the issues which are considered when making findings and recommendations.

As noted in Section 4.2, the Tasmanian *Coroners Act* mandates that a coroner *must* conduct an inquest when investigating the work-related death of a worker (but not a bystander) unless the senior next of kin requests that an inquest not be held.

Coronial investigations take place either with or without an inquest. Investigations without inquest are effectively an office-based evaluation of evidence provided to the coroner following investigations by police and by a WorkSafe inspector. In some cases the coroner may request further investigations if it appears that some aspects of the incident remain unclear. In some cases the brief of evidence provided to the coroner by the police investigator will include suggestions regarding recommendations which the coroner might consider making. Reports from WorkSafe inspectors tend to be focused more on whether a breach of the Work Safety Act may have occurred, providing grounds for a prosecution.

If the investigation involves an inquest, the coroner will hear evidence from individuals who are familiar with the circumstances of the death. During the course of an inquest, a coroner may describe recommendations that might be made, and invite comments from the employer, although that opportunity is not available during investigations without inquest.

A recent development in coronial practice in Tasmania has resulted in coroners accepting written statements of evidence from witnesses who are unable to attend the inquest in person.

In terms of the different models of accident causation, coroners tend towards a system-centred rather than a person-centred view, although legal constraints may lead to the system-centred view involving a focus on the role of individuals within the system.

When finalising investigations and inquests, the coroner will complete a checklist which identifies those individuals and organisations who should be provided with a copy. These may include employers, Marine and Safety Tasmania, the Minister for Workplace Relations, the Director of Industry Safety, Tasmania Police, the Rail Safety Regulator, and Worksafe Tasmania. Once the coroner's findings (including any recommendation) are complete they are sent to the individuals and organisations identified by the coroner, and any individual or organisation to whom a recommendation has been directed will receive a copy. However there does not appear to be a collated list of all recommendations made, or of the relevant

responses. Even though there is no established procedure to ensure that coroners' findings are received by those to whom recommendations are made, the Coroners Office believes that it is highly unlikely that recommendations would not be transmitted promptly and reliably.

Unlike Victoria, Tasmania's Coroner's Act **does not** have a requirement for organisations to respond to these recommendations, and coroners almost never receive feedback regarding recommendations which they have made, or information about responses. This is seen to be a shortcoming of the current process, and coroners would welcome details of responses if those were provided. There is a view from the Coroners Office that an amendment to Tasmanian *Coroners Act* requiring government entities to provide a response to the coroner, similar to Section 72 of the Victorian *Coroners Act*, would be a welcome enhancement to the overall process.

Coroners appear also supportive of an increased level of collaboration between WorkSafe and their office, and mentioned an arrangement being established with the Tasmanian Health Service (THS) involving regular meetings as a model for what might be introduced. This arrangement is intended to improve bi-directional communication - provision of information to the Coroners Office by THS, and transmission of reports to THS by the coroner.

Findings published on the website may be removed after a time, but copies are still held (electronically as far back as 2005). These could be provided for review subject to appropriate approval being obtained. Findings are also submitted to the National Coronial Information System (NCIS).

Identification of recommendations relevant to WorkSafe Tasmania may not always be straightforward. A number of types of investigation such as marine incidents, motor vehicle accidents and self-inflicted harm may or may not be industry related, and worksite incidents may involve people other than employees.

Coroners operate with a significant degree of independence, making it inappropriate to consider any formal guidelines or structural advice regarding the conduct of an inquest or office-based investigation. The need to be seen by the community to be independent and impartial also inculcates an understandable degree of caution about coroners engaging directly in any formal discussions with organisations such as WorkSafe Tasmania or the Tasmanian Health Service. Liaison with the manager rather than coroners themselves is seen as an acceptable alternative.

4.4.2 The coronial process in other states

This section summarises information about coronial processes in other states obtained from telephone discussions and a brief review of relevant information sources (journal articles, websites, legislation and publications by organisations).

Victoria

In Victoria, the legislative reforms which resulted in the 2008 *Coroners Act* were seen as a significant milestone in shaping the coronial function, and have generally been viewed as a positive development.

Section 72 of the *Coroners Act* 2008 provides for a coroner to make recommendations about any matter connected to a fire or death, including recommendations about public health and safety, to any Minister, public statutory authority or entity. The *Act* also includes a

requirement for public statutory authorities and entities are required to respond in writing to the coroner within three months, with responses published alongside coroners' findings.

When a death occurs, it is common for most larger employers, particularly government departments, to conduct their own investigations. The results of these investigations then provide a basis for the response to coroners' recommendations.

The Coroners Prevention Unit (CPU) within the Victorian Coroners Court that carries out independent research involving both specific case analysis and patterns of workplace deaths. The Unit, which is highly regarded locally, was established as a way of enhancing the preventative role played by coroners. According to a brochure provided by the Unit:

"The Coroners Prevention Unit (CPU) is a specialist service for coroners created to strengthen their prevention role and provide them with expert assistance by:

- reviewing a range of reportable and reviewable deaths
- collecting and analyzing data relating to reportable and reviewable deaths
- assisting coroners in the development of prevention-focussed coronial recommendations
- receiving and publishing coronial recommendations.

"The central goals of the CPU are to:

- improve the quality and applicability of coronial recommendations
- increase the uptake and implementation of coronial recommendations
- contribute to the reduction of preventable deaths in Victoria."

(Coroners Court of Victoria, 2013)

The unique role of the unit was recognised. Although roles providing support for the coronial function are in place in other jurisdictions, Victoria's CPU represents a valuable and highly evolved model resource which is probably not matched elsewhere in Australia. It was also not clear from the discussions whether independent research units into occupational safety issues would carry out complementary functions in Victoria and/or other jurisdictions.

Queensland

In Queensland, responses to coroners' recommendations were published in an annual report between 2008 and 2013, but are now provided within six months, and published alongside the findings on the Coroners Court website. Most government responses to coroners' recommendations are provided by the relevant minister, rather than by individual departments.

There is a wide degree of variation in the extent to which an investigation or inquest will examine the causative details of a fatality. One commentator observed that coronial processes have improved significantly since earlier days when "Coroners' investigations were largely just calling in the police to investigate, and the police doing their job by looking for someone to blame." Coroners in the Greater Brisbane region now have a reputation for including well organised research activities in their investigations.

Employers and government organisations in particular, pay close attention to coroners' recommendations when they address patterns of fatality, or where the coroner sees a need to repeat an earlier recommendation.

However, problems can arise for employers when an isolated death gives rise to a series of recommendations for system change which are specific to the originating incident, and appear out of proportion in a broader context.

New South Wales

In New South Wales, there is a trend for coroners' findings to acknowledge the limitations of their expertise, and to avoid making detailed recommendations about technical and work-related process changes designed to reduce risk and prevent fatalities. In high profile cases in particular, coroners give much attention to the adequacy of systems to ensure competency, and the actions of individuals. It is common for coroners' findings to offer compassionate acknowledgement of the impact of the loss of the individual on the family, the workplace, and the community.

South Australia

In South Australia, coroners' findings are published on the internet, in MS Word and PDF format, but as files are not indexed, there is no convenient way to retrieve findings which include recommendations, or findings about deaths in the workplace.

A recent high profile coronial case involving multiple deaths in a bushfire incident gave rise to widespread concerns about the coroner's findings and recommendations. In particular, the findings were criticised as being ill-informed and impractical. Criticisms included that the coroner failed to recognise the uniqueness of the situation, and made inappropriate generalisations; that many of the causative factors went unrecognized; that the training which the coroner recommended may not have contributed to survival; and that the findings represented an implied criticism of the role of volunteers.

The controversy resulted in a more general public discussion about the role of the coroner. Questions arose about the extent of the coroner's technical expertise and credibility, the balance between risk prevention and case-by-case risk assessment, and the ability of a coroner to understand a broader context, beyond the scope of the incident being investigated.

Western Australia

The Western Australian Coroners Act was reprinted with minor amendments in 2005, but the extensive changes which were discussed in the review of the Act by the Law Reform Commission (Hands, 2012) have so far not been enacted.

There have been a number of collaborative investigations involving Western Australia, South Australia, New South Wales and Queensland, using data linkage to combine coroners' findings with occupational health and safety databases, trauma registries, and ambulance records, and to enhance the use of ICD codes.

Key themes

A number of key themes emerged from these interviews.

It is evident that there is wide variation both between jurisdictions and within jurisdictions, in the approaches taken with coronial investigations and inquests. This variability is seen as having both strengths and weaknesses. It allows the coronial process to be adapted to suit the particulars of an individual case, but makes it difficult to identify common features patterns of similar incidents, where systemic solutions might be appropriate.

Variability is particularly evident with coroners' use of technical expertise in conducting investigations and framing recommendations for systematic changes in work practice. There are also variations in the focus of investigations, with an emphasis variously on identifying and assembling evidence of fault, through the bare establishment of the facts of the case, to taking a therapeutic perspective, exploring with family, co-workers and community what happened to the deceased, and differentiating facts from speculation while acknowledging the impact on those who have experienced loss.

There is some tension evident within coronial practices between a common goal of finding solutions (within a collaborative approach) and identifying possible liability or illegal or negligent practices or actions. These tensions are moderated by differences in the various coroners acts, with coroners in some jurisdictions being prevented from making any finding about culpability.

There appears to be a common interest among all coroners in generating learning from their investigations, and formulating ways to address risks and the causes of fatalities in order to prevent a recurrence. This common interest extends in some cases to identifying and addressing patterns of fatal accident, although there do not appear to be any well-documented systems for identifying trends and common patterns between cases.

There is also a growing awareness of the value of coronial findings in stimulating and supporting regulatory agencies in their role of growing a culture of safe work awareness, competence, behaviours and risk identification reporting and reduction. This is signalled by an increase in the number of systematic publications, and in the increase in the quality of visibility of responses to coronial recommendations, particularly in jurisdictions where responses are published. The developing role of the NCIS and the Victorian Coroners Prevention Unit provide clear examples of this trend.

4.4.3 WorkSafe

Interviews with WorkSafe staff were used to identify the way in which information about workplace fatalities is managed, and to ascertain what options might be available for tracking coronial recommendations following a workplace death.

When there is a serious workplace event (hospitalisation, death, fire or explosion) the Person Conducting a Business or Undertaking (PCBU) must "...ensure that the regulator is notified immediately after becoming aware that a notifiable incident arising out of the conduct of the business or undertaking has occurred." (Work Health and Safety Act, 2012, sec. 38 (1)) Notifiable serious events include those affecting bystanders and contract workers, as well as employees. The notification can be provided either in writing, or by telephoning the WorkSafe Tasmania Helpline. If the notification is by telephone, Helpline staff will record the details provided on an internal form, which is used to generate a TRIM record. The PCBU must then submit a written notification within 48 hours of the initial notification. If the initial notification is in writing, and contains sufficient detail, a follow up notification may not be necessary, even if the WorkSafe form has not been used. This written notification is then attached to the TRIM record.

In the case of a fatality, the WST Helpline usually receives notification from the police as well, and notifications may also be provided by ambulance staff, the fire service, or members of the public. These additional notifications are also attached to the TRIM record, and any duplicates resolved.

The TRIM record is routed to the team leader in the Inspectorate, who will decide whether an investigation is needed. The Director of Industry Safety is advised of high-profile notifications which involve a fatality or hospitalisation, or is likely to generate media interest.

The Helpline form may go to several places within WorkSafe, and then to staff maintaining the Workers Compensation Information Management System (WIMS) for data entry. Some notifications are received which initially appear to be workplace related, but on investigation are not. In such cases, the records are subsequently amended.

WIMS manages all data about fatalities and injuries, and the associated workers' compensation claims. WIMS is also used as a source of statistical information about workplace fatalities and serious injuries. However the definitive record of investigations is maintained within TRIM, not in WIMS

The Inspectorate also add details of the police investigation to the form which is then used for manual entry into WIMS. This could take 1 to 2 months to arrive. The form should also be logged into TRIM. WIMS does not include details of Worksafe investigations. About 50% of deaths involve insurance claims.

WorkSafe also maintains a "Recommendations Register" which records details of all recommendations made to WorkSafe, identifies who is to prepare the response, and tracks the actions taken to respond. It is likely that slight modifications involving the Helpline process, TRIM record keeping, WIMS and the Recommendations Register would have the capacity to strengthen the way in which WorkSafe tracks coroners' recommendations following a fatality, although the necessary modifications have not been mapped.

4.4.4 Other Tasmanian organisations

Interviewing Tasmanian stakeholders about coroners' recommendations proved to be a challenging undertaking. Despite repeated requests and reminders from the project team, industry representatives on the Steering Committee found it difficult to identify suitable individuals to be interviewed within their respective industries. However, after multiple 'cold calls', it was possible to make contact with a small number of government and employer representatives who had direct knowledge of responses which had been made to coroners' recommendations. Again, some degree of reluctance was evident but some useful information was generated.

Coroners' recommendations about two industries – fishing and forestry – were discussed with interviewees in some detail. The forestry case involved the death of 'Mr S' in 2012. The coroner's findings included recommendations for changes to the Forest Safety Code Tasmania 2007, as well as recommendations about the training and accreditation of forest workers. These latter recommendations, directed towards the Tasmanian Forest industry Training Board (TFITB), suggested that all manual tree fellers should be reassessed by a trainer/assessor every 12 months. The recommendation was reviewed by the Tasmanian Forestry Safety Standards Committee, which decided that reassessment every 12 months would place an excessively high burden on fellers, and would test the capacity of trainers and assessors to conduct these assessments. The Board decided that reassessment every three years, at the time of certification renewal, would provide a satisfactory alternative, and that practice was instituted.

The role and function of the TFITB has now been transferred to Forest-Works but the same requirements for recertification are maintained.

These changes had a mixed reception from workers in the industry. Some expressed anger at the changes. They felt that as commercial forest operators undertaking these tasks every day as part of their normal activities, their competence should not be brought into question. However other workers understood the reason for the change, and accepted it.

It does not appear that any advice was provided to the coroner about the changes which were reviewed and implemented by the TFITB.

A second case involving a death in the fishing industry, reported in 2010, led to a number of recommendations from the coroner regarding the certification of dinghies used in fisheries. Marine and Safety Tasmania (MAST) accepted those recommendations, which involved confirming the adequacy of buoyancy fitted to commercial dinghies. New standards for survey were introduced, and MAST progressively went through the entire Tasmanian fishing fleet to make sure that the upgraded requirements were met.

In 2013 the Tasmanian Fisheries Standards were rescinded, and replaced by national requirements managed by AMSA. This effectively meant that MAST's more stringent requirements for effective buoyancy in commercial dinghies could no longer be applied.

Again, the coroner was not advised of the actions which were undertaken or the subsequent change under national management by AMSA.

A second fisheries case resulted in a recommendation from the coroner that MAST should liaise with Tasmania Police to review the processes used for issuing certificates of competency to operate vessels. The actions recommended in this case were beyond the capacity of MAST, as the certificates in question are issued under uniform national legislation.

The overall perspective provided by these telephone interviews was that recommendations generally receive the full attention of the organisations to which they are directed, and the responses are prepared with careful attention.

5. Synthesis of results

This chapter presents a synthesis of the evidence gathered from the literature review, review of legislation, data analysis and interviews which were undertaken as part of this research.

5.1 A preventative focus

The findings from the coroner's investigation, with or without inquest, may include recommendations to one or more individuals or organisations deemed to have a role or capability in the reduction of the likelihood of another death in similar circumstances. Those processes have been viewed as an example of a public health activity (Bugeja et al., 2012; Sleet et al., 2003), and that perspective has been adopted in this report

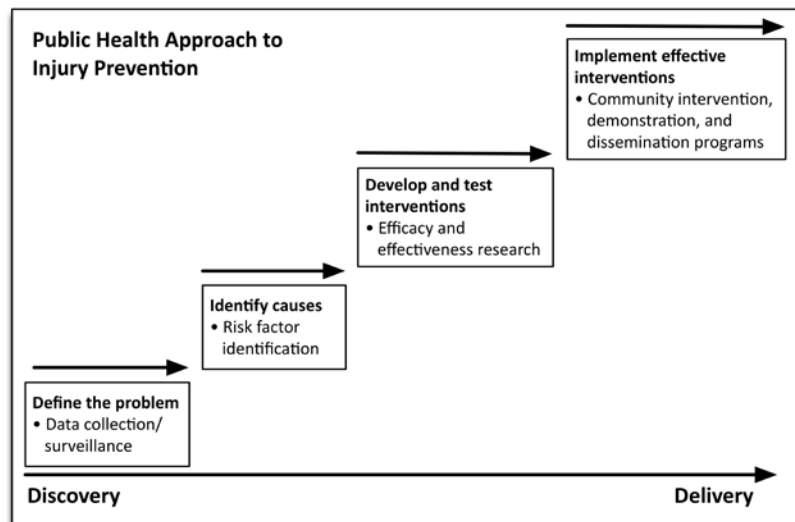


Figure 3: The public health model of injury prevention (after Sleet et al., 2003, p. 99)

A public health process involves a cycle of activity: a fatal incident in the workplace is followed by an investigation by worker safety inspectors and police. The reports of these investigations are given to the coroner, who will then decide whether there are grounds for a full public inquest, or whether an investigation based on the information provided will give sufficient detail to allow the matter to be concluded.

Individuals and organisations are expected to consider the recommendations made by the coroner; if direct recommendations are seen as appropriate and actions will be taken to address those recommendations.

The process of making recommendations and responding to them sits within a cycle which includes the original incident, an investigation, a recommendation by the coroner, and a response; this can be referred to as the Incident-Investigation-Recommendation-Response (IIRR) cycle. The anticipated impact of this cycle of incident, investigation, recommendation and response is to progressively reduce the risk of death in the workplace, by strengthening the barriers between hazards, risks and fatal incidents, while feedback about responses can help to enhance the quality of coroners' recommendations.

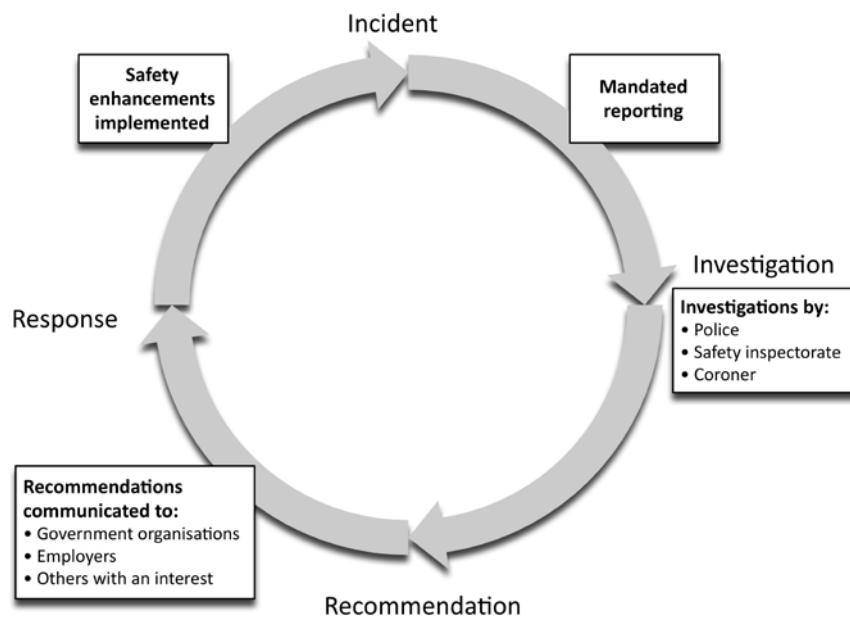


Figure 4: Expanded Incident-Investigation-Recommendation-Response (IIRR) cycle

The IIRR cycle itself, sits within a broader body of activity directed towards the management and improvement of workplace safety, which is intended to reduce the incidence of workplace death, but also the incidence of serious non-fatal injury. These activities include the development of safety standards and regulations, design and implementation of safe working practice, education and training, the investigation of fatal and nonfatal accidents (including patterns of accidents), enforcement of regulations, the imposition of enforceable undertakings, and prosecution.

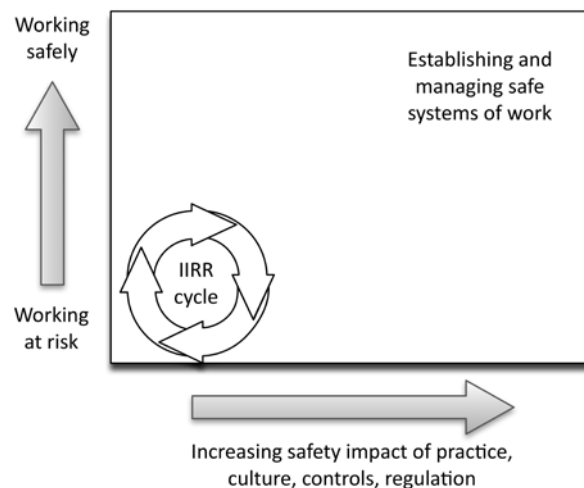


Figure 5: The IIRR cycle within the overall safety landscape

The way in which these actions are managed by the regulator and delivered by employers is variable, and depends on several factors: the industry, nature of the workforce, size of employer, worker skill level. It is an open question as to whether the IIRR cycle is to be viewed as an integral component of that framework, or whether it simply acts as a 'backstop' if all other preventive measures have failed. In either case, its effectiveness

depends on the making of appropriate recommendations, and the delivery of valid responses to those recommendations, preferably within a reasonable timeframe.

5.2 Coroners' recommendations and responses

The research shows that a range of factors can have an adverse effect on the smooth operation of the IIRR cycle, thus limiting its potential beneficial impact. These factors can affect the recommendations which coroners make, and the responses of organisations to those recommendations. Factors which have been shown to reduce the effectiveness of coronial recommendations include:

- a. Recommendations which are inappropriate or unfeasible (either in perception or in reality);
- b. Recommendations which are made when the causative factors for the fatality have already been addressed;
- c. Recommendations made to the wrong person or organisation, or to an organisation which no longer exists;
- d. Recommendations which are made but not communicated effectively to the intended recipient; and
- e. Recommendations which are made some years after the fatality.

There is no clear evidence that any of these factors are present in a Tasmanian context, although they have been noted in other parts of Australia and New Zealand. However if the IIRR cycle is to work effectively then it would be appropriate to ensure that these factors are actively managed, rather than trusting that they have been addressed as a side effect of diligent practice. Approaches which might lessen or avoid the impact of these factors include:

- a. Evaluating the appropriateness and feasibility of each recommendation before it is finalised;
- b. Seeking advice from intended recipients about any corrective actions which may have been completed between the original incident and the finalising of recommendations;
- c. Specifically identifying the individual or organisation to whom each recommendation is directed, and confirming that the actions suggested are within the scope of their authority;
- d. Seeking acknowledgement that the recommendation has reached the recipient; and
- e. Working to ensure that all individuals and organisations involved in the investigation process understand the benefits which flow from a prompt, efficient process.

It must be emphasised that some or all of these suggested management practices may already be in place.

Similarly, there are issues which might impair the effectiveness of responses to coronial recommendations:

- a. The response by the individual or organisation does not include actions which address the causative factors which led to the incident;

- b. The response involves a managerial or bureaucratic approach to dealing with causative factors ('box ticking'), rather than tackling systemic or cultural contributors to the death; or
- c. The individual or organisation receiving the recommendations chooses to take no action, or delays or resists taking appropriate action.

Again, there is no evidence from this research to suggest that any of these factors are in play within Tasmania. Corrective action could be considered, but in the absence of a legislated requirement for organisations to respond to coroners' recommendations, and of a requirement for recommendations and responses to be published, it is difficult to envisage how such action might be taken.

Furthermore, there is evidence that government organisations are more likely to conduct their own internal investigation into a death if they know that any coroner's recommendation will require a response. It is also likely that coroners will give more attention to the way in which recommendations are framed if they know that the recommendations and the resulting responses will be made public.

There is some evidence that the introduction of a feedback loop such as that implemented in the Coroners Act 2008 (Vic), requiring organisations receiving a recommendation from the coroner to provide a response within a specified time, could be effective in increasing the frequency with which responses are made to coroner's recommendations. While the legislative approach has merit, there may be less onerous ways to achieve the same outcome. In New South Wales responses are mandated through the application of a Premier's instruction, and in Queensland responses are provided as a matter of routine practice. One possible shortcoming with these options is that while these obligations are imposed on government organisations, they have no impact on private individuals or firms.

Industry responses

The response by employers can be viewed in two stages - the response to the death itself, and the response to any coroner's recommendation which is made. Sally Haines (Haines, 1995) categorised two types of response to a workplace death:

"Responses by organizations which contributed to the death, fell into two major categories: either "virtuous", where extensive changes were made to prevent repetition of the death; or "blinker" (ie lacking in virtue) organizations which made minimal changes, or whose changes simply involved reducing legal liability, such as changing company name."

(Haines, 1995, p. v)

In one case reported publicly by a Victorian coroner (Kelly 2006), the finding included a comment that recommendations would have been made about both of the companies involved in the fatality, if both had not already been placed into liquidation.

Examples of a "virtuous" response tend to involve prompt, decisive action following a fatality, with remedial measures implemented before the conclusion of the coroner's investigation. In such cases the coroner may simply acknowledge and possibly endorse the changes which have been made.

Large employers typically have comprehensive safety management structures in place at the time of the accident; these are then reviewed, and updated if necessary. However, the literature suggests that this process may be undertaken as a bureaucratic or 'managerial' activity which has little effect on the 'safety culture' of the workplace.

A third category of response – recalcitrance or resistance – has also been noted, in organisations not directly associated with fatal accidents. It has recently been suggested that a major construction company undertaking a high profile development has deliberately under-reported serious incidents, and that it routinely 'hides' safety issues, both internally and from the safety regulator (Joyner, 2016). This was described as being part of a companywide culture;

“...driven from the very top of that project itself all the way down to the guys at the ground level, even to the supervisors.”

(Joyner, 2016)

Small vs Large Firms

From the review of the literature, it is evident that there are substantive differences in the response to a workplace fatality based on the size of the organisation.

Small employers typically have little or no formal safety management practices in place before the event. In response to the death the organisation is likely to implement a comprehensive range of safety management controls, often with the help of an outside safety professional. Whether these newly implemented safety management practices will be maintained and updated in the medium to long term, and continue to be effective in protecting against serious and fatal accidents, remains an open question.

This issue has been highlighted in a recommendation by a Queensland coroner:

“Recommendation 1

“The recommendation made now is for the policy makers and advisors of Workplace Health and Safety Queensland to consider the circumstances of Mr Forster's death to see what else may reasonably be done or done better to educate very small business operators in order to foster a culture of workplace health and safety into their operations.”

(Response: *Inquest into the death of Adam Douglas Forster*, 2015)

Pastoral care

When there is a lengthy period between a workplace death and the conclusion of the coroner's investigation the effectiveness of any recommendations can be reduced, with recommendations more likely to be seen as inappropriate or irrelevant. In Australia, coroners' investigations do not commence until all work safety actions are complete.

The investigation process after a workplace death can have a devastating impact on those affected, particularly on the family of the deceased, and the impact on a bereaved family is likely to be much worse if the investigation process occurs over an extended period. This impact can be more severe if investigators are unable or unwilling to advise the family of any interim findings.

Access to recommendations

There is no convenient mechanism by which recommendations can be retrieved. Access through the NCIS involves a lengthy ethics approval process, and limitations on the subsequent dissemination of parts of the findings. This situation places a significant limitation on the value and usefulness of recommendations and responses as a resource for enhancing workplace safety. The same issue is likely to apply to other types of coronial investigations where recommendations are made.

5.3 Summary

In summary, it is possible to provide answers for the questions which were posed at the end of Chapter 2:

What factors shape a recommendation by a coroner?

When investigating a workplace death, coroners will consider both person-related and system-related causes. Coroners advise that they are more likely to adopt a system-centred view, rather than focusing on proximate and specific causes of the accident. Within that perspective, legal considerations may lead coroners to examine whether the way in which an individual has acted, or failed to act, has contributed to the death, and evidence suggests that coroners' views of causation may be more person-centric than they realise.

When developing an understanding of a case, coroners will rely to some extent on the results of investigations conducted by police and safety inspectors. The investigators' results may colour the coroner's findings and recommendations, particularly when there is no inquest. However coroners operate independently and in the end arrive at their own conclusions.

What is the overall quality of coroners' recommendations, and how appropriate are they?

The analysis of responses to coroners' recommendations in Queensland New South Wales and Victoria suggests that the majority of their recommendations are quite specifically directed to those organisations and executives who are accountable for the area of concern.

The analysis of recommendations made in Tasmania (where responses are not available for review) suggests that recommendations may be more broadly directed, particularly for cases finalised before 2012. A significant number of the recommendations are loosely framed, and advise the broad adoption of a general attitude to safety, rather than a specific implementable action. Again, this problem appears more pronounced with older cases.

These observations suggest that there may be opportunities to enhance the impact of recommendations, and that publication of both recommendations and responses may help. The use of a formal structured document for managing responses (such as that used in Queensland) allows recommendations and responses to be considered in context, as a single document. That context is likely to provide stronger feedback, both to the coroner and to the respondent, than the mechanisms used in Victoria or New South Wales.

How do employers and government organisations respond to recommendations?

In Queensland, New South Wales and Victoria, most recommendations to government organisations are accepted and adopted, either as framed by the coroner or in a modified form. The processes used in Queensland and New South Wales allow for the publication of successive updates about an organisation's responses as progress is made.

Recommendations to private organisations are more variable. Examples from Victoria include both comprehensive descriptions of remedial actions which have been undertaken through to a simple acknowledgement that a recommendation has been received and noted, with no mention of any particular action in response.

Responses in Tasmania are harder to evaluate overall, but the evidence suggests that for the small number of recommendations for which follow-up was undertaken, well framed recommendations were given formal consideration, and adopted in either the original or a modified form.

How effective are the individual responses?

There is limited evidence about the extent to which actions taken in response to a coroner's recommendation will reduce the risk of a subsequent workplace death. Taken at face value, many of the responses published in Queensland, New South Wales and Victoria appear to offer effective approaches to reducing repeat deaths, but there is no objective evidence of their impact. The numbers of workplace deaths are relatively small, and coroners in mainland jurisdictions are less likely to make recommendations than those in Tasmania. As noted above, there is no convenient way of evaluating all responses to recommendations by Tasmanian coroners.

How effective is the overall process?

There is little objective evidence, from the literature review, data analysis or from interviews, about any overall benefit derived from the operation of the IIRR cycle. It is likely that a beneficial outcome results from the long-term effect of police and work safety investigations, followed by the coroner's findings, with recommendations focusing attention on particular risks. It will be a challenging task to identify any positive impact from this overall process. The number of workplace fatalities is relatively small, and any improvements generated will be embedded within longer term trends towards increased workplace safety in developed countries.

What other issues affect the relevance and effectiveness of the process?

In addition to the issues canvassed above, there are a number of factors which could erode the effectiveness of the IIRR cycle. These include:

- Delays in any part of the process;
- 'Blinkered' employer responses, to both the death and any recommendations;
- Companies adopting 'managerialism' in their safety response to an incident;
- Particular issues for small firms; and
- Commercial pressures forcing a careless attitude to safety.

What are the mechanisms by which coroners' recommendations could have an enhanced impact on workplace safety?

An ideal coroner's investigation into a workplace death will identify one or more causative factors which have not previously been well understood. Recommendations by the coroner will then focus attention on those causes, and lead to remedial action. If this process is to be successful, it will require effective investigations, by (at least) the police, the work safety inspector and the coroner, as well as carefully framed recommendations which address the principal causative factors, followed by an effective response. In most cases it will be preferable for the response to involve generalised actions to address identified causes across a range of settings, rather than a narrow response limited to one employer or to a localised region.

There is an open question as to whether recommendations made by a coroner provide unique insights, or whether the causes which the coroner addresses have become generally self-evident following the death. Taken as a whole, it is likely that coroners' recommendations will include a mix of both the self-evident and the insightful, with the weight of the coroner's findings providing an impetus for a considered response.

6. Recommended actions

This chapter presents evidence based recommendations to Worksafe Tasmania regarding changes to legislation, administrative instructions or practice which could enhance the effectiveness with which Worksafe Tasmania or industry more broadly responds to coroners' recommendations in the future.

6.1 WorkSafe and the Coroners Office

Develop a Memorandum of Understanding with the Coroners Office in order to enhance interactions between the two organisations.

There is evidence that the beneficial impact of responses to coroners' recommendations can be improved by ensuring that an effective framework for collaboration is in place to support interactions between coroners and work safety regulators. A number of options might be considered for this framework, including periodic meetings, or a memorandum of understanding between the Coroner's Office and WorkSafe Tasmania.

The Coroners Office meets periodically with the Tasmanian Health Service, but given the relative scarcity of coroners' cases in which WorkSafe Tasmania might have an interest, a negotiated Memorandum of Understanding (MoU) between WorkSafe Tasmania and the Coroners Office may provide a more effective approach. This MoU should be supported by an identified primary contact within each organisation to ensure that any issues which might arise can be addressed in a prompt and seamless manner.

Matters which to be considered for inclusion in the MoU might include:

- The way in which WorkSafe Tasmania's inspectors provide advice to police investigators and the coroner;
- Arrangements for WorkSafe Tasmania to access interim and final results of police investigations;
- Maintaining an accessible deidentified collection of all recommendations, separate from findings; and
- Advice from WorkSafe Tasmania to the Coroner's Office about the appropriateness and practicability of recommendations which are being considered in work-related cases, noting that such interaction should avoid any perception that the independence of coroners is being compromised.

The MoU may also make reference to WorkSafe Tasmania's involvement in industry responses to coroners' recommendations resulting from workplace deaths, as discussed in Section 6.4, if Recommendation 4 is adopted.

Recommendation 1:

It is recommended that WorkSafe Tasmania develop a Memorandum of understanding with the Coroners Office, to ensure effective and timely communication between the two organisations.

6.2 Structured responses

Commit to a structured process for responding to coroners' recommendations.

The evidence suggests that the therapeutic effect of responses to coroners' recommendations is enhanced when those responses are formulated without undue delay, and reported to the coroner. The impact of this feedback is further enhanced when responses, along with recommendations, are made publicly available, and particularly so when recommendations are responded to, and responses are provided in a format which is clear and easily understood (as is the case in Queensland – please see the example in Appendix 5).

In the absence of a legislated or mandated requirement for a response to the coroner (such as those which apply in Victoria and New South Wales) WorkSafe Tasmania should set internal benchmark times for these processes. As an example, WorkSafe Tasmania might within 21 days provide written acknowledgement to the coroner that the recommendation had been received, and commit to completing its response within three months. Advising the Coroner's Office of the response is not currently mandated in Tasmania, but this feedback is likely to be welcomed by coroners.

Recommendation 2:

It is recommended that WorkSafe Tasmania consider establishing a disciplined internal process, as if Section 72 of the Victorian Act applied in Tasmania. This process will ensure that:

- Receipt of a recommendation is acknowledged in writing;
- A response is provided to the coroner within a defined period (for example three or six months);
- The format used for the response includes a brief de-identified summary of the case acceptable to the coroner's office, the recommendation, and response.

These suggested steps are in anticipation of a likely amendment to the Tasmanian *Coroners Act* along the lines of the provisions in the Victorian legislation.

If successful this approach could be promoted within government as a best practice model to be followed in other departments.

6.3 Access to recommendations and responses

Evaluate options for improving access to coroners' recommendations and responses

When a Tasmanian coroner makes a recommendation following a workplace death, that recommendation is only recorded within the findings of the coroner's investigation. The findings will be distributed to 'interested parties' identified by the coroner, including those organisations to which recommendations have been made. The findings will be published on the Coroners Court website as a PDF document, but not if the coroner has chosen to mark those findings as confidential. There are currently no circumstances in which responses to those recommendations will be published. (The current practice in Victoria is for confidential findings to be published, but with identifying information redacted).

Publication of coroners recommendations could provide a valuable workplace safety resource, particularly if they were made available in an accessible format, and indexed by industry type and hazard category. If an appropriate format was used for publication, any responses which the Crooners Office received could be included within the document.

Recommendation 3:

It is recommended that WorkSafe Tasmania approach the Coroners Office to request that recommendations made within the findings of investigations into work-related deaths be published, as standalone documents, in an accessible format, with identifying details redacted if necessary.

The published documents could include responses to those recommendations if and when they are received.

In some cases, coroners give their endorsement to recommendations of actions by others, rather than making separate recommendations of their own. These endorsements should be treated as recommendations for the purposes of publication.

6.4 Industry responses

Support and monitor industry responses to coroners' recommendations

When a coroner makes a recommendation following a workplace death, it is anticipated that the response to the recommendation will contribute to improvements in workplace safety, and in the best case prevention of another fatality in similar circumstances.

In order for this beneficial outcome to occur it will be necessary for the recommendation to be framed appropriately, and for the response to also appropriately address the risks and hazards which have contributed to the death.

The collective expertise which WorkSafe has at its disposal could make a valuable contribution to ensuring that both the recommendation and the response have an effective impact on workplace safety, not just in the organisation to which the recommendation has been made, but for industry more generally.

In order for this to occur it will be necessary for WorkSafe to be aware of recommendations which have been made to other organisations, and to communicate with recipient organisations about the coroner's recommendations and the response that will be made. This process will also ensure that organisations which receive coroners' recommendations appreciate the importance of providing an appropriate response.

Recommendation 4:

It is recommended that WorkSafe Tasmania discuss with the Coroner's Office possibility of ensuring that WorkSafe receives a copy of all coronial findings about workplace deaths which include a recommendation, and also contact recipient organisations about the recommendations to which they have been asked to respond.

6.5 Small business

Review support which WorkSafe is able to provide for small business in managing safety and responding to a fatality

In the context of workplace fatalities and the ensuing coroner's investigation there is evidence that small firms face particular problems which are not experienced by larger companies. The pattern of activity which is likely to occur in a small firm following a workplace death commonly follows one of two paths. The organisation may adopt a "blinkered" response, where there is no acknowledgement of responsibility for the death that has occurred, and a minimal response. In extreme cases, this may involve placing the company into liquidation, and resuming business within a different company structure.

The second 'virtuous' response involves the managers and owners of the company accepting a significant degree of responsibility for what has occurred, and attempting to rectify any safety deficiencies which have been exposed by the incident. This often involves engaging an external consultant to implement a full suite of safety policies, procedures and documentation, as a way of demonstrating that the organisation now has mechanisms in place which would be likely to prevent a recurrence. However, much of the time and effort required for this response is likely to be wasted. Because this safety initiative has been delivered from an outside source, rather than generated from within the organisation, it is less likely to promote a safety culture, or for the documentation and procedures being used in practice. After a period of years it is likely that this intensive safety effort will have left no trace on working practice, with the causative factors which led to the original incident still evident.

There is an opportunity for WorkSafe Tasmania to provide support for small organisations to assist them in the development of internal policies and procedures, at a scale appropriate for the organisation, as a way of avoiding the likely "overkill" that could result from the use of external consultants. This approach is also more likely to encourage a safety culture within the organisation.

Recommendation 5:

It is recommended that WorkSafe Tasmania review its capacity to support small businesses following a fatality, and consider whether a support and advisory role might promote the development of a safety culture in such organisations.

6.6 Safety culture

Ensure that employers foster a safety culture within their workplaces, in addition to documenting appropriate safety policies and procedures.

The evidence suggests that there can be a risk of safety management being addressed through "managerialism", particularly in large organisations. When this occurs safety matters are dealt with through formal bureaucratic processes, providing the external

appearance of a well-managed, well documented safety framework. However, this activity does not necessarily extend to the development and maintenance of a healthy 'safety culture'. Risks are taken as a matter of routine, and any accident which occurs will be a clear breach of safety policy, and seen as a consequence of the worker not following the procedures which are in place.

An opportunity exists for WorkSafe to ensure that the importance of its efforts to introduce and support a 'safety culture' in organisations, particularly in high risk industries, is not underestimated or undervalued.

Recommendation 6:

It is recommended that WorkSafe Tasmania consider whether additional opportunities exist for it to foster and support a safety culture in workplaces (particularly in large organisations) over and above the maintenance and application of documented safety management systems.

6.7 Pastoral care

Ensure that effective measures are in place to provide families and co-workers with appropriately supportive pastoral care following a death in the workplace.

Ensuring that appropriate pastoral care is provided for families and colleagues of deceased workers emerged as an important issue in the literature. The evidence shows that the consequences of a death at work can include a devastating impact on families and workers. This impact can be reinforced by the ensuing investigations, (by police, work safety inspectors and others), by limited access to information about the incident, and by the protracted nature of work safety and coronial processes.

It may be that suitable arrangements are already in place – there are a number of sources of support to families and workmates, including unions, religious organisations, professional counsellors and Lifeline, although there may be particular issues in work-related deaths which some of these services do not address effectively. Furthermore, it was not clear whether any of these services were immediately and reliably made available following a fatality.

Unless WorkSafe Tasmania has a clear understanding of the process of making pastoral care available, it will be worthwhile investigating the provision of pastoral care in more detail. It would be beneficial for WorkSafe Tasmania, police, and the Coroner's Office to have an agreed roster of sources of pastoral care to be referred to in the event of a fatality.

Recommendation 7:

It is recommended that WorkSafe Tasmania undertake a review of the pastoral support that is made available, by WorkSafe and others, for the families and work colleagues of deceased employees following a fatality.

6.8 Responses to the Coroners Office

Recommend to the Coroners Office that the relevant legislation be amended to require responses from government organisations, with publication of responses (similar to Clause 72 of the Victorian Coroners Act)

As noted in Section 6.2 above, there is evidence to suggest that the therapeutic effect of responses to coroners' recommendations is enhanced when those responses are formulated without undue delay, and reported to the coroner, and both recommendations and responses are published.

There is a possibility that to the Tasmanian *Coroners Act* could be amended to require responses from government organisations to recommendations made from the coroner. The most appropriate format for these changes is likely to be modelled on the provision included in the current Victorian legislation (*Coroners Act (Vic)*, 2008, sec. 72).

This legislated change would result in Tasmanian coroners receiving feedback about how recommendations have been received, and responded to. There would also be a public record of responses that had been made to coroners recommendations.

These changes would provide an added impetus for government organisations to respond promptly, and in a way that the community finds acceptable.

When appropriately implemented, suitably implemented, this change is likely to have a number of beneficial effects:

1. Recommendations and responses will be publicly available and become a resource for enhancing safety. This publication will also serve to increase community confidence in the coronal process
2. Organisations will be encouraged to develop a formal response in a reasonable time; the responses provided must be able to withstand public scrutiny
3. Coroners will now be aware of how their recommendations have been received, and responded to. They may also be more likely to choose to frame recommendations in a way that invites a substantive response

These outcomes are likely to be enhanced if the recommendations and responses are published in an integrated, accessible format, such as that in use in Queensland, rather than in a way which involves multiple formats (such as Victoria) or formats which are less user-friendly (such as New South Wales).

Recommendation 8:

It is recommended that WorkSafe Tasmania discuss with the Coroners Office the possibility of the *Coroners Act* (1995) being amended to require responses from government organisations, with publication of those responses.

A model for these changes is provided by Clause 72 of the Victorian *Coroners Act* (2008).

An additional change – one that is not currently included in any *Coroners Act* in Australia - would give Tasmanian coroners the power to invite (not mandate) a response from non-government organisations to whom recommendations have been made.

This change may be more contentious.

7. Topics for further research

During the course of this project, the eHSRG have identified a number of opportunities for additional research which could be undertaken or commissioned by WorkSafe or other organisations. It is accepted that these suggestions may include activities that prove to be inappropriate or impractical, or which are already under way. The suggested areas for further research are:

- Enhancing the usability of recommendations made by coroners.
- Enhance the quality and impact of coroners' recommendations.
- Enhance the capacity of WorkSafe Tasmania to promptly distribute safety advice.
- Safety in small firms
- Information management
- Validation of the impact of coroners' recommendations and responses on workplace safety and on fatality rates
- Exploring the balance between prosecution and collaboration in regulating work safety
- Professional development to support and enhance existing investigation skills
- Review quality assurance for NCIS data, and explore options for enhancement

For WorkSafe

7.1 Evaluate options for professional development to support and enhance existing investigation skills

The beneficial impact on work safety which can be derived from the cycle of incident, investigation, recommendation, and response depends to a significant degree on the quality of the recommended recommendations which are made. Coroners' findings and recommendations are likely to be influenced to some extent by the investigation reports provided to them by police and work safety inspectors, and these reports are in turn influenced by the models of causation which those inspectors apply.

In order to maximise the preventative impact of the overall process it would be worthwhile to ensure that all of those involved in the investigation process have a sound understanding of models of causation, including an appreciation of which models are most appropriate in particular circumstances.

Work safe may wish to consider a project which:

- Evaluates training needs and likely acceptance of training resource;
- Evaluates existing training resources; and
- Develops a tailored instruction toolkit for Tasmania.

7.2 Review mechanisms available for the prompt distribution of safety advice.

It became apparent during the course of the project, particularly during steering committee discussions, that there are a range of communication channels for safety information in Tasmania, but that that these are poorly delineated and not fully understood. There may be some benefit in reviewing the methods of communication which are currently used for distributing safety advice within Tasmania. This review would explore:

- The types of communications which are involved (including guidance material and codes of practice);
- The role of formal and informal industry groups, and their ability to engage small firms;
- The extent of delays in achieving the desired communication outcome;
- The identification of target groups for specific safety communications; and
- The most effective and appropriate communication channels from the perspective of workers, employers, and organisations.

This review could then be complemented by an analysis of the status of communication about workplace safety, and suggested options for enhancements, including new communication channels to address specific identified gaps.

7.3 Explore mechanisms for supporting safety in small firms

Recommendation 5 (Section 6.5) identifies an opportunity for WorkSafe Tasmania to provide support for small organisations to assist them in the development of internal policies and procedures, and proposes that WorkSafe Tasmania review its capacity to support small businesses following a fatality, and consider whether a support and advisory role might promote the development of a safety culture in such organisations.

As a way of implementing this recommendation, this research would:

- Evaluate attitudes to safety and safety policies and practices within small business in a range of industry sectors in Tasmania.
- Review the way in which small business in Tasmania has responded to workplace fatalities; and
- Identify possible mechanisms and benefits of support from WorkSafe Tasmania, having regard to the resources that could be deployed for this activity.

7.4 Evaluate mechanisms for managing safety documentation

Anecdotal comments during the project suggested that some safety systems can generate an onerous clerical overhead for workers.

There is a view in some quarters that safety procedures represent an unreasonable bureaucratic overhead reducing the efficiency of the workplace. This attitude may result in a "managerial" approach, with safety Management coming to be seen as a "box ticking" activity.

Tools such as Safe Work Method Statements (SWMS), are paper-based and therefore office-based. This means that when circumstances change at a worksite there is a need for updated or revised SWMS. However the delay involved in that update process may not be practicable. There may be scope to provide electronic support for SWMS management, especially in the field.

It may be of benefit to conduct an evaluation of the potential for using a technology supported version of safety management documentation (maybe tablet based) as a way of reducing the clerical overhead, and making safety management practice more relevant in the workplace.

For others

7.5 Investigate the feasibility of legislating for mandated responses to coroners' recommendations, with publication.

This research has shown that the visibility of coroners' recommendations and the subsequent responses in Tasmania is limited. Recommendation 8 of this report proposes that WorkSafe Tasmania discuss with the Coroners Office the possibility of *Coroners Act* (1995) being amended to require responses from government organisations, with publication of responses.

This change would result in Tasmanian coroners receiving feedback about how their recommendations have been received, and responded to. There would also be a public record of responses that had been made to coroners' recommendations.

These changes would provide an added impetus for government organisations to respond promptly, and in a way that the community finds acceptable.

An additional change – one that is not currently included in any Coroners Act in Australia – would give Tasmanian coroners the power to invite (not mandate) a response from non-government organisations to whom recommendations have been made.

This change may be more contentious.

For WorkSafe and others

7.6 Enhance the usability of recommendations made by coroners.

Most coroners' recommendations are promulgated only within the state or territory in which they have been made, but are likely to have more general national applicability. This can present problems for small jurisdictions.

Currently coroners' recommendations are stored within an unstructured free text document (pdf), along with identifiable personal information. This means that it can only be retrieved by individuals or organisations with ethics approval from the Victorian Justice Human Research Ethics Committee for Level 1 access. Once that access has been granted there is no simple way to search for recommendations which might be of particular interest.

It is possible to extract recommendations from findings as free text, de-identify those recommendations, and organise them into a searchable format, but this process will require advice from NCIS about the process of the identification and publication.

One option would be to store de-identified recommendations and responses separate from findings, in an accessible format, such as that used in Queensland (and shown in the Appendix). These recommendations could be categorised by industry or industry sector, type of activity, and any plant involved. They would then represent a national resource which could be made available to selected groups and individuals as a resource for enhancing workplace safety.

This may represent a parallel process to activities that are already managed through WorkSafe and Safe Work Australia, but there are questions about the degree of overlap between WorkSafe's advisory notes and coroners' recommendations.

There are a number of questions to be addressed in considering the scope of this work:

- Coroners might prepare a separate file containing de-identified recommendations at the time that findings are prepared; that these could then be loaded into an extension of the NCIS database.
- NCIS could conceivably extract recommendations from coronial findings.
- WorkSafe or Safe Work could undertake this process, given appropriate access to coroners' findings within the NCIS, but this would require some degree of NCIS oversight.

7.7 Validate the impact of coroners' recommendations and responses on workplace safety and on fatality rates

As noted elsewhere in this report, the literature review was unable to identify any clear evidence, either positive or negative, about the impact on workplace safety and on fatality rates of recommendations by coroners, and responses to those recommendations by government organisations, employers or industry more generally.

A number of factors lead to a conclusion that such evidence may be difficult to produce:

- The number of instances in which a worker dies are small, and not every workplace death results in a recommendation;
- Collection of statistically representative data would need to take place over an extended period;
- Several other safety initiatives which are likely to improve workplace safety are likely to be undertaken concurrent with any study

In spite of these challenges, there is scope for a carefully designed long term prospective study to search for the missing evidence. This study would need to include multiple Australian jurisdictions, and would ideally be conducted Australia wide. Support would be needed from WorkSafe and coroners offices in each state and territory included in the study, as well as Safe Work Australia and the NCIS.

7.8 Evaluate available options for providing pastoral care

A death at work can have a devastating impact on families and workers, with the impact made worse by the investigations which follow. Recommendation 7 (Section 6.7) proposes that WorkSafe Tasmania undertake a review of the support that is made available, by WorkSafe and others, for the families and work colleagues of deceased employees following a fatality.

Suitable arrangements may already be in place, but unless there is a clear understanding of the pastoral care that is available, the provision of pastoral care should be investigated in more detail. Research to advance this recommendation would involve:

- Interviewing bereaved families and work colleagues about their experience of the process, to assess what support they had received and what gaps they experienced;
- Identifying support resources which are currently available or potentially available; and
- Identifying what other options exist for support and pastoral care.

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Appendix: Example of a published response (Queensland)

Inquest into the death of [REDACTED]

[REDACTED] died on [REDACTED] 2011 at [REDACTED] in [REDACTED] where he was employed as [REDACTED]. [REDACTED] was sweeping up spillage from the floor of the mill room. He came too close to the rotating ball mill and became ensnared by the protruding bolts and was dragged underneath the ball mill which continued to rotate, causing his fatal injuries.

Coroner Alan Comans delivered his findings of inquest on 4 March 2014.

The Queensland Government responds to recommendations directed to government agencies at inquests by informing the community if a recommendation will be implemented or the reason why a recommendation is not supported. Further information relating the implementation of recommendations can be obtained from the responsible agency named in the response.

Recommendation 1

The recommendation made now is for the policy makers and advisors of Workplace Health and Safety Queensland to consider the circumstances of [REDACTED]'s death to see what else may reasonably be done or done better to educate very small business operators in order to foster a culture of workplace health and safety into their operations.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Treasury.

On 12 September 2015 the Treasurer, Minister for Employment and Industrial Relations and Minister for Aboriginal and Torres Strait Islander Partnerships responded:

The response recognises two challenges in engaging with small business operators. First, there are nearly 150,000 small businesses in Queensland. Second, small businesses have limited resources for understanding and complying with regulations.

The Office of Industrial Relations Queensland (OFSWQ) operates a small business program dedicated to educating and supporting small businesses and assisting them to foster a culture of workplace health and safety in their operations.

The program offers free workshops held in various centres across Queensland, free workshop consultations with a safety advisor on request and coaching sessions for small groups of businesses in similar industries or locations. The program also promotes information in printed and online formats including tools, templates and checklists for safety management systems, workplace hazards, policies and procedures.

As part of a longer term strategy, the program is also partnering with Queensland industry associations to deliver tailored tools, advice and workshops to their small business members on health and safety. The Industry Partnership Program has started to work in the electrical and construction industries with plans to expand into other priority areas during 2015.

In December 2014 OFSWQ and WorkCover Queensland partnered to launch a safety and compensation one-stop shop. This partnership established a single phone number (1300 362 128) and website (www.worksafe.qld.gov.au) for Queenslanders to access the services of WorkCover, Workplace Health and Safety, the Electrical Safety Office, and the Workers' Compensation Regulator.

All Queensland businesses, including small businesses, now have a single point of contact to raise queries with any of these entities, report incidents, and make claims.

This partnership also assists the government to communicate with small business regarding workplace health and safe issues. When businesses contact WorkCover via the Worksafe website they are also presented with safety and injury prevention information, alerts, and events. Opportunities to further capitalise on this new proactive relationship are being expanded throughout 2015. Some of the initiatives in planning include:

- Developing a permanent small business presence on the homepage slider.
- Developing a new [URL](#) that redirects relevant enquiries directly to the small business landing page.

The government's [business and industry portal](#) is specifically aimed at new businesses or those thinking of starting a business. . It contains information on establishing, running and growing a business and also serves as a gateway to the Queensland WorkSafe website for more specialised safety and compensation information and services.