Work health and safety cases about disability service provision

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Introduction

This digest is provided to promote awareness of work health and safety issues in disability service provision. These cases relate to both employees and people supported.

The information provided is taken directly from the regulators' websites[1], without additional comment. The amount of detail provided by each regulator varies greatly. No representation is made as to the accuracy or fairness of the regulators' summaries.

The editor is aware of a case where a disability service provider was prosecuted but the provider was found not to be guilty. The decision recognised the principle of dignity of risk. The regulator does not report its loss in its case reports.

If any reader is aware of other cases, please let me know by emailing me.

Should you require a machine-readable version of this document, again, please email me.

For an analysis of WHS and human rights for people with disabilities in disability service provision, see: Marsh, Dru. (2021). 'Disability versus work health and safety: a safe workplace and the right to an "ordinary life" …' *Research and Practice in Intellectual and Developmental Disabilities*, 8(2), 111-118. https://doi.org/10.1080/23297018.2021.1957706.

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Trigger warning: The cases reported here concern the death or serious harm to people with disabilities or to disability workers.

- [1] ACT: https://www.worksafe.act.gov.au/laws-and-compliance/enforcement-and-prosecutions/prosecutions/list-of-prosecutions
- NSW: https://www.safework.nsw.gov.au/compliance-and-prosecutions/prosecutions
- NT: https://worksafe.nt.gov.au/laws-and-compliance/prosecutions
- Qld: https://www.worksafe.qld.gov.au/laws-and-compliance/compliance-and-enforcement/prosecutions/work-health-and-safety-and-electrical-safety-prosecutions/court-summaries, and https://www.owhsp.qld.gov.au/
- SA: https://www.safework.sa.gov.au/enforcement/prosecutions
- Tas: https://worksafe.tas.gov.au/topics/laws-and-compliance/enforcement-and-prosecutions/prosecutions/court-summaries
- Vic: Source: https://www.worksafe.vic.gov.au/prosecution-result-summaries-enforceable-undertakings
- WA: https://prosecutions.commerce.wa.gov.au.

Australian Capital Territory

Disability Support Worker left client in hot car for an hour

"A carer [disability support worker] [who] left a man with severe disabilities in a hot car for an hour was fined $8000 in the ACT Magistrates court. The defendant plead guilty to failing to comply with a health and safety duty – Section 33 Category 3 offence."

Date of record: 11 February 2021

NSW

Only cases under the current Act are reported.

The client, a child, and worker both killed: Govt dept prosecuted

"On 5 November 2017, a child and his disability support worker were fatally injured when they were struck by a truck on a Motorway near Cameron Park NSW. The worker had followed the child onto the motorway after he exited the vehicle he was being transported in, whilst it was stopped.

"After a SafeWork NSW investigation, the defendant, State of New South Wales … was charged with a breach of section 32/19(2) of the Work Health and Safety Act 2011.

"On 18 June 2021, the defendant was convicted by the District Court and fined $150,000."

Date of record: 18 June 2022. For a better summary of the facts of this case, see: McGregor-Lowndes, Myles & Hannah, Frances (2021) ACPNS Legal Case Notes Series: 2021-64 Safework NSW v Snap Programs Limited and State of NSW [2021]NSWDC 259. [Working Paper] https://eprints.qut.edu.au/212286/

Same case: Not-for-profit provider prosecuted

[The facts are set out in the case above.]

"After a SafeWork NSW investigation, the defendant, [the provider], was charged with breaches of section 32/19(1) and section 32/19(2) of the Work Health and Safety Act 2011.

"On 18 June 2021, the defendant was convicted by the District Court and fined $60,000 under section 32/19(1) and $30,000 under section 32/19(2) of the Act."

Date of record: 18 June 2021

Northern Territory

There appear to be no relevant cases at the time of reporting.

Queensland

Residential care worker fined $15k for incident involving resident's fall from bed

"On 13 September 2021, a residential care worker was sentenced in the Bundaberg Magistrates Court for breaching section 32 of the Work Health and Safety Act 2011 ('the Act'), having failed to comply with his health and safety duty as a worker pursuant to section 28 of the Act.

“The defendant was employed in a high-needs residential care facility in Bundaberg. On 9 October 2018, he was working alone in that facility caring for three high-needs residents, who were each entirely dependent on assistance from their carers at all times. Earlier that afternoon, the defendant performed several care tasks for one resident which required him to lower the siderails on the resident’s bed. The resident was non-verbal and unable to communicate freely, relying instead on hand and arm gestures. Carers were instructed that siderails were to remain in the raised position unless the activities undertaken necessitated the siderails to be lowered. However, upon completing the tasks, the defendant failed to raise the siderails as required.

“At around 9:30pm, the defendant entered the resident’s room and observed him on the floor. The siderails were in the lowered position and the resident had fallen approximately one metre from his bed. The defendant picked up the resident, placed him into his bed and raised the siderails. The defendant finished his shift at 10:00pm and did not advise the oncoming shift worker that the resident had fallen nor did the defendant record the incident in the daily running sheet.

“The following morning the on-coming morning shift worker was concerned for the resident, who appeared to be agitated and in extreme pain, and called an ambulance to transport the resident to hospital for treatment. That worker contacted the defendant to enquire if an incident had occurred during his shift and the defendant revealed the incident of the resident falling the evening before. The resident suffered significant injuries with fractures to both pelvis and further fractures to his leg, for which he received medical treatment.

“In sentencing, …His Honour said that he did not know why the defendant did not seek medical assistance, and after hearing submissions from the defendant’s counsel this was still unexplained. He accepted the prosecution’s submission that the failure to report the incident was an aggravating factor he was required to take into account when determining an appropriate penalty. He accepted the worker was very experienced and would have known of the appropriate action to take upon discovering the resident on the floor of his room…

“His Honour stated that any penalty he imposed was required to take into account general deterrence and denunciation of the defendant’s conduct as well as material before him indicating the defendant’s straitened financial circumstances. He noted that the defendant’s personal circumstances needed to be balanced against this breach which was a very serious example of this offence. His Honour convicted and fined the defendant $15,000.

“His Honour declined to record a conviction, noting the numerous character references provided by the defendant, though observed the decision was finely balanced.”

Date of record: 13 September 2021

South Australia

Integrity Care (SA) Ltd

This case is currently before the courts.

Worker sexually assaulted by client

"[The provider] pleaded guilty to a breach of its health and safety duty under the Work Health and Safety Act 2012 (SA).

"In early 2018, a female employee of [the provider] was sexually assaulted by a client of [the provider] when she was visiting the premises at which that client lived. [The provider] knew of the existence of the risk of sexual assault.

"[The provider] was found to have failed to:

- provide adequate supervision of the client
- provide adequate information about the risk to the employee
- inform the employee of the requirements visitors were to adhere to when attending the premises.

"The South Australian Employment Tribunal (SAET) imposed a conviction, a fine of $42,000 (reduced by 30% from $60,000 for the defendant's early guilty plea) and ordered [the provider] to pay legal costs."

Date of record: 16 December 2020

Tasmania

There appear to be no relevant cases at the time of reporting.

Victoria

Client assault of care workers

"The Crown in Right of the State of Victoria … ('the Department') is the successor of the Disability and Child Protection Services division of the Department of Health and Human Services.

"The provider is a registered charity providing residential support to the elderly, disadvantaged and disabled community, as well as residential care for vulnerable young people who have been removed from their families.

"The Department and [the provider] pleaded guilty in relation to the risk of occupational violence by a young person ('the young person') against residential care workers in a residential care home in [location].

"The young person and his family came to the attention of the Department in approximately 2011. The Department had received reports of concerning behaviours shown by the young person, in particular, threats and the carrying out of violence. In early 2015 the young person became an active case within the Child Protection Services division of the Department, as he was identified as being a risk to the community, himself, and his family due to violent, threatening and aggressive behaviour. Around this time the young person was diagnosed with an intellectual disability, attention deficit hyperactivity disorder, post-traumatic stress disorder, conduct disorder, and pervasive developmental disorder.

"While the young person was at a residence in [location] operated by [the provider], staff were (among other aggressive acts) punched and kicked by the young person over a number of months, including in the staff office where they would sometimes seek refuge. The young person also caused

damage to walls and doors of the residence. The incidents intensified in the later period of his care when new staff began working with him to enable his transition to care at a more permanent home in [another town].

“Various support documents pertaining to the young person recorded a number of his “triggers” including ethnicity and unfamiliarity with the residential care workers. The documents available to staff about how to manage the young person’s behaviour discouraged staff from seeking refuge in the office when he became aggressive.

“The Department pleaded guilty to one charge under section 23(1) of the OHS Act. The charge alleged that it was reasonably practicable for the Department to reduce the risk of injury to residential care workers by ensuring that the behavioural management and support documentation for the child did not discourage workers from taking refuge in the office when the child engaged in threatening behaviours.

“The Department pleaded guilty and was, without conviction, sentenced to pay a fine of $55,000.

“Pursuant to section 6AAA of the Sentencing Act 1991, had it not been for the plea of guilty, the Department would have been sentenced, with conviction, to a fine of $110,000.”

Date of record: 5 August 2022

Same case: Provider prosecuted

[The facts are set out in the case above.]

[The provider] pleaded guilty one charge under section 21(1) and (2) of the OHS Act. This charge alleges two contraventions, charged as a single offence pursuant to section 33 of the OHS Act.

“The charge alleged that it was reasonably practicable to reduce the risk of injury to residential care workers by providing and maintaining systems of work in which:

- the behavioural management and support documentation did not discourage workers from taking refuge in the office when the child was engaging in threatening behaviours; and
- recognised that residential care workers should not be rostered on if they were at greater risk of assault by the child because of their skin colour and the fact that they had not previously worked with him.

“[The provider] pleaded guilty and was, without conviction, sentenced to pay a fine of $55,000.

“Pursuant to section 6AAA of the Sentencing Act 1991, had it not been for the plea of guilty, [the provider] would have been sentenced, with conviction, to a fine of $110,000.”

Date of record: 5 August 2022

Student with disability dies after injuries after wheelchair runs away

Although this case concerns a school, it is directly relevant to disability support provision.

“['The school'] is a State Government Special School and enrolment is open to students aged between 5 and 18 years who have a diagnosed intellectual disability.

“There was a 7 year old boy who was a student at the school. This student was severely intellectually and physically disabled and was confined to a wheelchair ('the deceased').

“On Monday, 26 November 2018, the deceased and the other students were in the classroom getting ready to move from the classroom to the oval. They were lined up at the door. The deceased was at the front of the line and another student was holding onto his wheelchair. Another student then had an unexpected behavioural incident requiring the immediate intervention of the classroom teacher and the teacher's aide. Normally, one of those persons would wheel the deceased down the ramp. Also present in the classroom was a student teacher. The student teacher was asked to start walking the children out and the other teachers would catch up. The classroom door was then opened by the student teacher. The student that had been holding onto the deceased's wheelchair let go and he started to move fast down the ramp. The student teacher tried to catch the wheelchair but couldn't. The wheelchair tipped over at the bottom of the ramp and the deceased hit his head on the concrete. He was treated by the school nurse and returned home after school that day. Ultimately, the deceased passed away four days later on the Friday.

“Upon WorkSafe's attendance at the school, a prohibition notice was issued regarding the ramps. The school engaged an expert to inspect the ramps. The expert concluded the ramp subject of the incident did not meet the landing flush and that that ramp, and a number of the other ramps at the school, did not comply with various Australian Standards and the Building Code of Australia. The ramps therefore posed a risk to the health and safety of the students. By its plea, the offender acknowledged that it was reasonably practicable to professionally assess construction plans and maintain all ramps in use at the school (charge 1).

“WorkSafe's investigation also revealed the student teacher was not given any induction or introduction about the children's special needs or medical conditions, and while there was evidence that teachers pushed the deceased's wheelchair between classrooms, there was no documented evidence that teachers, substitute teachers, aides and trainee teachers were adequately trained in the supervision and mobility requirements of the deceased based on adequate specific risk assessments and care plans. By its plea, the offender acknowledged that it was reasonably practicable to provide such instruction and training to its teaching staff (charge 2).

“The Court accepted the offender:

- was remorseful and apologised to the family of the deceased;
- indicated an intention to plead guilty at an early stage for the incident that occurred 3 years ago;
- was to be given credit for pleading guilty given the current COVID-19 pandemic;
- had made a number of significant safety improvements at both the school, and across its other primary schools in the State.

“Pursuant to s.6AAA of the Sentencing Act 1991, had the offender not pleaded guilty, his Honour indicated the offender would have been sentenced to pay an aggregate fine of $300,000.00 with conviction on each charge.

“The offender pleaded guilty and was with conviction on each charge sentenced to pay an aggregate fine of $200,000.00.”

Date of record: 26 November 2021

Hospital staff not warned or protected about patient's behaviours of concern

Although this case concerns a hospital, it is directly relevant to disability support provision.

"[The Health Authority] is part of the Victorian Government's public health network and operates the [a series of hospitals] as well as a number of other specialist and allied health services.

"On 6 October 2015 a patient was admitted to the [Hospital 1] Intensive Care Unit ("ICU"). The patient suffers severe autism and has a severe intellectual disability that impacts all elements of his functioning. Physical aggression was noted as a "behaviour of concern" and it was stated that due to his limited communication skills, he is often frustrated and expressed those frustrations physically.

"On 13 November 2015, the patient was transferred to the [Hospital 2] into a rehabilitation wing. A behavioural plan was created however there was no reference to the use of mechanical restraints or the wearing of personal duress alarms. Between 13 November 2015 and 6 December 2015 there were a number of incidents involving the patient physically grabbing treating nurses and on 6 December 2015 a nurse was physically assaulted (hair pulled, pushed, punched, head butted and kneed in the face).

"The matter was subsequently referred by the [Union] for investigation under s.131.

"Employees were exposed to risk by the offender's failure to:

- Inform its employees that the patient's behavioural issues included physical aggression and violence, and that there was a risk of injury to employees;
- Inform its employees that the management of the patient's behaviour, during his admission at the ICU, included the use of mechanical restraints, when necessary, and the wearing of personal duress alarms;
- Instruct its employees to develop a Behaviour Management Plan for the patient that included the:
    - use of mechanical restraints, if necessary; and
    - wearing of personal duress alarms; and
- Train its employees in the use of mechanical restraints and personal duress alarms.

"The offender had no prior convictions.

"The offender pleaded guilty and was without conviction sentenced to pay a fine of $25,000.00 and to pay costs of $9,019.00."

Date of record: 5 December 2018

Sexual assault of worker by client

"[The Department] funds and manages the Disability Forensic Assessment and Treatment Service Centre … (the workplace). On 9 June 2011, a 25 year old Disability Development and Support Officer was sexually assaulted by a resident of that facility. The offender failed to provide to employees such information as was necessary to ensure that sufficient information regarding a resident's risk of violence (including sexual violence) was communicated to all staff working directly with a resident. This exposed employees to health and safety risk of being seriously injured due to a physical and/or sexual assault committed by a resident. The offender pleaded guilty in the County Court and was sentenced without conviction to an adjourned undertaking for twelve months with a special condition that they pay $50,000.00 to Djirra (a charity that provides practical support to all

Aboriginal women and particularly to Aboriginal people who are currently experiencing family violence)."

Date of record: 18 June 2018

Resident left unattended on therapeutic equipment

"[The provider] ("the offender") operates residential home care sites for the elderly and those with a disability. On 18 May 2015, a resident of the offender was left unattended on a tilt table by his carer. The offender had a documented training and instruction guide for the patient's exercise on the tilt table, which stated that the patient should not be left alone, but there was no documentary evidence that the carer was trained in the use of the tilt table or the requirement that the patients be supervised at all times whilst using the table. The patient, who was unable to bear his own weight, was performing routine exercises on the tilt table under the supervision of his carer. During the exercises another resident called out to the carer for assistance, the carer left the patient on the tilt table in a squatting position. As he left he told the patient he would be back in 5 minutes and gave him the controls. While alone the patient pressed a button to change the angle of the tilt table. The button he pressed in fact changed the angle of the table so that a significant amount of pressure was placed on his legs. Unable to support his own weight, he fell to the floor. The tilt table was angled in such a way that the patient's legs were supporting his entire body weight and as a result, both legs (tibias) were broken due to the weight. He required a significant hospital stay after the incident. [The provider] failed to notify WorkSafe immediately after becoming aware of the incident in writing within 48 hours of the incident. The offender submitted an Enforceable Undertaking to WorkSafe which was accepted on 11 May 2017."

Date of record: 11 May 2017

Provider alleged not to provide safe work environment when transporting client after behaviours of concern

"On 1 September 2015, [the provider] was found guilty of one charge under s 21(1) of the OHS Act. The matter had proceeded as a contested hearing on 8 and 9 December 2014 and His Honour Cotterill had reserved his decision. The offence related to a failure by [the provider] to provide a safe working environment for carers when transporting a particular client, who had previously assaulted her carer. [The provider] was fined $15,000, without conviction, and ordered to pay WorkSafe's costs. Peter Matthews of Counsel prosecuted the matter. (Bendigo Magistrates' Court)

"On Appeal: [The provider] was again found guilty of one charge under s 21(1) of the OHS Act. The matter proceeded as an appeal hearing from 24-26 August 2016. [His Honour] Judge Patrick set aside the orders imposed at the Magistrates' Court and [the provider] was convicted and fined $10,000 and ordered to pay WorkSafe's costs of the Magistrates' Court and County Court proceedings."

Date of record: 26 August 2016

Supported employee loses fingers when operating saw

"[An] undertaking was provided by [the provider] and resulted from an incident on 4 June 2010 when a supported employee of [the provider] had three fingers severed whilst operating a Holytek HCS-18R cross cut-off saw. The undertaking required [the provider] to provide assistance to other disability support provider[s] in relation to occupational health and safety policies and procedures as relevant to supported workplaces, host a number of workshops to other disability service providers

and produce a number of publications in relation to the incident and the enhancements it has made to its safety systems."

Date of record: 21 March 2012

Western Australia

There appear to be no relevant cases at the time of reporting.