Australian Government

Comcare

INSPECTOR REPORT

COMCARE REFERENCE	MC00010724		**Report No.**	1
PCBU DETAILS	**Name**	Australian Postal Corporation		
	Address	People and Community, PO BOX 1777, MELBOURNE, VIC		
	ABN	28864970579		
REPORT ISSUED TO	**Name**	Greg Wong		
	Position	Safety Standards and Compliance Consultant		
COPY OF REPORT GIVEN TO	**Name**	Anthony Veal		
	Position	Health and Safety Representative, Postal Delivery Officers (PDOs), Abbotsford Delivery Centre (DC)		
RELEVANT WORKPLACE/S OR WORKSITE	**Name**	Abbotsford DC		
	Address	45 Grosvenor Street, Abbotsford, VIC 3067		
	Date	02.05.2019		
OTHER PERSONS ATTENDING WITH INSPECTOR	**Name**	Eva Materia		
	Position	Assistant Director		

PURPOSE OF INSPECTION

1. The inspection was conducted in response to a request received by Comcare from the Australian Postal Corporation Pty Ltd (APC) for a review of a Provisional Improvement Notice (PIN), in accordance with ***s100*** of the ***Commonwealth Work Health and Safety Act 2011*** **(the Act).**
2. The PIN was issued to APC by a Health and Safety Representative (HSR) representing PDOs at APC's Abbotsford DC site on 01.04.2019 under ***s93(1)*** of **the Act**, requiring APC's compliance with the notice by 11.04.2019. APC requested the review by email to Comcare on 08.01.2019, meeting the 7-day time limit imposed for such a request to be made under ***s100*** of **the Act**.
3. The PIN cited multiple contraventions of ***sections 22, 23*** and ***25*** of **the Act** by Australia Post, arising from alleged risks of piercing injury to Postal Delivery Officers (PDOs) from the handbrakes of Electric Aussie Mail Bikes (EAMBs).
4. The PIN was based on a single incident in South Australia (SA) in March 2019. The incident occurred when a PDO riding an EAMB was pierced in his leg by the handbrake when the bike fell over while he was riding it. The PIN stated that *'it appears that it [the handbrake] may have pierced an artery, which is life threatening'.*
5. The HSR sought remedies to the contraventions relating to changes in the design/retrofitting of the handbrake on EAMBs, by providing a blunt end to the handbrake. According to the HSR, this [could] be done *'by increasing the radius of curvature of all sharp surfaces on the handbrake and/or providing shock absorbing padding on the brake, to the point where the risk of a lever piercing soft tissues of a rider has been eliminated. Retrofit suitable modifications to existing EAMBs as soon as possible'.*
6. An inspector was appointed to review the PIN under ***s101*** of **the Act.** The role of the inspector was to inquire into the circumstances of the PIN and decide on the review in accordance with ***s102*** of **the Act.** This provided options for the inspector to: confirm the PIN, confirm the PIN with changes, or cancel the PIN in accordance with ***s102(1) (a), (b)*** or ***(c)*** of **the Act**.

OUTCOMES

7. The inspector cancelled the PIN due to significant defects or irregularities in the PIN, taking into consideration the provisions of ***s98(a),*** in that the inspector considered that they caused or were likely to cause substantial injustice to APC. These irregularities related to the HSR citing multiple contraventions of duties held by designers, manufacturers and suppliers under **the Act**, after he incorrectly identified APC as the designer of the EAMBs.

8. However, the inspector also found additional issues relating to a lack of information being provided by APC regarding the exact causes of the incident in SA, as APC's investigation into the incident was incomplete at the time. Incident data provided by APC also indicated that, while comparatively low in number, there appeared to be some potentially serious near misses involving the handle bars and handbrakes on the EAMBs.
9. The inspector also found that, while some minor modifications were made to the EAMB Mk2 since it was introduced into APC worksites in 2015, a risk assessment review of the EAMB Mk2 had not been undertaken by APC since it was introduced and the modifications were made.
10. While cancelling the PIN, the inspector noted that APC held duties as the primary duty holder under ***s19*** of **the Act**, requiring it to ensure the health and safety of workers and others, so far as reasonably practicable under **the Act.**
    This included ensuring compliance with ***s17*** of **the Act** and associated ***WHS Regulations 2011*** (**the Regulations**) and ***Code of Practice*** **(CoP)** relating to management of risks in workplaces. It also included multiple provisions of **the Regulations** relating to Plant, and the Consultation provisions under **the Act** (referenced in detail below).

Agreed Outcomes:

11. As a result of the inspection, APC agreed to conduct a risk assessment review of the EAMB (review), including the handlebars and handbrakes and incorporating the following matters:
    - Risks of piercing due to the handbrake levers.
    - Modifications made to the EAMB since it was introduced.
    - The findings and outcomes from the SA incident investigation, including any recommendations arising from the investigation.
    - The adequacy of current risk controls and any improvements/changes required.
    - Safety instructions and warnings provided in the User Manual regarding the set-up and location of the seat, handlebars and handbrakes of the EAMB, outlined in **Paragraph 29, point 6**, below.
    - Incident data provided by APC regarding handbrakes on EAMBs, outlined in **Paragraph 29**, **point 7**, below.
    - Ensuring no new risks or hazards occur as a result of any changes to the EAMB (plant) itself and any associated procedures or systems resulting from the review, so far as is reasonably practicable under **the Act.**
12. The process for the review will include:
    - Technical input/advice. This is to be overseen by Stephen Hehir, APC's Manager Safe Design.
    - Consultation with the designer, manufacturer and supplier of the EAMB, Electric Vehicles P/L (EV).
    - Consultation with the HSR who issued the PIN.
    - Consultation with other HSRs representing PDOs across the wider affected working group, given EAMBs are utilised in multiple sites across APC nationally.
    - The consultation is be conducted in accordance with ***Part 5 – Division 2*** of **the Act – *Consultation with workers***, with particular consideration given to the requirements of ***s48*** of **the Act – *Nature of Consultation*** and ***s49 – When consultation is required.***
    - The review will be completed in one month.
13. APC will also provide to the inspector the following documents when completed and/or within one month:
    - A full copy of its investigation report into the SA incident, including findings, outcomes and recommendations,
    - A copy of the risk assessment review.
14. The inspector will conduct a follow up Verification Inspection in six weeks. The purpose will be to meet with APC and the HSR who issued the PIN (the parties) to go through the risk assessment review and outcomes and determine next steps.

ACTIONS AND OBSERVATIONS

15. Prior to the site visit, the inspector spoke to both parties and requested further information and documents regarding:
    - the circumstances and matters that were the subject of the PIN.
    - consultation or communications undertaken by the HSR with APC prior to issuing the PIN.
    - APC's response and the attempts by the parties to resolve the issues that were the subject of the PIN.
    - information from the HSR confirming his election, Work Group and completion of HSR training in accordance with ***Part 5 – Division 3, subdivisions 4*** and **5**, particularly ***s72(1)(b)*** of **the Act**.
16. The inspector reviewed a range of documents, provided by the parties prior to the site visit. These included copies of email and other communications between the parties regarding the PIN, information regarding the SA incident, and the design and manufacture of the EAMB.
17. The inspector attended the site, accompanied by the Assistant Director, Regulatory Operations Vic/Tas (Assistant Director), where they spoke with the parties regarding the PIN and the concerns

raised applicable to that. Whilst at the workplace, some EAMBs and handbrakes were inspected and photographed. The inspector also provided an overview regarding the purpose of the inspection, the inspector's role and functions under ***s102*** of **the Act**.

18. The inspector requested additional information regarding the SA incident. The inspector discussed with APC the reasons why the incident was not notified to Comcare. APC advised that this was because the injured PDO was not admitted to hospital and it was therefore not notifiable under **the Act**.

Key Observations of the Inspector:

19. Based on the information available, the inspector made the following key observations:
    - APC confirmed in writing to the inspector that Electric Vehicles Pty Ltd (EV), located at 24/12 Henderson Road, Knoxfield Vic 3121 was the designer, manufacturer and supplier of the EAMBs to APC.
    - The EMB Mk2 model was introduced into APC worksites in 2015. According to APC's advice, the EMB Mk2 was designed by EV in consultation with APC, specifically for use as a postal delivery vehicle on Australian roads and footpath networks.
    - Load capacities and performance parameters of the MK2 were designed to meet the requirement of Australia Post Delivery Rounds. It also met or exceeded applicable Australian Standards ASNZ 1927:10. This included the handbrake lever attachment and location, deemed a 'PASS' in ATTAR's Assessment Report (referenced in **Paragraph 20**, above).
    - The EV User Manual (EV Manual) provided only generic information regarding the handbrake and handbrake levers on the EMB Mk2.1 model. It did not specifically address safety issues or identify any safety instructions regarding the unprotected ends of the handbrake levers.
    - Other information provided by the HSR was too generic or did not specifically apply to EAMBs. The BIA and Tektro brochure related to bicycles generally and the MESIC research paper related to the design of handbrake levers on motorcycles specifically.
20. While the EV Manual was generic in nature, the inspector observed that the Manual devoted several pages to the set-up of the seat and handlebars on which the handbrake levers are located on the EAMB. This included safety instructions and warnings.

Incident Data:

21. A summary of incident data (data) provided by APC identified three (3) incidents found for Abbotsford DC: In November 2013, the brake cable snapped. The other two (2) incidents (October 2014 and August 2015) related to applying the brakes and then losing control and falling.
    - The data also identified that, since the introduction of the EAMB in 2013/2014, there were 104 incidents reported nationally (including Abbotsford DC) that reference the 'brake'. According to APC, only the SA incident related to the type of injury *'caused by the brake lever to the driver's leg'.*
    - 78 of these incidents were due to loss of control during the application of the brake. There were five (5) incidents where the brakes were damaged due to contact made and 5 where the brake component allegedly failed (e.g. cable or lever snapped).
    - According to APC, these incidents were relatively small in number comparative to the total number of EAMBs (more than 2,500) and total hours (>600,000per annum) that they were on the road nationally.
    - However, the inspector noted that some of the incidents involved some potentially serious near misses/problems with the handlebars and handbrakes. Given the involvement of the handlebars and handbrake lever in the SA incident, the inspector determined that it was prudent for APC to further enquire into these matters.

PIN Validity:

22. The inspector considered matters regarding to the validity of the PIN. The inspector observed that:
    (i) The HSR was a duly elected HSR under Part 5 of the Act.
    (ii) The HSR represented PDOs in the relevant Work Group.
    (iii) The HSR had completed initial training in accordance with s72(1)(b) of the Act.
    (iv) There were adequate attempts by the HSR to consult with ACP before issuing the PIN, in accordance with s90(3) of the Act. This included email communications between the parties leading up to the PIN being issued.
    (v) The Delivery Manager (DM) and Safety Advisor also held a meeting with the HSR to understand his concerns on 2.4.2019.
23. While the inspector noted that these matters were not in dispute, the inspector identified some significant irregularities with the PIN. These related to the HSR incorrectly identifying APC as the designer and manufacturer of the EAMB.
24. As a result, the inspector found that the HSR incorrectly cited multiple contraventions by APC of ***sections 22(2)(a), 23(1)(a), 23(2)(f)*** and ***25(2)(a)***, all being duties held by designers,

manufacturers and suppliers under **the Act**. The inspector also considered information provided by APC, confirming EV as the designer, manufacturer and supplier.

25. The inspector also considered the provisions of **s98(a)** of **the Act**. These state that a PIN is not invalid only because of a formal defect or irregularity, unless it causes or is likely to cause substantial injustice or fails to correctly identify the person to whom the notice is issued.
26. The inspector considered that the irregularities in the PIN were substantial, in that APC did not hold the duties identified in the alleged contraventions. As a result, the inspector cancelled the notice in accordance with **s102(1)(c)** of **the Act**.
27. The inspector noted that there was insufficient evidence at this stage to support the PIN, both in terms of the alleged contraventions and remedies identified. However, this did not mean that further enquiries should not be made into the incident to determine the root causes and any associated potential safety risks and measures required to prevent a recurrence.
28. The inspector noted that, while APC was not the designer, manufacturer or supplier of the EAMB, it was able to and had previously initiated requests for modifications of the EAMB with EV and consulted with them regarding their requirements.

SA Incident causes and investigation:

29. While APC provided some information to the inspector regarding the SA incident, they were not able to provide a copy of their investigation report into the incident as requested by the inspector, as it was not yet concluded.
30. Information provided to the inspector by APC prior to the site visit indicated that the root cause of the incident was a misjudgement by the PDO on the required angle of approach to the driveway. As a result, the front wheel was caught by the raised edge on the driveway.
31. At the site, APC also advised the inspector that the handlebars had rotated to a 180-degree angle and this may have contributed to the incident and undertook to provide the inspector with a copy of their incident investigation report following the site visit.
32. Following the site visit, APC advised the inspector that the investigation was yet to be completed and their enquiries were continuing, some two months after the incident occurred. According to APC, this was to allow it to conduct more comprehensive investigations into why the handlebars had rotated to a 180-degree angle.
33. APC undertook to provide the inspector with a copy of their incident investigation report once completed.
34. The inspector also requested information regarding the interim actions taken by them to ensure the health and safety of workers, so far as is reasonably practicable under the Act. APC advised they had conducted a national tool box talk brief ***Starting with Safety (27)***, issued to workers following the incident, a copy of which was provided to the inspector following the site visit, along with photos of the incident.
35. This included a photo showing a change in the surface (raised edge) from the road transitioning to the footpath and driveway. It also included a photo showing the injured PDO lying on the ground with what appeared to be a puncture wound and blood on his right thigh and a person applying a makeshift tourniquet at the top of his thigh above the wound.
36. The inspector noted that the toolbox reinforced the risk controls in place and safety instructions for PDOs when entering driveways. This included requiring PDOs to enter driveways straight on rather than at an angle. It also advised PDOs to take an alternative route if unsure of possible hidden or additional hazards on the preferred path.

Key Issues Identified by the Inspector:

37. Based on the information available, the inspector identified the following key issues:
    - APC undertook a risk assessment of the Mk 2 in 2015 at their Preston site. Following this, some minor modifications were made to the EAMB, which resulted in minor increases in loads carried and larger bags on either side of the bike.
    - According to the HSR, the Mk2 also had bigger brakes and tyres and these modifications together increased the load of the bike, which would have the effect of causing it to fall more heavily and apply more force in the event of an accident such as the SA incident.
    - The EAMB involved in the SA incident was a Mk 2 version.
    - APC had more than 2500 EAMBs on the road nationally every day and there would be a significant cost to retrofitting all of them. APC also advised that out of more than 600,000 hours spent by PDOs on the EAMBs collectively every day, there had only been 1 incident since the EAMBs were introduced. In APC's view, the modifications were minor and the nett increase in weight was still within the weight and load limits of the bike.
    - While there had been only 1 incident involving a handbrake lever piercing a PDO, it appeared to be a serious incident with potentially fatal consequences. This view was supported by information in the ***Starting with Safety*** toolbox, which stated that the PDO had:

      'received a deep puncture wound to the inside part of their thigh which could have easily resulted in both permanent damage to the leg as well as personal life altering outcomes – a potential serious injury or fatality.'

- According to APC, the SA incident was an isolated incident and only 1 of its type in the four years since the Mk2 bike was introduced and the incident had occurred due to the bike/handlebars turning 180 degrees after the PDO approached the footpath incorrectly, and this needed to be further investigated before determining remedial measures.
- The risk assessment on the Mk2 had not been reviewed since its introduction in 2015 or since the modifications were made on the bike. In addition, the risk assessment was due for review in 2019.

38. The inspector considered it timely for APC to conduct a review of the risk assessment, given the SA incident, modifications made to the bike and the other matters outlined above. The inspector noted that, while the PIN was cancelled due to irregularities, APC nonetheless held duties as the primary duty holder under ***s19*** of **the Act**. This included ***sections 19(1)(a), 19(3)(b)*** & ***(d),*** and ***s17*** of **the Act** relating to managing risks in the workplace.
39. The inspector also noted the requirements of ***Chapter 3*** of **the Regulations – *General risk and workplace management***, particularly ***Regulation 38(2),*** which required a duty holder to review and as necessary revise control measures to maintain, so far as is reasonably practicable, a work environment that is without risks to health or safety in the following circumstances:
    (a) The control measure does not control the risk it was implemented to control so far as is reasonably practicable. This included where a notifiable incident occurs because of the risk,
    (b) Before a change in the workplace that is likely to give rise to a new or different risk to health or safety that the measure may not reasonably control,
    (c) A new relevant hazard or risk is identified,
    (d) The results of consultation by the duty holder under the Act or Regulations indicate that a review is necessary,
    (e) A health and safety representative requests a review under ***Sub Regulation (4),*** where:
        i. a circumstance in ***(2)(a), (b), (c)*** or ***(d)*** affects or may affect the health and safety of a member of the work group represented by the HSR, and
        ii. the duty holder has not adequately reviewed the control measure in response to the circumstance.
40. The inspector also noted the requirements of **the Regulations** relating to Plant, particularly Regulation ***203,*** as well as ***Regulations 35, 36*** and ***37.***

Consultation:

41. The inspector also referenced the consultation provisions of **the Act**, particularly ***s49.*** The inspector discussed with APC ensuring that any risk assessment review was undertaken in consultation with the HSR who issued the PIN and other relevant HSRs for the work group as appropriate, given the EAMBs were used across multiple APC sites nationally.
42. As a result of the site visit and the inspector's discussions with the parties, APC agreed to conduct a review of the risk assessment regarding the EAMB Mk2, including specified agreed criteria to be considered as part of the review. The HSR also agreed to this approach. Details are provided under **'Outcomes',** above.

POWER EXERCISED (if any)

Section of Act	Nature of Inspector action/decision
None	Not exercised

COMPLIANCE STATUS OF PREVIOUSLY ISSUED NOTICES (if any)

Notice	Description	Status

REPORT ISSUED BY	**Inspector:**	Jeanette Sdrinis	**Phone:**	+61399146319
	Email:	Sdrinis.Jeanette@comcare.gov.au	**Region:**	VIC/TAS
INSPECTOR'S SIGNATURE	**Signature:**	J. Sdrinis	**Date:** 22/05/2019	

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