The Independent Review of SafeWork NSW

Final Report by the Hon Robert McDougall KC, Independent Reviewer

15 December 2023

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1 Preface

I present this report to the Minister for Industrial Relations (**Minister**),[1] in response to the Terms of Reference dated 7 November 2022 that were set for me.

I express my appreciation to SafeWork NSW (**SafeWork**) for its active cooperation during the Review.

I am also grateful for the input of the individuals and external stakeholder groups who provided written submissions and, in many cases, supplemented those submissions in interviews. I wish to thank, in particular, two organisations determined to bring about improvements in workplace health and safety and its regulation, whose determination is driven by their lived experience of the deaths of or injuries to loved ones. Those organisations are the Family and Injured Workers Support and Advisory Group and the Touched by Christopher Foundation. I acknowledge the suffering that those comprising, and whose interests are represented by, the two organisations have endured, and I wish to pay public tribute to their desire to assist in reducing the incidence of workplace deaths and injuries so that others will not have to suffer as they have suffered.

Robert McDougall KC

Independent Reviewer
Dated: 15 December 2023

[1] At the time of my appointment I was engaged by the Minister for Customer Service. However, by the time of my Interim and Final Reports, responsibility had passed to the Minister for Industrial Relations.

2 Terms of Reference

1. I was appointed, by Terms of Reference dated 7 November 2022, to undertake a review of the performance by SafeWork of its functions under the *Work Health and Safety Act 2011* (NSW) (**2011 Act**).

2. The Terms of Reference are as follows:

> *The Review will examine SafeWork NSW's performance of its regulatory functions (including educational functions) under the* Work Health and Safety Act 2011 *(NSW).*
>
> *The scope of the Review is to inquire into, report on and where thought desirable make recommendations as to:*
>
> *(1) The performance and effectiveness of SafeWork NSW's compliance and enforcement functions. This part of the Review will consider complaints, inspections, investigations, and prosecutions, and will include consideration of SafeWork's Triaging and Investigation Decision Making Panel processes.*
>
> *(2) The performance and effectiveness of SafeWork NSW's educational functions.*
>
> *(3) The governance and culture of SafeWork NSW, including complaints as to alleged unlawful or undesirable conduct in the workplace.*
>
> *(4) Appropriate measures to ensure that workers and their representatives (including Health & Safety Representatives), and the families of injured and deceased workers, have a genuine voice in the complaints, investigation, and enforcement processes.*
>
> *The Review will be an inquisitorial rather than adversarial process. While specific cases and detailed issues raised can be considered as part of the Review, the Review will not make determinations relating to specific work health and safety cases. The Review's focus will be on identifying deficiencies and recommendations at the organisational level.*

3. As required by the Terms of Reference, I provided an Interim Report to the Minister on 31 May 2023.

4. I provided a second Interim Report, not required by the Terms of Reference, on 29 September 2023. The circumstances giving rise to the second Interim Report are addressed at [49] to [55] below.

3 Executive Summary

3.1 Review Methodology

5. I received submissions from numerous respondents, including members of the public, injured workers and the families of injured and deceased workers, current and former inspectors of SafeWork, current and former other staff members of SafeWork, unions and other organisations representing the interests of workers, organisations representing the interests of employers, other organisations and from SafeWork itself.

6. In this Report, I shall refer to present and former inspectors simply as "inspectors", and to present and former SafeWork staff members simply as "staff".

7. I, or members of my Review Team, conducted interviews with many of those who had made submissions. My Review Team requested and was supplied with documents going to various aspects of SafeWork's performance of its functions. In addition, an external firm of consultants, Nous Group (**Nous**), was commissioned to consider the first, second and part of the third areas covered by my Terms of Reference.

8. When this Report was finalised in draft, it was provided to SafeWork and to the Department of Customer Service for comment. Their comments have been taken into account in this Report.

9. I have been greatly assisted by the submissions that I received and the interviews that were conducted. Where an interview was not conducted, it was not because I regarded the submission as unimportant, but because it was unnecessary for me to clarify any matter in the submission.

10. The submissions identified or suggested a number of areas where there were inadequacies in SafeWork's performance of its functions, and where improvement was required. Many of the very personal submissions I received showed the terrible impact that failures to observe safe work practices have had on individuals and their families. Those experiences underscore the need to have an effective workplace health and safety regulator in this State.

11. Before I move to summarise my findings on the four areas covered by my Terms of Reference, I note that although I received detailed and helpful submissions from

individuals and organisations involved in the health care sector, they did not cover the most recent public reports of workplace health and safety problems in that sector. The timing of those reports means that I have been unable to give any consideration to them.

3.2 Terms of Reference: Part 1

12. I address compliance and enforcement functions, including the processes of triage and the IDMP, in Section 7 of the Report (paragraphs [68]-[210]) and make Recommendations 1-18 on this issue.

13. In general, at the time it was examined by Nous, the system as a whole was functioning reasonably well. However, SafeWork had from time to time fallen down in its performance of its compliance and enforcement functions, and from time to time its triage and IDMP decisions had not been made in a way which permitted any accurate assessment of their correctness.

14. There was some disconformity between criticisms and problems identified, and comments made, in the relevant submissions and the generally favourable conclusions stated by Nous in its report. I consider the possible reasons for those disconformities in the relevant sections of this Report.

15. Nous made suggestions aimed at improving this aspect of SafeWork's performance of its functions. I endorse all but one of those suggestions and have made them recommendations of this Report. The one not specifically endorsed I have recommended to SafeWork for consideration. In addition, I have made further recommendations dealing with particular points raised in submissions on this first issue.

3.3 Terms of Reference: Part 2

16. I address the second issue – SafeWork's educational functions – in Section 8 of the Report (paragraphs [211]-[276]) and make Recommendations 19-31 on this issue.

17. The comments made in submissions on SafeWork's educational functions do not always align to comments made by Nous.

18. Nous concluded that SafeWork's internal training functions (for inspectors, and for staff performing triage and IDMP work), were conceptually sound, and generally well administered in practice. However, it found that training documentation was

often complex and confusing, and that it should be very carefully reviewed and refined.

19. I agree with the conclusions that Nous reached.

As before, Nous made suggestions for improvement, which I endorse and have made recommendations of this Report. In addition, in this area also, I have made recommendations going beyond those suggested by Nous.

3.4 Terms of Reference: Part 3

20. I address the third issue – SafeWork's governance and culture – in Section 9 of the Report (paragraphs [277]-[344]) and make Recommendations 32-42 on this issue.

21. As to governance, it is my clear view that the present structural and governance arrangements for SafeWork are unsatisfactory. It is, at present, one of a number of regulators housed as separate agencies within the Department of Customer Service (**DCS**). Its head is subject to the direction of the Secretary of the Department. In my view, there are several reasons, discussed in the Report, why it is inappropriate for a regulator such as SafeWork to be governed in this way.

22. I have recommended that SafeWork be reorganised as a statutory corporation with a board comprising representatives of employer and employee organisations with experience and interest in workplace health and safety, and including a representative of a group such as the Family and Injured Workers Support and Advisory Group (**FIWSAG**) to represent the interests of injured workers and the families of injured and deceased workers. There should be provision made for regular parliamentary review of its performance, and it should be subject to the oversight of a parliamentary committee such as the Standing Committee on Law and Justice.

23. The second aspect of this third area concerned the way in which SafeWork handled internal workplace complaints of matters such as bullying and harassment. In my view, the present arrangements, whereby those complaints are handled in the first instance by the People and Culture Division of the Department of Customer Service, are inadequate. When SafeWork is reconstituted in accordance with my recommendation, care should be taken to institute a "best practice" grievance handling process that is effective and that is subject to external review. Precisely how this should be done is a matter beyond the scope of my Terms of Reference,

but not beyond the wit of humankind to devise. It should be considered along with my recommendation as to the change in structure and governance of SafeWork.

24. Nous made a number of recommendations aimed at improving the complaints process. I endorse those recommendations and have made them recommendations of this Report. In addition, I have formulated, and include in this Report, yet further recommendations on this topic.

3.5 Terms of Reference: Part 4

25. I address the fourth issue – greater involvement of injured workers and their families, and the families of deceased workers – in Section 10 of the Report (paragraphs [345]-[387]) and make Recommendations 43-46 on this issue.

26. SafeWork must take further steps to ensure that there is greater involvement of injured workers and their families, and the families of deceased workers, in its operations. This should be done in at least two ways. First of all, where an investigation is under way into a workplace incident that led to death or injury, those people should be kept informed of the process: what will happen, what is happening, and why. And when a decision is made to prosecute, or instead to take some other enforcement action, those people should be informed, and again told why. Further, health and safety representatives should be more involved in these processes, as should unions where, to SafeWork's knowledge, one of their members has been killed or injured in a workplace incident.

27. Further, in this area, I think that the current system of formal meetings between SafeWork and FIWSAG should be maintained. Input from those most directly affected by serious workplace incidents, is I think, of enormous value to SafeWork, at a number of levels, including at least the regulatory level (what is to be done in response to the incident) and the educational level (what can be done to attempt to prevent recurrence). Further, the process will institutionalise the role and voice of people whose lives have been devastated by death or serious injury arising from a workplace incident. They are entitled to no less.

28. Again, in this area, I have made a number of recommendations which, if implemented, should ameliorate the often-justified criticisms of the way in which SafeWork deals with the families of injured and deceased workers.

3.6 Conclusion

29. I believe that if SafeWork is reorganised along the lines if have suggested, and if the numerous recommendations that I have made are followed, it is capable, with adequate funding, of becoming a "best practice" and effective workplace health and safety regulator. It is in the interests of everyone in this State that this should happen.

4 List of Recommendations

Recommendation		Report section
Triage		**7.7**
1	SafeWork should ensure triage documentation is more user friendly.	
2	SafeWork should better embed its regulatory priorities into the triage process each year.	
3	SafeWork should formalise the oversight and review of triage decisions, as well as responses to challenges and issues identified as part of that review and oversight process.	
4	SafeWork should give careful consideration to consolidating the three groups involved in triage under one directorate.	
5	SafeWork should formalise training to equip staff with the skills they need for effective triage.	
IDMP		**7.7**
6	SafeWork should give consideration to establishing a policy that wherever possible, the membership of the IDMP should include at least one legal practitioner with relevant experience in the area of workplace health and safety law and in prosecutions for breach of obligations under that law.	
7	SafeWork should simplify documentation supporting the IDMP process.	
8	When the IDMP process documentation is reviewed by SafeWork in accordance with recommendation 7, SafeWork should ensure that that documentation directs the attention of staff preparing submissions to the IDMP to consider the strategic regulatory priorities established from time to time by SafeWork, and to state expressly how the submission supports (to the extent that it does) those priorities.	
9	SafeWork should formalise the oversight and review of the IDMP decision-making process and improve the analysis of insights.	
10	SafeWork should incorporate a greater strategic focus into the IDMP process.	
11	SafeWork should develop tailored IDMP process training, including content with a specific focus on strategic decision-making.	
12	SafeWork should improve communications with staff following decisions.	
13	The legislature should give consideration to amending section 219 of the 2011 Act so that it provides that: (1) a person must not without reasonable excuse	

	contravene, or fail to comply with or perform, a provision of a WHS undertaking; and (2) the person alleging the existence of a reasonable excuse must prove it on the balance of probabilities.
14	When recommendation 9 is put into practice, SafeWork should institute a formal process to use the data collected to enable, among other things, a regular and continuing sampling of IDMP decisions for the purpose of re-examining the decision reached on each of the selected files to evaluate its correctness at the time it was made, and to see if there were alternative decisions that could be and should have been made on the evidence originally available to the IDMP.
15	SafeWork should train more of its inspectors specifically in dealing with psychosocial hazards, or alternatively, employ additional personnel to be trained as inspectors with specific training in dealing with psychosocial hazards.
16	SafeWork should work with employer groups, unions and HSRs in individual industries to create industry forums whose role is to identify psychosocial hazards in the relevant industry, to educate PCBUs and workers about those hazards, and to develop and implement strategies to minimise them.
17	SafeWork should establish a system to enable SafeWork to have access to claims data held by workers insurance insurers for the purpose of identifying at-risk industries, PCBUs and workers and targeting programs of education and inspection accordingly.
18	To the extent that there may be legislative prohibitions or restrictions that would prevent or inhibit that access, the legislature should give consideration to enacting legislation to remove any such prohibitions and restrictions.
Training	**8.3**
19	SafeWork should seek to achieve greater consistency in mentoring and field work opportunities.
20	SafeWork should continue to focus on the workforce planning required to enable the best possible teaching and learning experience.
21	SafeWork RTO should review its assessment attempt approach to ensure it continues to meet good practice.
22	SafeWork should fully implement a framework to assess the impact and outcomes the NITP is delivering and for sustaining organisational capability over time.
23	SafeWork should institute formal assessment for HSR training participants.

24	SafeWork should update EPH training to reflect more contemporary training practices.
25	SafeWork's approval process for providers of EPH and HSR training should continue to be more focused on review and continuous improvement process.
26	SafeWork should increase current oversight resources and consider an expansion to supervising student outcomes over time.
27	SafeWork should prepare formal triage training materials by SafeWork and then regularly refreshed.
28	SafeWork should administer simple triage skills assessments for new starters post training and for existing staff before they deliver training**.**
29	SafeWork should give consideration to instituting a formal process of assigning new inspectors to work, for a period of three to six months, in pairs with existing and experienced inspectors when performing those aspects of an inspector's functions that involve dealing with PCBUs over complaints and notifications, and their investigation.
30	SafeWork should review all its educational functions, both internal and external, with a view to identifying and utilising the best possible combination of theoretical and practical learning, and that FIWSAG or some equivalent body should be enlisted, assuming its continuing willingness to do so, to have input into both the design and the delivery of internal and external training. That review should extend to a consideration of the desirability and content of on-the-job training, or continuing education, for all staff whose roles involve dealing with PCBUs, workers, unions, HSRs and members of the public in connection with complaints, referrals, requests for service, investigations, and prosecutions.
31	When SafeWork reviews its educational functions, it should ensure that the review extends to the content and delivery of training (including continuing education) of its Customer Service Centre (or Advisory Service) Staff.
Structure and Governance of SafeWork NSW	**9.1.2**
32	SafeWork should be established as a statutory corporation, an example of this structure being the Environmental Protection Authority (**EPA**) constituted under the *Protection of the Environment Administration Act 1991* (NSW) (**PEA Act**).
33	SafeWork should be governed by a board comprising representatives of employer and employee organisations with demonstrated interest and expertise in the field of workplace health and safety. The board should also include at least one person who works and is expert in the field of workplace health and safety, and a representative from an organisation such as FIWSAG.

SafeWork NSW's complaints function		**9.2.1**
34	SafeWork should update the Positive and Productive Workplace Policy and accompanying intranet material.	
35	SafeWork should invest in new processes and supports to ensure accessibility of complaints process for all SafeWork employees	
36	SafeWork should better track delivery times for complaints and grievance issues.	
37	SafeWork should expand training for managers to identify and support the resolution of workplace grievances.	
38	SafeWork should consider clarifying how confidentiality is maintained and balanced against effective investigation of issues.	
39	SafeWork should revise triaging tool to support more consistent decision-making to determine the appropriate pathway for complaint resolution.	
40	SafeWork should ensure record keeping and oversight is systematised, and automated where appropriate.	
41	SafeWork should ensure greater consistency and support in the complaints and grievance handling work performed by the People & Culture team on behalf of SafeWork NSW.	
42	Within a period of 9 to 12 months from the delivery of this Report and its publication, SafeWork should undertake a further review of the complaints and grievance handling processes of SafeWork to identify whether the deficiencies in those processes identified in the Nous report have been rectified, and whether the complaints handling function has improved both as to efficiency and as to correctness and consistency of outcomes.	
Workers, their representatives and families		**10.1**
43	SafeWork should, when restructured, formalise and continue the process of regular meetings with FIWSAG, at least quarterly and more often as circumstances require.	
44	When investigating a workplace incident and considering what action to take, SafeWork should wherever possible make contact with HSRs of the workforce of the PCBU at the location of the incident, and seek their input both as to evidence that may be available of an unsafe system of work and (where enforceable undertakings (**EUs**) are being considered) as to the precise terms of the EUs that may be negotiated with the PCBU.	
45	SafeWork should develop, formalise and follow a procedure requiring it, when a workplace incident has resulted in the death of or serious injury to a worker:	

	a. to advise the family of that worker, and where applicable the injured worker, of the steps to be followed in the investigation of the incident; b. to keep the family and the worker informed of progress of the investigation; c. to inform the family and worker if a prosecution is to be taken and, if it is, to keep them informed of the progress and outcome of that prosecution; d. to inform the family and worker, if a prosecution is not to be undertaken, of the reasons for that decision; e. to consult the family and worker as to the terms of any EU that the PCBU may request and SafeWork may decide to consider; and f. to offer the family and worker the opportunity to have input into the precise terms of that EU.
46	Where a worker who is killed or seriously injured in a workplace incident is to the knowledge of SafeWork a member of a trade union, SafeWork should take, with all appropriate changes, steps in accordance with (a) to (f) at recommendation [45] above to inform and keep informed the relevant officials of that trade union of the progress and outcome of the investigation.

5 Background

30. As noted in my first Interim Report at [4] to [8], legislative regimes relating to workplace health and safety have been in force in this State for many years, and inspectors have been a consistent feature of those regimes.

31. Appendix 2 to my first Interim Report contained a summary of the legislative history of inspectors and the workplace health and safety regulator in NSW. Given the importance of that history to the issues that arise about SafeWork's future governance structure, and for ease of reference, I repeat in the following paragraphs what was said in Appendix 2.

5.1 Summary of the legislative history of inspectors and the Workplace Health and Safety Regulator in New South Wales

32. Inspectors of work health and safety have operated in NSW for more than 125 years. Under the *Factories and Shops Act 1896* (**1896 Act**),[2] inspectors of factories and shops were appointed by the Governor.[3] Inspectors had powers of entry and inspection including, in appropriate cases, with "*an officer of health or inspector of nuisances*" or, if needed, with a constable.[4] Occupiers of factories and shops were required to allow such entry and inspection[5] and it was an offence under the 1896 Act to obstruct an inspector.[6] Contraventions of the 1896 Act or related regulations were to be reported to the Minister for Labour and Industry by the inspector, and prosecutions instituted with the Minister's consent.[7] Each inspector was required to provide an annual report to the Minister for submission to Parliament.[8]

33. In 1909, a power was added whereby an inspector could notify in writing that an office, building or place was unfit to be used as a factory, with the notice recipient able to appeal to the Minister.[9] Inspectors were also given the power to conduct prosecutions in connection with offences against the 1896 Act and to attend and

[2] The *Factories and Shops Act 1896* came into force on 1 January 1897: s 1
[3] *Factories and Shops Act 1896*, s 4
[4] *Factories and Shops Act 1896*, s 7
[5] *Factories and Shops Act 1896*, s 8
[6] *Factories and Shops Act 1896*, s 9
[7] *Factories and Shops Act 1896*, s 44
[8] *Factories and Shops Act 1896*, s 17
[9] *Factories and Shops (Amendment) Act 1909*, s 4, inserting s 6B into the 1896 Act

examine witnesses at any inquest into the cause of the death of any employee while employed in a factory or shop.[10]

34. The consolidating *Factories and Shops Act 1912* broadly continued these arrangements, while repealing the 1896 Act.

35. In 1936, the Minister was given authority to appoint committees comprising representatives of employers and employees in any trade or industry for the purpose of investigating, considering and reporting upon conditions of work and means to be adopted for the prevention of accidents in factories.[11] This was replaced in 1941[12] by the Factory Welfare Board, comprising the Chief Inspector of Factories, a representative of employers, and a representative of employees. Broadly, the Board had powers to investigate, report and make recommendations regarding the safety or health of employees, and to encourage, assist in the establishment of, and direct and supervise, welfare committees in factories.[13] The Governor was also empowered to appoint factory welfare officers.[14] In 1943, further amendments were made to give the Factory Welfare Board power to enter and inspect any premises used as a factory and any work being carried on there.[15] In 1956, the Factory Welfare Board changed its name to the Factory and Industrial Welfare Board.[16]

36. The 1912 Act (and subsequent amending legislation) was repealed and replaced by the *Factories, Shops and Industries Act 1962* (**1962 Act**). The 1962 Act broadly kept in place the existing arrangements for inspectors (under the supervision of the Chief Inspector of Factories, Shops and Industries), the Factory and Industrial Welfare Board, welfare or safety committees and an annual report by the Under Secretary of the Department of Labour and Industry for submission to Parliament.

[10] *Factories and Shops (Amendment) Act 1909*, s 5, inserting s 7 (V A) into the 1896 Act
[11] *Factories and Shops (Amendment) Act 1936* ('the 1936 Act'), s 1(q), inserting s 36C into the 1912 Act. The 1936 Act also gave responsibility for annual reports to the Minister for transmission to the Under Secretary of the Department of Labour and Industry: s 2(i).
[12] *Factories and Shops (Further Amendment) Act 1941*, s 3(b), inserting s 36C into the 1912 Act
[13] *Factories and Shops (Further Amendment) Act 1941*, s 3(b), inserting ss 36C(2) into the 1912 Act
[14] *Factories and Shops (Further Amendment) Act 1941*, s 3(b), inserting ss 36C(4) into the 1912 Act
[15] *Factories and Shops (Amendment) Act 1943*, s 4(d)((iv), inserting ss 36(5) into the 1912 Act
[16] *Factories and Shops (Amendment) Act 1956*, s 2(d)(i), 2(e)(i)

37. In 1977, the role of Deputy Chief Inspector of Factories, Shops and Industries was created.[17] This was followed in 1979 by the creation of the role of Chief Inspector of Boilers.[18]

38. In 1981, the report of T.G. Williams, Commissioner, of the Commission of Inquiry into Occupational Health and Safety was presented to the Honourable P.D. Hills, MP, then Minister for Industrial Relations.[19] In his report, Commissioner Williams recommended that there be a single administering authority for all legislation pertaining to occupational health and safety.[20] He expressed "*a strong view of the undesirability of administration becoming the responsibility of a subdivision or branch of some existing Government department.*[21] While considering that it was proper that Ministerial control and responsibility should exist, the report stated that a measure of independence was "*certainly desirable, provided there is reporting to the responsible Minister of the progress of activities.*[22] The Inquiry made the following recommendations:

> *4.277 There should be established a Commission of the type existing in the United Kingdom. Its members, including the Chairman, should be drawn from government, management, labour, and one or more of the branches of the industrial and allied sciences (engineering, hygiene, medicine). Its functions and powers should be clearly defined. Its Chairman should be a full-time appointment. Subcommittees of members could be formed for particular purposes. Members other than the Chairman need not necessarily be full time appointees. Numbers should not exceed six, with the Chairman having, if required, a casting vote.*
>
> *4.278 The Commission should be supported by an executive of salaried officers, of whom one should be the Chief Executive Officer. Determination of needs, programmes, projects, and allocation of finance should be reserved to the Commission to whom the Chief Executive Officer should report.*

[17] *Factories, Shops and Industries (Amendment) Act 1977*, s 5 and sch 5
[18] *Factories, Shops and Industries (Amendment) Act 1979*, s 4 and sch 2
[19] T.G. Williams, Esq., Commissioner: *Report of Commission of Inquiry into Occupational Health and Safety*, 27 August 1981
[20] T.G. Williams, Esq., Commissioner: *Report of Commission of Inquiry into Occupational Health and Safety*, 27 August 1981, para 4.270, p 88
[21] T.G. Williams, Esq., Commissioner: *Report of Commission of Inquiry into Occupational Health and Safety*, 27 August 1981, para 4.248, p 84
[22] T.G. Williams, Esq., Commissioner: *Report of Commission of Inquiry into Occupational Health and Safety*, 27 August 1981, paras 4.246-4.247, p 83

4.279 The Commission should report regularly to the Minister within whose portfolio its activities fall. Its determination of the size necessary fort eh executive should require Ministerial approval.

4.280 The Executive should contain a number of divisions sufficient to encompass all of its operations, including the use of training, education, research, statistics, occupational health and safety services, codes of good practice, standards, enforcement, joint committees, tribunals, occupational health policies, and the inspectorate.

4.281 The Minister whose portfolio is most closely connected with relevant matters is the Minister for Industrial Relations, and the Inquiry recommends that he should have responsibility for the operations of the Commission.

39. The next legislative reform was the *Occupational Health and Safety Act 1983* (**1983 Act**), which created the Occupational Health, Safety and Rehabilitation Council of NSW, abolished the Factory and Industrial Welfare Board, and made provision for occupational health and safety committees in workplaces, among other changes. As explained by Adrian Brooks in his text on occupational health and safety law in Australia, the 1983 Act "*did not make any attempt to comply with Williams' recommendation that the various units exercising inspectorial functions under different pieces of safety legislation be brought together into a single body. However, this was achieved administratively, to some extent, by the bringing together of the various inspectorates within the Division of Inspection Services of the Department of Industrial Relations*".[23] This Department became known as the Department of Industrial Relations and Employment in 1986.

40. The next significant reform was the creation of WorkCover, which commenced operations on 1 January 1990 when the *WorkCover Administration Act 1989* came into force. In his Second Reading speech for the WorkCover Administration Bill and WorkCover Legislation (Amendment) Bill, the Hon John Fahey MP, then Minister for Industrial Relations and Employment and Minister Assisting the Premier, informed Parliament that a consultants' report found that the organisational structure of the occupational health and safety units of the Department of Industrial Relations and Employment had impeded the effectiveness of the delivery of occupational health and safety services to the state. It was recommended that all divisions of

[23] Adrian Brooks, *Occupational Health and Safety Law in Australia*, 4th Edition, 1993, ¶1045 p 490

occupational health and safety within the department be amalgamated with the Workers Compensation and Rehabilitation Authority (which had been established under the *Workers Compensation (Amendment) Act 1988*) (**WIM Act**)**,** to form a new self-funding WorkCover Authority. Under the new arrangements inspectors remained appointed under the 1962 Act, but were attached to the WorkCover Authority under the control of a Chief Inspector.[24] WorkCover's policies were determined by a Board of Directors, consisting of the General Manager and six part-time directors appointed by the Governor on the recommendation of the Minister.[25]

41. The *WorkCover Administration Act 1989* was replaced by the *Workplace Injury Management and Workers Compensation Act 1998*, which continued WorkCover's role and functions.

42. The *Occupational Health and Safety Act 2000* (**2000 Act**) followed a review of the 1983 Act by a panel chaired by Professor Ron McCallum[26] and the reports of the Legislative Council Standing Committee on Law and Justice's inquiry into workplace safety, which made various recommendations for the regulatory reform of workplace safety.[27] The 2000 Act repealed the 1983 Act and also the provisions of the 1962 Act concerning occupational health and safety. The 2000 Act contained new provisions governing the appointment of inspectors by WorkCover, the powers of inspectors (continuing their existing powers), the issuing of investigation, improvement and prohibition notices, and criminal and other proceedings. Also at this time, WorkCover issued a compliance and prosecutions policy.[28]

43. WorkCover remained the regulator of work health and safety following the *Work Health and Safety Act 2011* (**2011 Act**)**,** which implemented in NSW the model work health and safety laws which had been developed by Safe Work Australia.

[24] Adrian Brooks, *Occupational Health and Safety Law in Australia*, 4th Edition, 1993, ¶1147, p 570
[25] *WorkCover Administration Act 1989*, ss 5-6
[26] See Professor Ron McCallum, "Reflections on the role of the Panel which reviewed the OH&S Act 1983" in Parliament of New South Wales, Legislative Council, Standing Committee on Law & Justice, *Proceedings of the Public Seminar on Workplace Safety*, Report No. 4, 12 March 1997, pp 4-10
[27] Parliament of New South Wales, Legislative Council, Standing Committee on Law & Justice, *Report on the Inquiry into Workplace Safety: Interim Report*, Report No. 8, 22 December 1997; Parliament of New South Wales, Legislative Council, Standing Committee on Law & Justice, *Final Report of the Inquiry into Workplace Safety*, Report No. 10, 26 November 1998
[28] Parliament of New South Wales, Legislative Council, 26 May 2000, p 5937, Second Reading of Occupational Health and Safety Bill

Those model laws had specified the functions of the regulator, and accordingly section 152 of the 2011 Act provided that WorkCover had the following functions:

> *(a) to advise and make recommendations to the Minister and report on the operation and effectiveness of this Act,*
> *(b) to monitor and enforce compliance with this Act,*
> *(c) to provide advice and information on work health and safety to duty holders under this Act and to the community,*
> *(d) to collect, analyse and publish statistics relating to work health and safety,*
> *(e) to foster a co-operative, consultative relationship between duty holders and the persons to whom they owe duties and their representatives in relation to work health and safety matters,*
> *(f) to promote and support education and training on matters relating to work health and safety,*
> *(g) to engage in, promote and co-ordinate the sharing of information to achieve the object of this Act, including the sharing of information with a corresponding regulator,*
> *(h) to conduct and defend proceedings under this Act before a court or tribunal,*
> *(i) any other function conferred on the regulator by this Act*.

44. Under section 11 of the *Safety, Return to Work and Support Board Act 2012*, the NSW Legislative Council's Standing Committee on Law and Justice was designated as the Legislative Council committee to supervise the exercise of WorkCover's functions. This resulted in a review of WorkCover in 2014,[29] which recommended that consideration be given to establishing a separate agency or other administrative arrangements to clearly separate the roles of regulator and nominal insurer in the workers compensation scheme. The Review also considered WorkCover's multiple roles in the work health and safety sphere, noting that WorkCover acted as both the work health and safety regulator and as an advisor to workplaces. The Review commented that:

> *While synergies can be achieved in having a single organisation perform both regulatory and advisory roles in the work health and safety sphere, clear protocols must exist to minimise the possibility of conflicts of interest occurring.*

[29] NSW Legislative Council Standing Committee on Law and Justice, *Review of the exercise of the functions of the WorkCover Authority*, Report 54, 17 September 2014

> *The committee therefore recommends that WorkCover, in consultation with key stakeholders, review the procedures currently utilised to distinguish between the two functions and implement protocols to minimise conflicts occurring*.[30]

45. This separation was achieved in 2015, when WorkCover was abolished and replaced by three new agencies: SafeWork NSW, Insurance and Care NSW (**iCare**) and the State Insurance Regulatory Authority (SIRA). Under the *State Insurance and Care Governance Act 2015*, WorkCover's functions as the regulator under the 2011 Act were transferred to SafeWork. In his Second Reading speech of the Workers Compensation Amendment Bill 2015 and the State Insurance and Care Governance Bill 2015, the Hon Dominic Perrottet MP, then Minister for Finance, Services and Property, noted that WorkCover had already implemented an operational separation of its regulatory and insurance activities but with the creation of the three new entities, Safework would be "*an independent work health and safety regulator*".[31] He said:

> *Finally, the role of WorkCover in enforcing work health and safety legislation will be transferred to a separate statutory regulator, which will be called SafeWork NSW. The relevant provisions establishing SafeWork NSW are contained in schedule 13 to the bill, by way of amendments to the Work Health and Safety Act 2011. SafeWork NSW will focus on harm prevention and improving the safety culture in New South Wales workplaces. It will also include the establishment of a centre of excellence for work, health and safety in New South Wales. The new structure will be more transparent and accountable and, most importantly, lead to better outcomes for injured workers. There will be no job loss as a result of these improvements. The head office of WorkCover in Gosford and other regional offices will not be relocated as part of these changes. Staff moving to SafeWork NSW and SIRA will remain in the public service under the Government Sector Employment Act 2013 and in the Department of Finance, Services and Innovation. Their existing entitlements will be maintained.*

[30] NSW Legislative Council Standing Committee on Law and Justice, *Review of the exercise of the functions of the WorkCover Authority*, Report 54, 17 September 2014, p xii; see also para 3.56 and recommendation 3, p 32
[31] Parliament of New South Wales, Legislative Assembly, 5 August 2015, Second Reading of Workers Compensation Amendment Bill 2015 and State Insurance and Care Governance Bill 2015

46. As a consequence of the 2015 changes, the regulator became the Secretary of the Department of Finance, Services and Innovation, to be known as SafeWork NSW.[32] The 2015 Act provided that SafeWork was subject to the control and direction of the Minister except in relation to the contents of any advice, report or recommendation given to the Minister, any decision that relates to proceedings for offences under the 2011 Act, or any decision that relates to a work health and safety undertaking.

47. SafeWork was first housed within the "*Regulation Division*" of the Department of Finance, Services and Innovation and, from March 2019, within the "*Better Regulation Division*" (**BRD**), as the division became known.

48. The Department of Finance, Services and Innovation was abolished on 1 July 2019.[33] SafeWork was transferred to the newly formed Department of Customer Service **DCS**, remaining within BRD. DCS was formally designated "*the regulator*" under the 2011 Act from 13 January 2023.[34] As previously with the Department of Finance, Services and Innovation, the Secretary of DCS is, as the regulator under the 2011 Act, to be known as SafeWork NSW.

5.2 Recent changes to SafeWork and second Interim Report

49. On 29 September 2023 I provided a second Interim Report to the Minister. The second Interim Report was not required under my Terms of Reference but was a response to developments arising from a functional review undertaken by DCS of the structure and governance of SafeWork, and in particular a document which I had received proposing a possible future restructuring of SafeWork. The restructuring proposed for consideration in that document involved breaking out from the BRD three of the regulators that were then comprised within it, including SafeWork, and situating them as independent agencies within, and reporting to the Secretary of, DCS.

50. In light of those developments, in my second Interim Report I sought an instruction from the Minister as to whether I was to continue with my Review, or whether the date for finalisation of the Review should be extended for sufficient time to enable

[32] In relation to matters or the exercise of a power or the performance of a function concerning a mining workplace, the regulator under the *Work Health and Safety (Mines) Act 2013*
[33] *Administrative Arrangements (Administrative Changes – Public Service Agencies) Order 2019*
[34] *Statute Law (Miscellaneous Provisions) Act (No 2) 2002*, sch 3 [3.69]

submissions to be made as to and consideration of the operation of whatever new structure may be put in place.

51. On 16 October 2023 the Minister confirmed that she wished me to continue with the remainder of my Review. The Minister stated that in her view I need not consider the recent developments, including the appointment of an Acting Deputy Secretary. She described the restructure which was underway as "*an interim measure to bring all SafeWork NSW staff together as one distinct function in BRD*"…"*the necessary interim step of pulling the SafeWork NSW functions back together*" and "*an interim or temporary measure to accommodate the larger context of operational changes to the Better Regulation Division*".

52. The Minister stated that it would be particularly useful to have my views on the appropriate future structure and governance of SafeWork. I address these matters further in Section 9.

53. I note that a restructuring consistent with the proposal outlined at [49] above was implemented with effect from 1 December 2023, after I had completed the draft of this Report. I address this in Section 9 below.

54. Following confirmation from the Minister that I was to continue with the remainder of my Review, on 20 October 2023 I requested an additional two weeks in which to deliver my Final Report. This was necessitated by delay in appointing external consultants to provide advice on three specific matters relevant to my Review.

55. On 31 October 2023 the Minister formally confirmed her agreement to the requested extension of time, to 15 December 2023, for submission of my Final Report.

5.3 Limitation on matters covered by this Report

56. I should make it clear that my Review did not extend to the gig economy. That is not because it is unimportant, or unworthy of consideration, but because it falls outside my Terms of Reference. It is, nonetheless, an increasingly familiar and significant part of our society and economy, and one that in my view demands its own investigation.

6 Methodology

6.1 Public consultation

57. My Review Team sought submissions on matters relevant to my Terms of Reference. The call for submissions was promoted through the website of SafeWork and DCS and through social and traditional media channels. Members of the public, including of course interested organisations as well as individuals, were invited to make their submissions by mail or email. A secure mailbox was set up to receive electronic submissions.

58. The initial call for submissions was made on 2 December 2022, followed by print media notices. The call was repeated on 24 January 2023. I note that although a final date for submissions was stipulated, I was asked on several occasions to, and did, accept submissions made after (and in some cases considerably later than) that date.

59. Over 50 submissions were received from a range of individuals and organisations, including current and former SafeWork staff, the families of injured and deceased workers, unions and peak union bodies, employer groups, professional bodies and from SafeWork itself. The Review Team and I considered all submissions received, including, where applicable, the documentation, sometimes extensive, furnished in support of some submissions.

6.2 Review of documents

60. I sought and received over 3,580 documents from SafeWork, as well as documents supplied by other stakeholders.

6.3 Interviews

61. I conducted interviews with a number of those who made submissions. Those interviewed included SafeWork inspectors and staff, representatives of organisations that made submissions to the Review, families, and injured workers.

6.4 External expert reviews

62. DCS engaged Nous on my behalf to bring specific expertise and allow informed, in-depth exploration of certain topics. The topics covered by Nous' reviews were:

    a. The New Inspector Training Program (**NITP**), Health and Safety Representative (**HSR**) and Entry Permit Holder (**EPH**) training, and the training of SafeWork staff involved in performing triage functions;
    b. SafeWork's current Triaging and IDMP processes;
    c. The handling of complaints as to alleged unlawful or undesirable conduct in the workplace.

63. The reports of Nous will be published when this Report is made public.

6.5 Stakeholders' reviews of draft report

64. When this Report was finalised in draft, it was provided to SafeWork and to the DCS for comment. There were two reasons for doing so. The first was to enable those bodies to identify any errors of fact, and any conclusions which they considered were unsupported by the evidence, with a view to facilitating correction before the final report was published. The second was to enable them to comment, where appropriate, on the submissions summarised later in this Report.

65. DCS and SafeWork accepted the opportunity to make comments. They provided detailed and helpful comments on the draft. Some of those comments dealt with what were seen to be errors in submissions that I received and that are summarised later in this Report. I have not always attempted to correct those perceived errors in submissions. However, where there was said to be a clear factual error which should not stand, or where it appeared that there was an alternative view inconsistent with the submission, I have noted the comment that was made. Further, in some cases, what was said in the draft was either correct at the time it was written but superseded by later events, or reflected an apparent error in an aspect of a Nous report. I have corrected those matters to reflect the current or correct situation.

66. Several of the comments made by DCS/SafeWork related to the question of resourcing: pointing out, for example, that the implementation of a Recommendation would require further resources to be applied. The point is valid. I accept, as was put, that the allocation of resources between departments of government is a matter for the government of the day. It is not something in

which I can or should seek to interfere. However, my task is to undertake the inquiry required by my Terms of Reference, including to make recommendations as to the four specified topics. My intention has been to make recommendations that will strengthen SafeWork and enable it to function more effectively in its role of workplace health and safety regulator. Whether it needs, and if it does should be given, further resources to enable it to implement any of my Recommendations is, as I have said, a matter for the government of the day.

67. The third significant set of comments made by DCS/SafeWork relates to the structure that should be adopted in relation to the governance and culture of SafeWork (the third of the topics covered by my Terms of Reference). I had proposed that SafeWork be reconstituted as a state-owned corporation. The comment from DCS/SafeWork suggested that I should consider, instead, the reconstitution of SafeWork as a statutory corporation with its own primary enabling legislation, giving the example (or analogy) of the Environmental Protection Authority established under the *Protection of the Environment Administration Act 1991* (NSW).

7 Terms of Reference Part 1: The performance and effectiveness of SafeWork's compliance and enforcement functions

7.1 Triaging

68. I received many submissions commenting on SafeWork's triage system and expressing concern and frustration about its effectiveness.

69. Triage is, in summary, the assessment of matters that come to SafeWork's attention to determine the appropriate response. Such matters may come by notification of incidents by persons conducting a business or undertaking (**PCBU**), or by requests or referrals of matters by others (for example, workers, HSRs, unions, or members of the public). The response may be, for example, that an inspector should attend the site; that a so-called "*administrative response*" is appropriate (whereby a letter is sent to the PCBU); that the matter should be referred to another regulator; or that no enforcement action is appropriate (for example if the matter is not covered by the relevant legislation or there is insufficient information to enable triage to occur).

70. A number of inspectors said in their submissions that the triage process was too heavily slanted towards issuing an administrative response, even where a PCBU had clearly contravened legislation or where the matter involved a serious or dangerous incident, and an inspector response was warranted. An inspector said that triaging is "*ineffective, as often the officers that are triaging do not understand the WHS regulatory space and will file [requests for service] as a non-inspector response where there should have been an inspector response…I fear there will be a death caused by this type of triaging process one day*". Another inspector submitted that SafeWork was "*fixated on issuing advisory letters to businesses that clearly contravened the legislation. [SafeWork] held [a] view of 'self-regulation' by businesses by triaging legitimate complaints and serious/dangerous incidents to a letter response…The process was also heavily slanted to issuing advisory letters for clear contraventions*". Another inspector said that the triaging system "*frequently does not operate in alignment with its documented procedures…What really happens is a quick seat-of the pants decision…*"

71. According to the NSW Nurses and Midwives Association (**NSWNMA**):

> *The triaging process is not clearly understood or explained to workers contacting SafeWork NSW and matters posing a serious risk are inappropriately triaged for an administrative response when they should have been allocated to an inspector.*

72. Some submissions expressed concern that as well as being inappropriate, administrative response letters were frequently not received by the PCBU, and could not be proved by SafeWork to have been sent. Others made the point that in their view, there was ineffective action taken both by the PCBU and by SafeWork to follow up (including an overly narrow approach to "*verification*" rather than looking at a PCBU's compliance more broadly). One inspector submitted that "*[m]atters triaged to an advisory letter had limited follow up*", and that in his experience on most occasions, "*either the PCBU was not aware of the letter, or the workplace, notably construction, had moved on*". Further, the administrative response left workers without any information or feedback as to the resolution of their concerns.

73. Particular concern was expressed about the triaging of bullying matters and other psychosocial hazards, the triaging of matters relating to government agencies and the triaging of right of entry matters. In respect of that last category, the Electrical Trade Union (NSW Branch) (**ETU**) and the Construction, Forestry Maritime Mining and Energy Union (**CFMEU**) submitted that there was frequently delay.

74. Submissions expressed concern about the accessibility and ease of use the SafeWork phone line (announced as "*Customer Experience*") and website. Respondents suggested that the phone line is confusing and off-putting. According to the NSWNMA:

> *The [phone line] menu options are confusing and do not clearly signpost options for workers.*
>
> *There is nothing in the recorded message that clearly indicates to workers or their representative that this is an organisation that exists to ensure workers are safe and that calls from workers or their representatives about workplace health and safety concerns are a priority to the organisation.*

75. This was said to be a problem for, in particular, workers from culturally and linguistically diverse backgrounds.

76. The NSWNMA submitted, in relation to the website, that:

> *It is difficult to find information about the triaging system on the SafeWork website and requires searching through multiple lengthy documents…*
>
> *…Further searches of the SafeWork NSW website to find out what the triage process is are burdensome and unlikely to be undertaken by workers, particularly workers in distress or with language or literacy issues.*

77. Unions NSW submitted that the website is "*complex and almost impossible to navigate at times*", and that the contact number "*does not provide clear triaging for those not familiar with it*".

78. The Shop, Distributive and Allied Employees Association (**SDA**) said that many workers in its industry would prefer to speak to experienced staff directly about the complex issues facing them (which were often complex psychosocial issues), but that there is an absence of clear avenues to do this, with most complainants being encouraged to voice their concerns through the Speak Up app or the SafeWork website. This was echoed by a SafeWork staff member who said that the triage of psychosocial matters "*is difficult*" and "*relies on an online form managed by a small number of staff*".

79. Some respondents submitted that SafeWork's staff do not appear to have adequate skills, experience, knowledge and training to carry out the triage function effectively, and queried whether those responsible for triaging calls had knowledge across different industries. By contrast, it was said, when callers rang SafeWork's predecessor, WorkCover, they were able to speak to a trained inspector.

80. An inspector submitted that the practice of having staff other than inspectors deciding which complaints would receive an inspector visit and sending letters to PCBUs undermined confidence in the regulator. Inspectors reported that the customer contact centre staff (or, as DCS/SafeWork indicated it should be called, the SafeWork Advisory Service or SWAS) taking calls do not hold an inspector's authority, do not undertake visits to sites, and have not been extensively trained in the relevant legislation, yet are tasked with assessing complaints and providing guidance and advice to callers.

81. Unions and other respondents stated that they had to call an inspector directly to get intervention after receiving an inadequate response from the call centre (SWAS); that sites were released prematurely; and that callers were redirected

back to their own workplaces to resolve issues. Inspectors also reported that customer contact centre staff *"will tell a worker who is ringing to make a [request for service] that before the matter can be accepted, they must go away and try to resolve issues in the workplace before SafeWork would take their complaint. This is entirely inappropriate and indeed may place vulnerable people at significant risk. There is nothing in the legislation that details a requirement for a worker to have attempted to resolve a matter before SafeWork will take the matter up*".

82. The ETU referred to "*a divergence of decisions in matters that have substantially the same background facts*". The NSWNMA said that its members reported "*sending requests for service through to the regulator, including their contact details, and [hearing] nothing further*". It also reported its experience that many high-risk issues are triaged for an administrative response.

83. Some submissions reported delays in sending inspectors and getting on site following triage. In the CFMEU's view, this amounted to incidents being "*notifiable but not worthy of a visit*", with SafeWork attending fewer and fewer notifiable incidents. Others noted that there could be difficulty in getting information about when an inspector might turn up on site.

84. Some respondents expressed concern that the initial interview and triage takes too long when what is needed is an urgent on-site attendance (for example where on-site dry cutting is reported). It was submitted by the Asbestos Diseases Foundation of Australia that "*[o]n one view the triage process is so detailed it deters complainants from following through with the process.*"

85. The SDA submitted: "*We believe SafeWork's performance is hindered by the difficulties for workers to report incidents both online and on the phone. Workers should be able to easily make complaints directly to SafeWork NSW and to receive proper information and assistance from a properly trained person when required, including by an inspector if necessary.*"

7.1 Investigation Decision Making Panel

86. I received many submissions commenting on SafeWork's IDMP.

87. In summary, the role of the IDMP is to consider whether a matter will proceed to investigation. Among the decisions that may be made by the IDMP are: to refer a matter for investigation; to refer a matter back for further information; or indeed not to accept a recommendation for investigation. The IDMP may also consider

responses in place of or in addition to a full investigation (for example education of or other engagement with a PCBU). It is intended that the IDMP's decision will lead to a proportionate response to the level of risk and/or alleged non-compliance, will promote consistency, and will ensure that investigation decisions are transparent and those who make the decisions are accountable for them.

88. The submissions covered topics including lack of work health and safety knowledge on the part of members of the IDMP, inconsistent and subjective approaches to similar incidents, and managers making changes to inspectors' submissions to IDMP without consultation with or feedback to inspector.

89. One inspector made the point that the IDMP decision focused on whether to prosecute at a stage when that was premature given the often limited gathering of evidence at the time of submission to IDMP. An alternative view was that the IDMP does not make an assessment of individual proofs required for a successful prosecution, but rather relies on general descriptions of the incidents, the PCBU's history, and the consequences of the incident (i.e., injury). Concern was expressed about the assessment of matters by the IDMP being influenced by the capacity of the investigations team at any given time, rather than the merits.

90. One respondent submitted that the current system is too centralised and advocated decentralisation of investigations within the regulator.

7.2 Investigations and prosecutions

91. Some submissions commented on the existence of a separate investigations team, which some respondents perceived to be a "*silo*", resulting in a lack of investigation skills in the inspectorate. An inspector said that there was a need for the inspectorate to be "*skilled up*" to do investigations leading to a proper outcome based on evidence. Another inspector described the team as "*a specialist team that bottlenecks investigations*" and observed that investigative skills are no longer transferred and preserved among the wider inspectorate. Another inspector said that "*[o]nce Inspectors enjoyed doing a full gambit [*sic*] of work including investigations but these are now done by an investigation Team, which has complicated the process to the point that some Inspectors in that team now want out and do not enjoy the work, because they feel that they are overwhelmed with paperwork*".

92. The comments from DCS/SafeWork put a different view. They stated:

> *The resourcing capacity of the investigations teams is not a primary factor in determining whether matters are accepted for full investigation. A capacity update is provided at each IDMP meeting, however when resourcing is at capacity the investigation teams seek assistance from other Directorates to manage workload as required. This is currently evidenced by the fact there are two regional Inspectors and two RCEU Inspectors undertaking investigations under the management and oversight of the investigation team Managers.*
>
> *SafeWork provides an ongoing opportunity for Inspectors to rotate into the investigation team to build their capability and not become "siloed" in their role. SWNSW has recently introduced its approach to use prosecutions in the Local Court more frequently for noncompliance with notices. We are seeing a gradual upwards trend in terms of the number of charges commenced in either the Local or District Court. However, there are limitations on the allocation of resources in the investigations team and in the legal team which restricts any significant increase the number of investigations and prosecutions and any reductions in the time taken for enforcement decisions to be made. Resourcing would need to be increased to expand the number of matters and to reduce the time taken to complete investigations and prosecutions.*

93. An inspector submitted that the omission of the first responding inspector from the investigation team meant that "*first responders have little self interest in recording all of the facts and preserving items from an incident scene that may be relevant*", and that the inspector who took over the matter would "*weeks later [have] to reconstruct the scene not knowing what information may have become irretrievable. In earlier times the first responding inspector usually took full carriage of a file from start to finish*". The submission stated that "*[t]he case management process does not allow the investigating inspector to have control of significant decisions about the course of an investigation.*"

94. Some respondents expressed a concern that the assessment of matters was influenced by the capacity of the investigations team at any given time, rather than by the merits. Concern was also expressed that the investigations team uses the maximum allowable time to investigate a matter.

95. Some respondents submitted that they were not confident that SafeWork has a sufficient focus on prosecutions. They attributed this to either a lack of resources or a lack of willingness, or an emphasis on education at the expense of prosecutions. In relation to that last point, Unions NSW submitted that:

> *The emphasis on the education of [PCBUs] has resulted in a noticeable shift away from prosecutions and quick responses to complaints and incidents.*

96. Concern was expressed about SafeWork pursuing very few prosecutions, such that PCBUs no longer had much fear of prosecution. Respondents observed that the number of prosecutions appeared very low in proportion to the number of complaints. Inspectors commented that there was sometimes a reluctance to prosecute challenging matters and a reluctance to take on individuals or directors or untested situations. One organisation submitted that there should be a separation of the prosecutorial service from SafeWork's broader regulatory functions.

97. Particular concerns were raised about the lack of prosecutions of health agencies for work health and safety matters. It was suggested that SafeWork focuses on "*blue collar*" industries such as construction, but did not focus sufficiently on other high risk industries including healthcare. In the NSWNMA's view, SafeWork needs to give priority to target particular industries and hazards, and serious injury types and failures.

98. Families of injured and deceased workers also raised concerns about prosecution decisions in the cases concerning their loved ones.

99. Submissions also commented that charges are laid in the District Court only, not Local Court, and that it is mostly small businesses that are prosecuted. DCS/SafeWork stated in their comments on the draft report that this submission was factually incorrect in that "*SWNSW regularly commences proceedings in the Local and District Court".*

7.3 Government agencies and departments

100. Concern about SafeWork's approach to enforcement of work health and safety matters within government agencies and other government departments was a consistent and striking theme in submissions to my Review. This is in some ways linked to the issue of SafeWork's structure and governance, which I address in Section 9 below. It seems likely that SafeWork's immediately previous structure, as

a regulatory agency grouped with others within the BRD of DCS, may have been responsible to some extent for the perception that SafeWork is not a robust regulator of other parts of government. But given the number of submissions which raised this issue, and the range of government agencies in respect of which concern was expressed (which was not confined to government departments but extended to other bodies), I do not feel able to attribute it to this alone.

101. Respondents expressed concern that SafeWork *"seem[s] to go easy on government agencies"*. One respondent felt this indicated "*regulatory capture*" on the part of SafeWork. Another described "*reluctance*" to deal with government agencies. A number of respondents expressed specific concern about the system of having a "*portfolio manager*" or "*government sector team*" for government departments or other agencies, which was perceived to create a "*cosy*" relationship resulting in a lack of action, of matters not being looked into or addressed, and a "*soft approach*" to inspecting and investigating NSW government agencies for breaches of workplace health and safety legislation.

102. One respondent referred to "*the need for transparency around incidents reported, investigated and penalised within NSW Government Agencies by SafeWork NSW*" when compared with those within private organisations and industries. An inspector described what they perceived as "*the lack of transparency by [SafeWork] in their decision making, especially in relation to other Government Agencies*". Another submission expressed concern that the approach to government agencies leaves workers exposed*"*. In the words of one respondent, there is an "*abject failure*" to prosecute other government agencies. The NSWNMA stated that "*workers employed by government agencies are entitled to expect the same rights to a safe and healthy workplace as any other workers*" and expressed its concern that "*[p]ublic sector employers are not subject to the same regulatory activity as other sectors despite the large numbers of serious injuries sustained by public sector workers*".

103. I received a number of submissions that questioned decision-making in relation to particular incidents concerning government agencies. My Terms of Reference do not permit me to make determinations regarding the specific examples given. It is, nonetheless, concerning that respondents including current and former staff of SafeWork imputed to SafeWork what might be called an excessively light ("timorous" might be a better word) regulatory touch to SafeWork's investigation of complaints concerning other Government departments and agencies.

104. The comments from DCS/SafeWork stated, as to the approach taken by SafeWork to complaints involving government departments:

> *When incidents and complaints are triaged for an Inspector response, the relevant operational area of SWNSW initially manages them. Matters involving government departments can be complex, especially in cases of psychological risks, requiring a detailed line of inquiry to determine if a breach has occurred. Some matters are referred for full investigation, which are managed by SWNSW's specialist investigations team.*
>
> *SWNSW has obligations to comply with Prosecution Guidelines and the Premier's Memorandum process before initiating proceedings against any government entity. The Regulatory Practice Oversight Committee is reviewing SWNSW's current arrangements for "portfolio managers" across multiple government departments.*
>
> *SWNSW has provided evidence of investigation and prosecution matters in relation to Government agencies....*
>
> *SWNSW must establish evidence of a potential breach before progressing to a full investigation. Inspectors conduct initial inquiries through records of interview or issuing notices to the responsible party. Once a matter reaches full investigation, further inquiries are made to ensure admissible evidence and establish the elements of an offense beyond reasonable doubt.*

105. SafeWork provided some confidential material as part of this submission. I have omitted the reference to it, and have not referred to or reproduced the material to which SafeWork referred.

7.4 Psychosocial health and safety

106. A number of submissions commented on SafeWork's approach to psychosocial health and safety matters.

107. Although psychological safety is one of SafeWork's regulatory priorities for 2023, which aims to "*reduce the prevalence of psychological injury at workplaces, with a focus on mental health and wellbeing*", both individuals and unions expressed concern that SafeWork did not deal adequately with psychological work health and safety.

108. The SDA submitted that "*gaps in deep industry understanding mean SafeWork inspectors may not be conscious during visits to many 'invisible' hazards, particularly psychosocial hazards like workload*". The SDA urged the reinstatement of industry forums to develop understanding of these hazards.

109. The NSWNMA stated that SafeWork "*is failing to address emerging harms such as psychosocial harms and violence and aggression*". Further, it said:

> *Despite psychological injuries being identified as a priority hazard in both the National WHS strategy and in the SafeWork NSW roadmap due to rising claims and increased burden of disease, the processes for workers to report psychosocial matter to the regulator are unnecessarily arduous and appear designed to discourage reporting of these matters…*
>
> *The complex approach to psychosocial matters on the SafeWork NSW website and through the Customer Service Centre, appears designed to limit reporting of these matters to the regulator. This is a significant concern…given the large increases in psychological injuries as demonstrated by the SIRA data.*

110. The NSWNMA also expressed concern that SafeWork imposes an extra layer of review, or two-tier approach, in addition to the IDMP process, to determining whether psychological hazards will be investigated. A SafeWork staff member said, about the additional triage process for psychosocial matters:

> *What this does result in less workplace visits and notices for psychosocial hazards...there is competition for an inspector's attention with other matters seen as life and death and therefore seen as a priority over psychosocial hazards.*

111. An inspector said that triaging and investigation of bullying matters was of significant concern, with matters mostly dealt with by an advisory letter on the basis that the complainant had not followed internal (to their workplace) procedures. This was seen to be inappropriate given the vulnerability of people reporting bullying matters, and risked deterring complaints of bullying. The submission stated that "*reports of workplace bullying require a more determined response*" from SafeWork, including a willingness properly to investigate such matters and a willingness to review PCBUs' investigations into workplace bullying allegations. Inspectors also expressed concern that workers were sent away to deal with matters before SafeWork would step in, and that those reporting bullying were

required to take comprehensive steps before the matter would be accepted for triaging.

112. An inspector said that the long lead times of mental and substance-induced harms causes them to be given relatively little allocation of inspectors' time. A staff member submitted that "*psychosocial matters need more proactive attention to build capability and educate duty holders about legal requirements. Due to the work demands across the teams there are few proactive and educational activities for psychosocial hazards*".

113. The impact on the inspectorate of dealing with psychosocial hazards was another topic of comment. One staff member said that:

> *These matters are difficult for inspectors. They take longer. It is not a matter of taking photos and forming a reasonable belief. Large amounts of information need to be requested and amassed…These matters are particularly tough and inspectors are not able to cope with them constantly*.

114. The submission stated that "*the need for specialist psychosocial inspectors has never been greater*".

115. As to this topic, DCS/SafeWork stated in their comments:

> *NSW was the first jurisdiction in Australia to introduce the Code of Practice for Managing Psychosocial Hazards which commenced on 28 May 2021 and the first to implement specific regulations for managing psychosocial hazards and risk.*
>
> *Psychosocial matters have increased disproportionately to resources overtime, the referral form and triage process are designed to ensure matters with the greatest need and most alignment to WHS jurisdiction are prioritised.*

116. The matters referred to in paragraphs [112] and [113] may go at least part of the way to explain concerns expressed in some submissions about a lack of prosecutions that relate to psychosocial hazards, despite it being the area with the largest increase in claims. The NSWNMA urged that prosecutions must address new and emerging hazards, including psychosocial hazards.

117. Submissions from the families of injured and deceased workers also expressed concern about SafeWork's response to psychological injury. I also received a

submission from an individual who lodged a bullying complaint with SafeWork and felt there was a lack of support and direction in response.

7.5 Enforceable undertakings

118. A number of submissions commented on SafeWork's use of EUs. Inspectors expressed concern about their use and enforcement. There were essentially two, not entirely compatible, themes. One group of submissions took the view that SafeWork made excessive use of EUs. Thus, one inspector commented that EUs are used too much. The other theme did not so much perceive this to be a problem, as the failure to monitor compliance.

119. An inspector described a lack of enforcement of EUs, which was said not to be a process which verifies that the matters which the PCBU undertakes to do under the EU are in fact done. There was said to be a lack of independent verification of EUs. Concern was expressed that it is the "*big players*" who are able to propose enforceable undertakings, as they have the financial resources to commit to them, but these same financial resources could have been used to ensure safety in the first instance. The CFMEU expressed concern that EUs are not effective in changing the way PCBUs approach safety. The CFMEU perceived this as a particular problem in the case of small subcontractors, who are a notoriously malleable group of employees whose ownership structures and addresses change frequently, making any EUs given by them no more than writ on water.

120. As to this, the comments from DCS/SafeWork stated:

> *SWNSW completes regular periodic evaluations of its enforceable undertaking program to ensure it continues to meet the intention of the legislation and expectations of key stakeholders. The most recent evaluation was completed in 2020 and is published on our website. The evaluation found 94% of businesses who had completed an enforceable undertaking stated it led to long term changes in their business and improvements in their WHS culture.*
>
> *The Response Coordination and Enforceable Undertakings Verifications Team (RCEU Team) verify every strategy and terms agreed to an Enforceable Undertakings (EU). An EU is not discharged until every element of the strategy has been delivered.*

121. Family members and injured workers also expressed concern about the use of EUs, and expressed a strong desire to have input into EUs. One family member said

that "*SafeWork will waste time on EUs that to which [*sic*] semi-bankrupt companies have no means of complying*".

122. In a similar vein, an injured worker submitted:

> *We should have input to programs that are a part of an EU. As I found what was funded from the EU was not effective in changing people's way of looking at working safely…I believe if the injured workers and or families had the opportunity to review what has been agreed to, but before finalisation, the outcomes of an EU could be more relevant and effective. On the plus side, the advantage of families and workers have the change to make a positive input thus feeling validated and heard.*

7.6 Systems and data

123. Inspectors expressed frustration with SafeWork's systems, in particular the "WSMS" system. It was submitted that the system is archaic, tired, overly time-consuming and a poor system for operational information, that it is not fit for purpose and was not designed in such a way as to improve work health and safety outcomes.

124. I was told that within WSMS, business sites are listed separately, so that it is difficult to get an overall picture of the PCBU's history and compliance record. Thus, there will be a separate listing for each location at which, say, a building contractor is from time to time undertaking a project. The comments from DCS/SafeWork stated that there was functionality to record ARBNs within WSMS, and that if this were done, it would be possible to correlate and cross-check reports.

125. An inspector said of WSMS that it requires multiple entries for the same information (for example, for the same visit and the same business). It was further suggested that the resulting multiple entries create a misleading impression of the number of workplace visits or "*contacts*" that have been made. For example, when a visit is made to one construction site for one reported incident, the presence on that site of multiple sub-contractors, each of whom is a distinct PCBU, will result in the system's recording multiple visits. An inspector said that this makes it appear that SafeWork has made more site visits than was in fact the case. Given SafeWork's presentation of statistics about workplace visits and "*other reactive interventions*" in its annual reports, presumably as a measure or indicator

of performance, this issue goes beyond effective administration and operational systems. It would seem to facilitate the creation and publication of data that, at least potentially, could mislead.

126. Respondents expressed concern about the failure to use workers' compensation data effectively to inform SafeWork about at-risk workers, and PCBUs that may not be complying with their work health and safety obligations. One inspector said that there is no one place to locate workers' compensation data and licensing data and that it was difficult to search for an address. Another inspector reported that good data was not available to allow identification of problem areas or industries. Respondents also expressed frustration that there was not a proactive approach, including the use of internal and external databases to identify problem areas.

127. The comments from DCS/SafeWork stated that section 243(2)(a) WIM Act provided that the State Insurance Regulatory Authority (SIRA) could disclose to SafeWork information held by SIRA obtained under the workers compensation legislation regime. Thus, it was said, "*[i]t is not clear that there is a legal statutory impediment to the sharing of information, and any issues may be more operational in nature. However, the matter can be given further consideration".*

128. Submissions expressed a concern that administrative response letters had been sent to PCBUs without being recorded in the WSMS system, thereby masking the true compliance history of a PCBU and impeding effective follow-up and enforcement, particularly of "*recidivist*" PCBUs. The knock-on effect of this may be that the PCBU is not flagged for an inspector field visit response and is not included in project work and other industry focus initiatives that seek to address persistent non-compliance.

7.7 Nous Group's Triage and IDMP Report

129. As I have mentioned earlier, DCS engaged Nous to prepare three reports to assist me in this Review. The work to be done by Nous had been agreed with me before the engagement. One such report, dealt with the triage and IDMP processes. I summarise Nous' approach to its work, the findings made, and the recommendations (which Nous called "*improvement opportunities*"), in this section of my Report.

130. Nous considered the triage and IDMP processes separately. The questions that Nous set out to answer were:

> *Are SafeWork NSW's current Triage and IDMP processes and associated procedures effective? How can they be improved?*

131. In each case, the methodology adopted started with the development of an analytical framework for each of those processes. Nous then assessed the performance of those processes against that analytical framework. The matters considered in the analytical framework included the development of good practice principles for each process. Those principles were benchmarked against relevant legislative requirements and against policy documents emanating both from SafeWork Australia (responsible for the implementation and coordination nation-wide of uniform work health and safety policies and procedures) and from SafeWork itself.

132. My Review Team provided Nous with a thematic summary of issues raised in, and relevant anonymised extracts from, submissions related to the triage and IDMP processes. Nous reviewed that material to understand the perceived problems with the operation of those processes. It then conducted interviews with SafeWork staff at various levels (director, manager and inspector). It collated, with the assistance of SafeWork, a complete set of the documentation for each process, and analysed that documentation against the good practice principles that had been identified.

133. As part of its work, Nous examined specific triage and IDMP files (appropriately anonymised where necessary) to review the extent to which the work practices revealed by those files were consistent with the good practice principles that had been identified.

134. Finally, Nous identified areas of weakness and areas for potential improvement in each of the processes and formulated what it called "*improvement opportunities*", and I shall call "*recommendations*", to address those matters.

135. Starting with triage, Nous concluded that SafeWork had established an effective and well documented triage process. It gave a clear and detailed explanation of the reasons supporting that conclusion. Since the report in question will be made available upon the publication of this Report, I shall not repeat in this Report the full detail of what Nous said in its report. I should however note that I have given the Nous report detailed and careful consideration, and have concluded that it

represents a thorough analytical and investigative approach to the analysis of the triage and IDMP processes, and that the reasoning underlying the conclusions is clear and persuasive. I am confident that I can rely upon the conclusions reached by Nous and adopt the substance of the recommendations that it made. I add, to avoid repetition, that I took the same approach to my review of, and reached substantially similar conclusions as to, the two other Nous reports that were provided for the purposes of my Review.

136. Nous identified, in relation to triage process documentation, an opportunity to review it to make it both more fit for the training of new staff and easier for triage staff, once trained, to use.

137. Next, Nous concluded that the triage approach developed by SafeWork was properly aligned to relevant legislative and policy requirements. However, Nous identified that regulatory priorities could be better embedded into the triage process and made a recommendation accordingly.

138. Nous' review of the operation of the triage process in practice concluded that there was broad alignment with good practice, although with room for improvement. That was so, Nous thought, because there could be greater consistency of outcomes. It derived that insight from its review of selected triage files.

139. Nous noted that there was some dissatisfaction among inspectors with the outcome of the triage process in particular cases. That observation is consistent with what I have said above when summarising submissions made by inspectors.

140. Next, Nous concluded that there was insufficient oversight of the quality of the decision-making in the triage process. Nous pointed to the lack of any formal review process, and noted that such informal oversight process as existed was not clearly documented and was not always applied. That forms the basis for the third recommendation made by Nous.

141. Nous identified that the work of the triage teams could be better supported. It stated that this could be done both through improving their organisational structure and by improving training. As to the first of those matters, Nous noted that triage "*is performed by three distinct groups within two teams*". That, Nous concluded, created some difficulties for the work of the triage teams and individuals within them. Accordingly, it recommended consolidation of both teams

(two of which were located within one directorate and one of which was located within another), and their location within one directorate.

142. Nous's comments on improved training overlaps with observations made in its separate report reviewing training at SafeWork, and I shall return to this in considering the second of my terms of reference.

143. As I have noted above, Nous made a number of recommendations in relation to SafeWork's triage functions. I set out those recommendations:

Recommendation		Details
1.	**Ensure triage documentation is more user friendly**	Materials outlining the triage process should be updated to ensure they can be more easily used and understood by staff who perform triage related activities. This will allow SafeWork NSW triage staff to be better placed in periods of turnover and help staff make consistent decisions that are in line with legislative and policy standards. In particular: • SafeWork NSW should develop introductory materials to support new staff to understand triage approaches. This could include summary guidance and simplified process documents to support the practice of new starters. • SafeWork NSW should update current documents to include simple and clear signposting for how to the documents should be read and used. This should include sequencing guidance and 'quick reference' guides. • SafeWork NSW should establish checklists and procedure documents for triage. These should be designed so that triage staff can ensure they have completed all required steps in the triage process. These should also be formatted to enable easy and effective review of triage processes by third parties within SafeWork NSW but not directly involved in the triage process.

Recommendation		Details
2.	**Better embed SafeWork NSW's regulatory priorities into the triage process each year**	SafeWork NSW should regularly revisit its triage process to ensure it aligns with and supports the organisation's regulatory priorities. This will help to ensure triage decisions are made in line with the direction of SafeWork NSW, and best respond to SafeWork NSW's regulatory goals and objectives. Once aligned, tools and systems should be updated yearly to embed the regulatory priorities into the triage process. This may look like: • Triage process documents, guidelines and templates updated to better align triage practices to intended regulatory outcomes, ensuring a targeted approach is taken. This could include guidance on how to identify vulnerable cohorts, priority matters being referred straight to inspector response or administration response letters being pre-drafted for priority matters providing detailed education for a person conducting a business or undertaking (PCBU). • Systems, including the Workplace Services Management System (WSMS), should continue to be updated to ensure they support and enable the integration of regulatory priorities into the triage process. SafeWork NSW must communicate these changes effectively to staff who perform triage related activities, so they are able to follow the new processes and are explicitly aware of what the organisation's goals and objectives are. This is critical as SafeWork NSW's priorities change year on year.
3.	**Formalise the oversight and review of triage decisions, as well as responses to challenges and issues identified as part of that review and oversight process**	SafeWork NSW should formalise the oversight and review of triage decisions and make process improvements from these insights. In doing so, SafeWork NSW will align with best practice to ensure accountability of decisions and foster a culture of continuous improvement. To ensure that processes are being followed, SafeWork NSW should more clearly outline what reporting is expected of senior team

Recommendation		Details
		members and managers, how often it should be completed and to what degree of detail. Specific improvements could include: • Establishing a clear set of criteria against which triage decisions can be tested and assessed. • Developing a sampling approach and process that can be used to select triage decisions for review – this should include triage decisions at all levels, including decisions triaged for administrative action. • Putting in place appropriate procedures and controls to ensure that sample reviews occur, that the right criteria is used to assess them, that a neutral and appropriately experienced staff member conducts the review, and that relevant data is collected. • Ensuring there is a mechanism in place to 're-triage' decisions following a review. • Regularly revisiting and analysing the insights collected through this process to identify trends in triage practice and outcomes, as well as any issues that need to be responded to. Insights from these reviews should be actioned to make process improvements over time. When trends emerge from review data, managers should introduce process improvements.
4.	**Consolidate the three groups involved in triage under one directorate**	Nous recommends that all staff who perform parts of the triage function co-locate into one directorate. In practice, this would mean co-locating all staff in the SWAS team (including Contact Centre and Triage Advisor Staff) in the same directorate as the RCEU team. This will create a more streamlined function which can more readily implement process improvement. This will ensure triage staff are appropriately equipped and supported to work at their best.

Recommendation		Details
		Co-locating the triage functions will enable the teams to implement process improvements. Currently, if changes are made to the triage process, this messaging must be spread across the two teams and three groups involved in triage. Bringing staff together under one function will make the dissemination of process improvements simpler and avoid the message being diluted. Discussions between teams will be better facilitated, and may spark new improvement ideas, build a better understanding of how processes fit together or where pain points exist. This also complements the improvement opportunity made in Section 4.2 to formalise the oversight and review of triage processes and make improvements from insights. The quality of insights will improve as they will be made on the triage process as a whole, rather than in fragments. This will lead to improved overall outcomes at SafeWork NSW.
5.	**Training should be formalised to equip staff with the skills they need for effective triage**	**Note**: An improvement opportunity suggesting the formalisation of training for staff involved in triage is made in a separate report provided by Nous Group to the Independent Review. To avoid duplication, the advice outlined in that report should be followed.

144. In my view, the detailed discussion within the Nous report provides a solid foundation for the first, second, and third of those recommendations and I adopt them as **Recommendations** of this Report. As to the fourth recommendation, the case for it is argued cogently in the Nous report. However, I am somewhat concerned that there may be downsides to the consolidation that is the subject of this recommendation, and that I do not have any understanding of what they might be. There may have been a reason (other than administrative convenience, or departmental organisational priorities) for the original splitting up of the three triage teams and their location in two different directorates. I simply do not know.

145. Accordingly, whilst I see the logic underpinning the fourth recommendation, I am not persuaded that it should be adopted without qualification. Accordingly, I **Recommend** that SafeWork give careful consideration to that recommendation, with a view to adopting it if appropriate; and that if the decision, after that consideration, is not to adopt it, then the reasons for that decision be set out clearly and cogently in a document that can be made available to the staff concerned so that they may understand the reasons for their continuing dispersal.

146. The comments from DCS/SafeWork stated, as to the first five recommendations:

> *We note recommendations 1-5 having been previously identified as issues by SWNSW and a working group has been established to progress improvements. Information on this working group has been provided to NAUS [sic] consulting.*
>
> *We acknowledge that there are opportunities to improve the resourcing and management of the triage process as well as opportunities to streamline and improve the task function of triage.*

147. Those observations seem to me to confirm my decision to adopt the relevant recommendations (with the qualification as to the fourth which I have referred to above).

148. The comments from DCS/SafeWork also stated, as to the fourth recommendation:

> *Confirming that there are currently **two** groups that participate in the triage process. The SWNSW Advisory Service team and the Response Coordination and Enforceable Undertakings Verifications Team. Those two groups are now located in the same Directorate.*

149. I am unable to explain the discrepancy between this comment and the way in which Nous outlined the structure of the triage process. However, if the comment is intended to convey that the fourth recommendation has been implemented in practice, then it is unnecessary to pursue this apparent discrepancy any further.

150. The fifth recommendation relates to training, and Nous cross-refers to its report on that subject. I discuss that report in the next section of this Report. As will be seen, I consider that recommendation to be amply supported by the reasons that Nous gives in that report, and accept that it is one that I should adopt and make as a **Recommendation** of this Report.

151. I turn to Nous' consideration of the IDMP process. The mechanics of that process were explained in the Nous report as follows:

> *SafeWork NSW makes decisions about how to prioritise the most risky and/or harmful notifiable events to best utilise and respond with its full regulatory toolkit. Risky and/or harmful notifiable events are triaged as requiring response from an inspector within Compliance and Dispute Resolution (CDR). The information gathered through the inspector response informs how SafeWork NSW will respond as part of both the:*
>
> - *SIRP [the Serious Incident Review Panel]: identifying which matters should be escalated to the IDMP and in the alternate, which notices should be issued to ensure compliance amongst duty holders.*
> - *IDMP: who review, deliberate on, and decide which matters require a full investigation with a view to prosecution.*
>
> *Through this process, the IDMP process collects information to prioritise matters and respond through various compliance and enforcement tools from notices to investigation with a view to prosecute. It aims to enable SafeWork NSW to efficiently utilise limited resources to address the most important breaches of WHS legislation.*
>
> *CDR is primarily responsible for the IDMP process. Matters that are triaged as requiring an inspector response are allocated to inspectors within each Directorate of CDR. These inspectors gather information and prepare submissions for the SIRP that occur within each Directorate. The SIRP filters matters so only the most relevant are escalated to the IDMP and submissions are prepared within each CDR Directorate accordingly. Matters are reviewed by the IDMP which has seven members, one from each CDR Directorate (except Building and Construction Compliance), and one from IER. This team sits outside CDR and within the Investigations and Enforcement branch. The IDMP decides which matters progress to full investigation.*
>
> *…*
>
> *Nous understands the decision-making process based on document review and interviews with SafeWork NSW staff. The IDMP process begins when matters are allocated to directorates in the CDR and require an inspector response. Some matters are automatically accepted for full investigation and bypass the IDMP. Matters that are not eligible or admitted to the automatic*

> *acceptance route go through a SIRP that is specific to each directorate. The SIRP determines whether a matter should be submitted to the IDMP, or other enforcement or administrative actions should be taken. The IDMP decides whether a matter should proceed to 'full investigation' with a view to prosecute, against factors for decision-making. …*
>
> *…*

152. DCS/SafeWork said, in their comments, that it was not factually correct to say that "*CDR is primarily responsible for the IDMP process*", and that:

> *the Investigations, Engineering and Enforcement (IEE) team manage and are responsible for the IDMP process. CDR are the primary referrer of matters to the IDMP.*

153. The comments noted further that the recent (effective from 1 December 2023) restructuring of BRD has had the effect that some of the comments made by Nous may reflect the previous structure. That is hardly surprising, given that Nous had already undertaken the work required to complete its report well before this.

154. Having set out what it understood to be the basic mechanics of the IDMP process, Nous moved to identify and set out good practice principles for regulatory decision-making. I have reviewed those principles, and the explanation given for them. In my view, they are a well-reasoned and clearly articulated expression of the way a regulator should proceed in making decisions that have the power to affect, sometimes very significantly, members of the regulated community.

155. Although I do not propose to set out all of those principles, I do note that the last of them was that:

> *people with a stake in the process are kept informed.*

156. Nous elaborated this:

> ***External stakeholders personally affected by the decision must be sensitively and regularly engaged*** *– where appropriate, complainants or*

other stakeholders who will be personally affected by a regulatory decision should be consulted about its outcome.

157. I refer specifically to that because it ties in with an issue discussed below in Section 10 under the fourth part of my terms of reference. I add that somewhat later on in the Nous report, the point is reinforced as follows:

External stakeholders and organisation who may be affected by the decision should be briefed, if and where appropriate. Insights from stakeholder engagements have indicated that clear processes have been established for external communications, however there are still areas of miscommunication to be addressed.

158. Returning to Nous' examination of the IDMP process, the report proceeded along the way outlined above in relation to triage. Nous considered the documentation of the process. It conducted interviews with staff at various levels. It reviewed relevant details from submissions made to my review.

159. In general, Nous concluded that the IDMP processes and procedures are aligned to good practice, well documented, and supported by an appropriate range of materials. It said that staff were encouraged to work on the basis of evidence, applying risk-based principles to determine outcomes. However, Nous found, there was some inconsistency in approach, leading to inconsistency in outcomes. As Nous pointed out, that limitation had already been identified in a review of the Investigation and Decision Making Framework (**IDMF**) carried out in 2022. That inconsistency, Nous found, was both latent in different documentation of the process and evident in fact from insights provided by SafeWork's staff.

160. Nous considered that although the IDMP process documents supported consistency in decision-making and provided opportunities for improvements in that process, it would be desirable to introduce a process of quality assurance which would promote improvements.

161. Nous considered the extent to which the IDMP process aligned with legislation (i.e. the 2011 Act) and government policies. It found that alignment was a key focus of the process and that it had been very carefully established. Nous concluded, further, that the IDMP process embodied national work health and safety policy standards. However, it considered, the process did not sufficiently capture SafeWork's own strategic and regulatory priorities.

162. Given that the IDMF expressly directs attention to SafeWork's determination from time to time of its regulatory priorities, it is in my view essential that SafeWork's staff involved in making and deciding submissions to the IDMP should pay attention to those policies. Nous did not make a recommendation in relation to this. However, given what is said at paragraph 7.2 of Nous' report, I think it appropriate that I should make such a recommendation. Paragraph 7.2 concludes:

> *SafeWork NSW most recently refreshed its strategic priorities in 2023 (…). The IDMF indicates, at Priority Area 9, that the IDMP should have regard to 'new priorities' in making regulatory decisions (…). This focus is supported by provisions in the IDMP Submission Template, indicating CDR staff preparing the submission should provide the 'strategic relevance' of the matter subject to decision. However, the documentation supporting the IDMP process does not make significant reference to the use of SafeWork NSW's strategic regulatory priorities in decision-making. It could also do more to highlight the need for strategic factors to influence decision-making.*

163. In light of that conclusion, I **Recommend** that when the IDMP process documentation is reviewed in accordance with recommendation 7 (discussed next), specific attention be given to ensuring that that documentation directs the attention of staff preparing submissions to the IDMP to consider the strategic regulatory priorities established from time to time by SafeWork, and to state expressly how the submission supports (to the extent that it does) those priorities.

164. Nous reviewed the documentation that supports the IDMP process. It found that documentation to be "*comprehensive but not user friendly*", and recommended that it "*should be formatted for ease of understanding*". That arose in part because of the interrelationship between a number of documents describing different aspects of the IDMP process, with the need for staff to cross-refer from one to the other whilst preparing a submission. Accordingly, Nous recommended that the documentation be simplified. Nous noted, correctly, that the SafeWork 2020 Review of the IDMP process supported this recommendation.

165. Nous considered the extent to which the process of decision-making aligned with established processes and the good practice principles that it had identified. It concluded, based on interviews with SafeWork staff, that the documented IDMP process was closely followed, and that in general the correct inputs were used to make decisions. However, Nous's research suggested that staff held "*concerns for the lack of strategic and legal perspectives*". Nous referred, in this context, to the

kinds of evidence to support a case that might put before the IDMP for consideration of prosecution, to the involvement of inspectors (as the persons with "*on the ground*" knowledge of the incident), and to the lack of attention to strategic priorities and legal requirements in decision-making.

166. Nous identified that there was no formal embedding of quality assurance into the IDMP process. The consequences included missed opportunities to improve the process, and limited oversight of IDMP decisions. As Nous stated, "*good practice requires clear measures against which organisations can evaluate their processes to drive continuous improvements*" which can be facilitated "*by collecting data on decisions and their outcomes… [to] support the continuous improvement of the IDMP process*". Nous formulated a recommendation to this effect which in my view is well supported by the evidence and reasoning set out in the report, and is one that I should adopt as a **Recommendation** of this Report.

167. Nous returned to the relationship between decision-making and consideration of relevant strategic factors. It noted that "*there is limited consideration of strategic priorities when preparing submissions*". That was seen to result from the failure to embed strategic priorities in the IDMP process documents. As Nous said, "*the* [IDMP submission] *template does not specifically include a list of the strategic priority areas…*".

168. Nous spoke to inspectors in the course of its work. They confirmed "*that there is an absence of considering strategic factors*" which created at least the risk of "*inconsistent consideration of strategic priorities*". Staff who were working in the IDMP process noted "*the lack of strategic focus in its work… because there is too much focus on the individual merits of a case*". That concern was felt not only at the level of those staff who prepared a submission but also by some directors who were members of the IDMP.

169. Nous recorded that some staff noted, with particular reference to psychosocial risks, "*that psychosocial social hazard* [sic] *are put forward without sufficient regard for proportionality or public interest*". That, Nous said, "*again indicates failure to align with best practice principles of* [sic] *consistently applying a strategic lens to the decision-making process*".

170. The comments from DCS/SafeWork stated that:

> *NSW was the first jurisdiction in Australia to introduce the Code of Practice for Managing Psychosocial Hazards which commenced on 28 May 2021 and the first to implement specific regulations for managing psychosocial hazards and risk.*
>
> *Psychosocial matters have increased disproportionately to resources overtime, the referral form and triage process are designed to ensure matters with the greatest need and most alignment to WHS jurisdiction are prioritised.*

171. Nous recorded, further, that staff who prepared submissions were from time to time unhappy with the decisions made on their submissions. Some of those decisions were perceived to reflect the "*vested interests*" of members of the IDMP. Others were seen to have been aimed more at diverting "*media attention or pressure from high profile matters*" at the risk of overlooking "*guiding principles and strategic objectives*". Some inspectors apparently said that in their view "*the IDMP was only viewed as a tool to prosecute without broad or strategic considerations to more deeply understand potential lessons learned and opportunities for prevention programs*".

172. I interpose to note that any process of regulation needs to balance its priorities in a way which does not overly promote one at the expense of another or others. The appropriate outcomes for a particularly serious incident may include investigation with at least two aims: to consider prosecution, and to facilitate consideration of the formulation of advice on improvement of workplace practices. Further, any regulator with limited resources must always take into account in its decision-making process the strategic priorities that it has determined from time to time, and the best way of meeting those priorities in particular cases. This would ordinarily require the balancing of the various outcomes of any particular incident (which may not be limited to those that I have indicated), and considering how the pursuit of one or more of those outcomes would best serve the relevant strategic objectives that the regulator has determined.

173. Nous formulated a recommendation for improvement of strategic input into the IDMP process, and that is a recommendation that I adopt as a **Recommendation** of this Report.

174. One particular point raised by staff, both those preparing submissions and those involved at the IDMP level in the consideration of those submissions, was the lack of legal expertise on the IDMP. The view expressed by some inspectors was that there was insufficient consideration of the quality of evidence "*due to a gap in the understanding of the requirements to prepare an evidence brief to take legal action*". Some inspectors attributed this "*to the deskilling of inspectors, due to the reduction of their role in response to the establishment of the IDMP as a governing body*".

175. The perceived problem was not limited to inspectors. Nous recorded that staff at the director level said that "*legal perspective within the IDMP is…. required*". And Nous recorded, also, that SafeWork had indicated that it would welcome the inclusion of a person with relevant legal qualifications as a member of the IDMP. That could be the Director of SafeWork's legal branch, or a nominee or deputy of that director.

176. In my view, the IDMP process would be improved, perhaps substantially, if there were a lawyer with relevant legal qualifications and experience among the members of the IDMP. The evaluation of evidence includes, of course, a technical aspect requiring an understanding of the industry in which, and the circumstances in which, the incident under consideration occurred. But if the investigation is being undertaken with at least one possible outcome being a prosecution, then it is essential that there be someone with a clear understanding of the law of evidence and its application to prosecutions for breaches of statutory duty to assist the IDMP in its assessment of the probative force of the evidence submitted. To take an obvious example: it is common human experience to act on what the hearer perceives to be reliable hearsay evidence, as though it were acceptable proof of the hearsay fact that is asserted. Each of us does it all the time in our own daily lives. But in any legal proceeding, the bases on which hearsay evidence may be admitted at all, let alone admitted to prove the asserted fact, are extremely limited. A recommendation for prosecution that was based on the belief that hearsay proof of a fundamental point was sufficient could not be sound. There is no need to give other and perhaps more realistic examples of the way in which analysis from a legal perspective could improve the decision-making of the IDMP where prosecution is being considered as a possible, or indeed appropriate, outcome.

177. Nous did not make a formal recommendation, but in my view, notwithstanding SafeWork's apparent acceptance of the proposition in principle, it would be

appropriate for me to do so. I therefore **Recommend** that SafeWork give consideration to establishing a policy that wherever possible, the membership of the IDMP should include at least one legal practitioner with relevant experience in the area of workplace health and safety law and in prosecutions for breach of obligations under that law.

178. The Nous report then turned to consider the way in which training and communication could be improved to provide better support for the work of the IDMP. It noted that there was no formal training or development process for staff working in the IDMP process. They "*do not receive formal training that is specific to strategic decision-making*", but "*rely on peers to explain the process and review of decisions in relation to strategic priorities*". There was a related concern that when managers attended the panel as the delegate of a director, they might not have appropriate qualifications or experience to participate in the panel's deliberations. That led to a specific recommendation, which in my view is more than adequately justified having regard to Nous' analysis, and is one that I shall adopt as a **Recommendation** of this report.

179. Nous then referred to the internal communication of IDMP decisions. It noted that the way in which the Panel's decisions were communicated to those who had prepared submissions was not uniform, and to some extent relied on "*the discretion of their manager*" with "*inconsistencies in messaging*". That was seen to be inconsistent with the need for "*inspectors to understand the rationale for decision-making*". That in turn gave rise to a risk "*that future contributions to the panel, through the collection of evidence and preparation of briefs, can't be informed by a shared understanding of what is required for appropriate deliberation*".

180. Nous noted that in those circumstances, there was some staff dissatisfaction with the level of feedback given to them on submissions that they had prepared, and a degree of discontent with the decisions themselves. Nous made a recommendation for improvement in communications with staff, and it too is one that in my view is more than adequately supported by the evidence and analysis set out in the report and is one that I should adopt as a **Recommendation** of this Report.

181. I now set out the recommendations that Nous made in relation to the IDMP process.

Improvement Opportunities		Details
1.	**Documentation supporting the IDMP process should be simplified**	Documentation supporting the Investigations Decision Making Panel (IDMP) process should be simplified to establish more user-friendly guidance and greater clarity of the end-to-end decision-making process. In particular: • **SafeWork NSW should create an overarching document to address the process end-to-end**. Improved process documentation would address the need to craft a simpler set of materials that allows staff, in particular new starters, to easily follow through the decision-making process. • **SafeWork NSW should incorporate more appropriate formats such as process maps as visual aids**. To counter the weight of textually dense documents, more appropriate formats such as using process maps may serve as visual aids to better illustrate the decision-making process. Illustrating the workflows can contribute to a greater understanding of the reasons for decision-making and the inputs required to make appropriate decisions. This opportunity has already been identified in the 2022 IDMP Review.
2.	**SafeWork NSW should formalise the oversight and review of the IDMP decision-making process and improve the analysis of insights**	SafeWork NSW should formalise the oversight and review of the IDMP decision-making process and improve the analysis of insights. This will ensure the IDMP decisions are revisited, to establish a clearer understanding of the context for determining outcomes, and the broader impacts these have on future matters. SafeWork NSW should clearly establish formal mechanisms for the review and collection of data on the decision-making process. This may be achieved through the following measures: • **Embedding a formal feedback loop into the decision-making process**. This has been acknowledged as potentially complex due to the need to de-identify matters, however, should be commenced by SafeWork NSW. This would support the formal oversight of

Improvement Opportunities		Details
		matters and instil clearer levels of accountability for decision-making in the process. • **The collection of data on the deliberation of matters and their outcomes**. It has been indicated that there is limited collection of data from the decision-making process. For matters that move to prosecution, data should inform the IDMP of whether or not the case was successful and why. For matters that don't go to prosecution, data should record how compliance should be enforced through other means, and the success of these measures in future prevention. • **Establishing actionable insights through the data**. Data collected on submissions to the IDMP and the outcomes should be analysed to provide insight on what makes a submission successful. This data can then be drawn on to establish actionable insights that will allow the IDMP and other staff to improve the process in the future, within the scope of their regulatory functions and other objectives.
3.	**SafeWork NSW should incorporate a greater strategic focus into the IDMP process**	SafeWork NSW needs to make decisions in accordance to its decision-making criteria with equal prioritisation of strategic and operational matters. This would enable satisfying both purposes of the IDMP, that is to ensure that individual notifiable events are subject to a full investigation where appropriate, and to leverage the investigation of individual notifiable events to pursue the strategic regulatory objectives of SafeWork NSW and the WHS Act. To better align with best practice, SafeWork NSW should embed strategic focus into the IDMP process, and clearly communicate how this is done to staff. To address the purpose of the IDMP in alignment with greater strategic focus, SafeWork NSW should: • **Embed strategic focus across the IDMP process.** This includes within Serious Incident Review Process (SIRP) when considering other compliance and

Improvement Opportunities		Details
		enforcement functions for the regulator as well as submission and the IDMP ToR. SafeWork NSW should ensure that the process, materials and training that enable decision-making by the IDMP encourage an appropriate balance between event-related and strategic decision-making factors. • **Communicate the consideration of strategic factors during decision-making to staff**. This requires communication to staff about the extent to which strategic factors were considered. SafeWork NSW should also ensure that there is better communication between staff involved in the IDMP process, and staff outside the IDMP, particularly regarding the strategic nature of decisions made by the IDMP. **Note**: A senior staff member of SafeWork NSW highlighted that the name of the IDMP may communicate the wrong intent to decision makers and staff. A title with a more general focus (e.g., Regulatory and Enforcement Decision Making Panel) may better communicate the purpose and focus of the IDMP.
4.	**Develop tailored IDMP process training, including content with a specific focus on strategic decision-making**	Detailed training and ongoing L&D materials should be developed for the IDMP process. These materials should incorporate guidance on strategic decision-making and the key priorities SafeWork NSW seeks to realise through this process. It should also include guidance on how the IDMP should be briefed and how outcomes of the IDMP process should be communicated and reported on. There is an opportunity through training for staff to be better equipped to make strategic decisions across the IDMP process. This applies to staff contributing to and making decisions during the SIRP, as well as managers acting on the Panel to contribute productively to IDMP discussions. Training will embed a more strategic focus into the IDMP process. As a result, staff will be enabled to implement a broader strategic perspective to the consideration of matters to be recommended for full investigation. This training should be:

Improvement Opportunities		Details
		• Offered to staff new to supporting or participating in the IDMP process. • Used to refresh the IDMP process knowledge and understanding of existing staff. • Updated as required to align with changes to practice. Staff should complete refresher training every one to two years, depending on the level of change to the IDMP process and the training materials.
5.	**Improve communications with staff following decisions**	SafeWork NSW should focus effort on ensuring that staff involved in briefing the IDMP receive clear feedback on the outcome of matters they submit to the panel. Understanding the IDMP's rationale for a decision would inform inputs to the panel and the pre-IDMP decision-making process in the future. Current staff discontent appears to be a symptom of poor communication. This contributes to inconsistency in what is being submitted to the IDMP. Staff are making decisions on what should be put to the panel in light of the outcomes reached on previous submissions. However, in the absence of clear communication, staff lack an understanding of why those decisions were made. Incorporating clearer feedback will align SafeWork NSW more closely with best practice by equipping staff with more consistent tools to approach decision-making. This feedback should be designed to: • Ensure staff are well informed about how the IDMP made the decision, • Communicate the factors the IDMP considered and did not consider, as well as the reasons for their decision; and, Support staff who may have had a significant investment in preparing for the briefing to IDMP to contextualise the value of the time they invested.

182. I adopt those recommendations and make each of them a **Recommendation** of this Report.

183. I referred at [118] and following above to criticisms made in submissions of SafeWork's acceptance and monitoring of EUs. I am not in a position to say that EUs have been used inappropriately. I accept that there will be cases in which valid reasons exist for accepting EUs rather than prosecuting. The decision to do so is highly fact-dependent, and should be informed by, among other things, the regulatory priorities that SafeWork has set itself from time to time. It is however essential that when SafeWork decides to take EUs instead of prosecuting, the reasons for doing so be expressed clearly and given to both internal and external stakeholders. I return to the latter group in Section 10 of this Report.

184. The comments from DCS/SafeWork on the draft Report included a submission to the effect that there was an effective process in place to monitor EUs and to ensure that all the obligations that were the subject of EUs were fulfilled. I am unable to reconcile that with the submissions to the effect that EUs were not properly followed up and monitored. It is hardly necessary for me to say that if a decision is made to accept an EU, it is incumbent on SafeWork to monitor compliance and to ensure that the PCBU fulfils completely each and every one of its obligations under that EU.

185. Section 219 of the 2011 Act provides that a person must not contravene an EU (in this part of the Act called "WHS undertakings"), and prescribes a penalty for contravention. Sections 220 to 223 make further provisions as to EUs, but I put them to one side. I suggest that consideration be given to amending section 219 so that it provides, in effect, that a person (for convenience, **the defendant**) must not without reasonable excuse contravene, or fail to comply with, or fail to perform, a provision of an EU, and that the defendant bears the burden of proof of reasonable excuse on the balance of probabilities. That, if done, would give real teeth to EUs. I make a **Recommendation** accordingly.

186. I add that when SafeWork does agree to accept EUs from a PCBU, it is essential that the PCBU be shown to be capable of complying with its undertakings, and that its compliance be monitored. HSRs can play a valuable part in doing so. As with the decision to accept EUs in the first place, I am not in a position to say that

SafeWork has been lax in monitoring compliance with EUs, and I note its comments on this topic summarised above.

187. As noted earlier in this Report, I make the following further **Recommendations**:

a. I **Recommend** that when the IDMP process documentation is reviewed in accordance with recommendation 7 specific attention be given to ensuring that that documentation directs the attention of staff preparing submissions to the IDMP to consider the strategic regulatory priorities established from time to time by SafeWork, and to state expressly how the submission supports (to the extent that it does) those priorities.

b. I **Recommend** that SafeWork give consideration to establishing a policy that wherever possible, the membership of the IDMP should include at least one legal practitioner with relevant experience in the area of workplace health and safety law and in prosecutions for breach of obligations under that law.

c. I **Recommend** that the legislature give consideration to amending section 219 of the 2011 Act so that it provides that: (1) a person must not without reasonable excuse contravene, or fail to comply with or perform, a provision of a WHS undertaking; and (2) the person alleging the existence of a reasonable excuse must prove it on the balance of probabilities.

7.8 Reconciliation of submissions with findings in the Nous Triage and IDMP Report

188. The first thing to say about the submissions that I have summarised earlier in this Report is that they represent the subjective, although I accept sincerely held, views of the individual or organisation making the submission. They are based on the reactions of the individual or the organisation to particular events. It is not always the case that the individual or organisation is able to put the subject matter of the submission into the context of the functioning of SafeWork as an entity.

189. I think that this applies not just to submissions from organisations and members of the public generally, but also to submissions from inspectors. The current organisation of SafeWork is so structured that inspectors are effectively managed, and the results of their work are processed, by teams who are quite separate from the inspectorate. Further, and this is a point confirmed by Nous and addressed in one of its recommendations, there appears to be clear evidence that the decisions made upon inspectors' submissions are not always communicated, or

communicated clearly, to the inspectors who made the submissions. Where the decision on a submission is otherwise than in accordance with the inspector's recommendation, or comprises the inspector considered to have been an inappropriate outcome, it is likely that the inspector will be dissatisfied. That dissatisfaction is likely to be exacerbated if there is no explanation given which enables the inspector to understand why it was that the decision was reached.

190. Another factor at work is that SafeWork must set its regulatory priorities from time to time, and must seek to ensure that its resources are dedicated to addressing those priorities in the most effective manner. Those who have made submissions to my Review may not have understood what the regulatory priorities were at any given time; or may have understood them, but disagreed with them. That can be a source of tension. Again, at least part of the solution to reducing tension might be the provision of better and clearer explanations.

191. Some of the recommendations made by Nous and adopted by me may go at least some part of the way to addressing the problems raised in submissions. I refer in particular to better training of triage and IDMP staff, and to the introduction of a consistent process of review of decision-making at those levels. The third recommendation made in relation to the triage process would require the creation of a formal review system whereby specific triage decisions are sampled and, in effect, re-reviewed: tested and assessed to ensure alignment with regulatory and statutory priorities. As Nous suggested, that should be done for triage decisions at all levels, including those triaged to letter or administrative response.

192. In my view, the second recommendation made in respect of the IDMP process could be expanded and adapted to include provision for a regular and formal re-review of sample IDMP decisions. Although Nous' recommendation does not go so far, I consider that the data collected should be sampled to facilitate a re-review of selected IDMP decisions.

193. I therefore **Recommend** that when the second of Nous' recommendations in relation to the IDMP process is put into practice, a formal process be instituted to use the data collected to enable, among other things, a regular and continuing sampling of IDMP decisions for the purpose of re-examining the decision reached on each of the selected files to evaluate its correctness at the time it was made, and to see if there were alternative decisions that could be and should have been made on the evidence originally available to the IDMP.

194. Another reason for the apparent disparity between the views expressed in submissions and the generally positive findings in the IDMP Report may relate to the fact that, as I note elsewhere in this Report, the procedures of SafeWork appear to be in a state of some flux. It may be that some of the matters that were the subject of complaint arise from incidents at a time when neither the workforce nor the policies and procedures of SafeWork were as developed as they are now. If this is a partial explanation, then it is to be hoped that the adoption of the recommendations in this Report will lead to further improvement in the triage and IDMP processes, with a greater consistency of outcomes.

195. Yet another explanation may be, simply, that SafeWork is under-resourced. There is no doubt that the number of inspectors is below the ILO minimum standard of one inspector per 10,000 participants in the workforce. It also seems to be the case that a number of those who are classified as inspectors do not in fact do an inspector's work, in the sense of making field visits, dealing with workers and PCBUs in respect to complaints, notifications and requests for service, and the like. Whilst I am not to be taken as expressing a view that it is undesirable for managers and more senior personnel to have qualifications as inspectors, I am most definitely expressing the view that to the extent that there are managers and senior personnel so qualified, they should not be classed among the ranks of active inspectors for the purpose of testing their number against the ILO minimum unless they spend at least a substantial part of their time working as inspectors.

196. There are other factors referred to elsewhere in this report that will have an impact on the ability of inspectors to do their actual "*inspecting*" work (one example being the use of inspectors in the New Inspector Training Program). As will be seen, I think that the role that inspectors play in that program is valuable, and that the way to reduce workload pressures is not to take them out of teaching but to provide more inspectors overall.

197. In relation to the question of psychosocial hazards, there were as I have noted submissions made to the effect that SafeWork should employ more inspectors with specific training in dealing with such hazards. As I understand it, that would mean either giving additional specific training to some existing inspectors to equip them to deal with psychosocial hazards, or employing new personnel to be trained specifically to work as inspectors in that field. That does seem to me to be a valuable, indeed extremely important, point.

198. I therefore **Recommend** that SafeWork train more of its inspectors specifically in dealing with psychosocial hazards, or alternatively, employ additional personnel to be trained as inspectors with specific training in dealing with psychosocial hazards. The numbers to be so trained, and the locations from which they are to work, are administrative matters upon which I neither can nor should express a view, except to say that there must be enough such inspectors to provide support to the inspectorate generally when confronted with psychosocial hazards.

199. There are two more points I wish to consider in the area of psychosocial hazards. The first is the SDA's submission referred to at [108] above. I think that industry forums of the kind suggested may be able to play a very important role in educating workers and PCBUs about, and therefore assisting in the identification and minimisation of, such hazards. That is likely to be an industry-specific process, as the nature of the hazards is likely to vary from industry to industry. I therefore **Recommend** that SafeWork work with employer groups, unions and HSRs in individual industries to create industry forums whose role is to identify psychosocial hazards in the relevant industry, to educate PCBUs and workers about those hazards, and to develop and implement strategies to minimise them.

200. The second point relates to the submission summarised at [111] above, and to similar submissions recorded elsewhere in this Report. It is sometimes the case that PCBUs will have processes in place to deal with workplace psychosocial hazards such as bullying or harassment. Workers should normally resort to those processes, when available, to have a complaint dealt with. It will often be appropriate for SafeWork to require a worker to have done so before SafeWork takes the matter up. Having said that, there will be cases where the worker is justified in bypassing those processes and going straight to SafeWork. It is important that SafeWork satisfy itself, in every case where a worker has bypassed the PCBU's complaints process, that the worker had valid reasons for doing so. "Return to Sender" should not be the default means of dealing with such cases.

201. I add that if SafeWork decides, in a particular case of serious bullying, harassment and similar misbehaviour, to accept EUs that include the creation of workplace processes to deal with such complaints, it is somewhat counterintuitive to suggest that an aggrieved worker should have used them at a time when the processes were either absent or inadequate. Conversely, if the processes have been put in place, it would generally seem appropriate to say that the worker should use them unless there is good reason shown to bypass them.

202. I return to the submissions summarised at [126] above. It seems to me that the interests of workers' compensation insurers and SafeWork align very closely (a topic to which I shall return). Insurers want to minimise claims. Safe workplaces tend to have fewer claims. SafeWork wants to promote safety at work. It would seem to be inarguable that the use of workplace and claims data held by workers' compensation insurers could assist SafeWork to identify industries and PCBUs with aberrant safety records, and to tailor programs of education and inspection directed at those industries and PCBUs.

203. I therefore **Recommend** that a system be established to enable SafeWork to have access to claims data held by workers' insurance insurers for the purpose of identifying at-risk industries, PCBUs and workers and targeting programs of education and inspection accordingly. To the extent that there may be legislative prohibitions or restrictions that would prevent or inhibit that access, I **Recommend** that the legislature give consideration to enacting legislation to remove any such prohibitions and restrictions.

204. In making these Recommendations, I acknowledge that the response from DCS/SafeWork said that there may not be a legal impediment to the sharing of information, given the provision of section 243(2) of the WIM Act which apparently allows SIRA to disclose information obtained under workers' compensation legislation to SafeWork, and that any impediments may be operational in nature. It goes without saying that any such operational impediments need to be overcome in giving effect to my Recommendations on this matter.

205. Summing up this part of my Report, I recognise that SafeWork, like any government agency, has resource constraints. What is desirable in an ideal world, and what is practicable in the world in which we live, are all too often very different things. However, a regulator that is not adequately resourced to carry out its task of regulation is a poor and ineffective regulator. Workplace health and safety is an area of critical concern both to workers and their families and to the community at large. Workers are entitled to a safe workplace, and families are entitled to have their loved ones returning home safe and sound from work each day. SafeWork plays a vital role in maintaining our system of workplace health and safety laws and ensuring that they are promoted and where necessary enforced.

206. I do not for a moment shrink from the proposition that it is PCBUs that have the primary duty of ensuring, by taking reasonably practicable precautions, that of course include compliance with any mandatory requirements under law, their

employees' safety in the workforce. I add that workers can and should play a valuable role in this, particularly but not necessarily only through the activities of HSRs and EPHs, for reasons including that workers' observations of inappropriate behaviour or unsafe work practices can be brought to light.

207. SafeWork does not have primary responsibility for ensuring workplace health and safety. Its role is to regulate, by dealing appropriately with matters coming brought to its attention, compliance with the law. But that is not its sole activity. Education is a vital part of workplace health and safety, and SafeWork is the appropriate body to take on the educative responsibility.

208. Further, SafeWork's activities cannot be channelled in one single direction. Unions will feel, understandably, that the primary role of SafeWork is to protect their members' welfare by dealing with employers who do not adhere to the requisite standard of care. Employers may have a different view. It is up to SafeWork to set its regulatory priorities from time to time, in a way that is consistent with its regulatory role, and to apply its resources to the efficient pursuit of those priorities. It is not appropriate for any one area of activity to be prioritised over another. Nor is it appropriate for preference to be given to the ideas of one interest group rather than another.

209. Transparency and accountability should be the key indicia of a healthy, functioning regulator. Firstly, the decisions of a regulator must be transparent, so that they can be seen to have been made properly, in accordance with applicable legal requirements and on the basis of appropriate evidence, and in a way that does not involve differentiation in treatment depending upon the parties involved. Secondly, the process of accountability, which can only exist where transparency in operation exists, is the way that regulators can be held to their work. The recommendations made already, and many of the further recommendations that I will come to, all have at their heart the promotion of transparency and accountability.

210. For those reasons, what I have said in the last five paragraphs goes beyond the particular subject matter of this part of my Report, being the triage and IDMP processes. They are comments of general applicability.

8 Terms of Reference Part 2: The performance and effectiveness of SafeWork's educational functions

211. Submissions to the Review about SafeWork's educational functions concerned the effectiveness of training (including training of new inspectors, HSRs, EPHs, and those undertaking triage functions) and the performance and effectiveness of SafeWork's educational functions of PCBUs, workers, their representatives and the wider community more generally.

8.1 Training

212. Submissions raised the following issues, among others, about training for new inspectors, HSRs, entry permit holders and those undertaking triage functions:

    a. The new inspector training program is classroom-based and lacks live and real scenarios;
    b. Additional training is needed for inspectors to improve their investigative and interview skills for compliance and prosecutions;
    c. The registered training organisation (**RTO**) providing training services to SafeWork is under-resourced;
    d. Material in HSR training is out of date;
    e. Training materials lack flow and structure;
    f. Customer Service Centre staff taking calls are not adequately trained or experienced and appear poorly informed about WHS legislation.

8.2 Education of PCBUs, workers, worker representatives and the wider community

213. The CFMEU commented that SafeWork's educational functions have a lopsided focus on larger employers, missing smaller employers at bottom of chain. This was echoed by inspectors, who described there being less focus on information and advice to small businesses. The SDA submitted that SafeWork should engage employers "*by industry and also around key hazards*". Business NSW expressed concern that reliance on digital channels to communicate with businesses is not suited to the needs of small business owners, suggesting that SafeWork develop a health and safety program for small business.

214. Inspectors urged joint educational activities with industry groups and a return to industry-specific publications, which were seen to be useful tools for inspectors to

distribute in the field, particularly when engaging with small businesses. In the view of one inspector, "*education of the regulated community is dysfunctional and inconsistent*".

215. Unions NSW acknowledged that SafeWork has produced some very worthwhile educational material. It submitted, however, that SafeWork does not support an emphasis on education, which Unions NSW perceives to be to the detriment of compliance and enforcement. The CFMEU also said that enforcement and education should be approached separately by the regulator.

216. Members of FIWSAG submitted that the group and its members could be used much more as part of SafeWork's educational functions, including in providing real-life lived experiences. One FIWSAG member said:

> "*I believe our role on the FIWSAG can be utilised so much more and we are here saying we can assist…our group is currently underutilised…*"

217. Another FIWSAG member urged that advertising campaigns by SafeWork could be more effective:

> *"Advertising and marketing campaigns through multimedia platforms are simply not communicating the message across to industry."*

218. Another FIWSAG member suggested that SafeWork could be more hard-hitting. In their view, the Speak Up app should be promoted more, as should videos produced by PCBUs (for example, as part of an EU).

219. DCS/SafeWork stated, in relation to the possible role of FIWSAG:

> *SWNSW is currently exploring options to expand the role of FIWSAG to engage in broader supporting processes.*
>
> *SWNSW fully supports the role that FIWSAG, including its promotion and awareness to families as a resource they can engage with when dealing with their grief, should they choose to attend the groups' meetings.*
>
> *Updates are currently provided to families and injured workers during the investigation, prosecution and EU process. In many cases, this support role is undertaken by our Family Liaison Team (FLT). However, where the FLT are not engaged, for example where there is not a full investigation, communication processes may not be applied consistently, and this is an area*

of improvement for SafeWork. SWNSW has identified the need to update our Customer Service Standard related to incident responses and investigations and this work is underway.

This additional support for families and injured workers will require additional specialists.

There may also be legal restrictions on the information we can share.

220. Those observations are relevant both to the particular subject presently under consideration, namely the training of new inspectors, and to the fourth of my Terms of Reference. I encourage SafeWork to continue with the process of engagement of organisations such as FIWSAG.

221. SafeWork inspectors expressed frustration at the perceived restrictions arising from being housed within DCS, for example being required to seek approval for information, images and publications used in project and educational campaigns through the media team and other channels. It was submitted that SafeWork needs a dedicated team to champion its educational functions, without the limitations imposed by being part of a broader agency.

222. An inspector submitted that:

It would be better to have an educational provider within SafeWork NSW that is central to provide that educational ability to the wider community…I would recommend a centralised educational centre to deliver…training that is resourced by inspectors and project officers that can cater for all industries.

223. SafeWork inspectors and unions submitted that educational resources were focused on supporting businesses and employers but were not developed for others, for example workers, their representatives and HSRs. The Asbestos Diseases Foundation of Australia expressed disappointment that its previous close relationship with SafeWork in developing and reviewing education resources and disseminating information and materials had dwindled. Unions NSW suggested that the previous program allowing grants to both employer associations and unions to deliver training programs should be reinstated.

224. Submissions also commented that:

a. There are fewer educational resources in languages other than English;

b. There is an over-reliance on codes of practice as a means of education, and few educational options for those who do not understand codes of practice;
c. Presentations do not explain adequately what is reasonably practical, instead tending to restate legislation;
d. There are missed opportunities to educate PCBUs in cases where enforcement action is not pursued. It was suggested that in such cases a report to industry or to PCBUs more broadly could be made, to assist PCBUs to learn what compliance looks like. This would make better use of information gleaned from investigations, even if the matter does not proceed to prosecution.

8.3 Nous Group's Training Report

225. Nous was asked to consider:

> *Is the training for the New Inspector Training Program, Health & Safety Representative Training, Entry Permit Holder Training and staff performing triage functions well designed and effective in building capability? In what ways can they be enhanced?*

226. Nous described the three training programs, and SafeWork's involvement in them, as follows:

> ***Each type of training was tested against a good practice framework***
>
> *SafeWork NSW plays a different role in each of the types of training considered in this report:*
>
> - *The NITP [New Inspector Training Program] is delivered by SafeWork NSW to its staff, drawing on an externally regulated Diploma program, as well as internally developed content.*
> - *SafeWork NSW creates the content for HSR [Health and Safety Representative] training, while its peer organisation SafeWork Australia creates the content for EPH [Entry Permit Holder] training. However, SafeWork NSW is responsible for approving third party organisations to deliver both EPH and HSR training, and for providing oversight over this delivery.*

- *Triage training is developed and delivered entirely in-house by SafeWork NSW. However, this training is largely informal and focused onboarding new staff into the organisation.*

227. The approach taken by Nous to its consideration of that question was methodologically similar to its approach to its consideration of the triage and IDMP processes, as described above. In short, Nous sought to identify good practice principles relating to training; to see how the training programs it was examining aligned to good practice; and to examine the practical delivery of those programs. Again, as part of that work, Nous identified areas of weakness and areas for potential improvement and formulated them in its summary of "improvement opportunities" (which, as before, I shall refer to as recommendations).

228. I start with the NITP. As Nous said, that "*is a 12-month compulsory training program provided to all new inspectors… administered by SafeWork NSW's registered training organisation (RTO)…"*. The training comprises two fundamental components: formal classroom training, and on the job experience. Those modules, as Nous said, are "*generally delivered in alternating 2-week training blocks of formal classroom – based training followed by on-the-field training*".

229. The formal training is necessary to enable the trainee to complete the Diploma of Government (Workplace Inspection) qualification. That is a mandatory qualification for all new inspectors. The diploma training program is part of a broader Public Sector Training Package. There are other diplomas: for example, Diploma of Court Operations and Diploma of Government Security.

230. The functions of inspectors are described in section 160 of the 2011 Act as follows:

> ***160 Functions and powers of inspectors***
>
> *An inspector has the following functions and powers under this Act:*
>
> *(a) to provide information and advice about compliance with this Act;*
>
> *(b) to assist in the resolution of:*
>
> *(i) work health and safety issues at workplaces; and*
>
> *(ii) issues related to access to a workplace by an assistant to a health and safety representative; and*

(iii) issues related to the exercise or purported exercise of a right of entry under Part 7;

(c) to review disputed provisional improvement notices;

(d) to require compliance with this Act through the issuing of notices;

(e) to investigate contraventions of this Act and assist in the prosecution of offences;

(f) to monitor compliance with this Act.

231. Nous concluded that the NITP provided trainees with the knowledge that they required to perform the functions of an inspector. It found that the training was relevant, aligned to the core training requirements for inspectors, and appropriately modified by SafeWork to suit the individual needs of its staff.

232. Nous considered the delivery of the NITP, noting that it "*is delivered primarily by active-duty inspectors, who provide training to new starters in addition to their normal role*". That, Nous said, "*is highly engaging for NITP participants*". It did however place "*a significant burden on the inspectors working as trainers*". Nous queried whether that burden would be sustainable "*if more participants or cohorts are required into the future*". If the ranks of inspectors are enlarged to meet at least the ILO minimum standard and as existing inspectors retire, which in my view is essential if SafeWork (however structured and named) is to be equipped to perform its work effectively, the burden identified by Nous will increase very heavily.

233. Nous looked at the training materials used for delivery of the NITP. It found that they were logically structured and formatted, and appropriate for both the purposes they said to serve and the needs of those who were to learn from them. Thus, Nous concluded, "*[t]he current iteration of the NITP aligns closely to good practice for training*".

234. Nous's consideration of the practical (or field-based) component of the training noted that it was valuable, but that there were challenges:

> *However, current participants, recent graduates and trainers also highlighted challenges with fieldwork. These include:*
>
> - *The lack of clear mechanisms to allocate trainees across 'live' workplace opportunities,*
> - *Variability in the quality and breadth of field work experience across participants, and*
> - *Variability in the behaviour and attitudes of mentors that may not exemplify a 'good' inspector.*
>
> *The nature of field work training participants engage in is largely dictated by the current demands on SafeWork NSW as an organisation. When suitable a workplace opportunity is in progress during a field-week, a participant will be assigned to it, providing them with valuable hands-on experience. However, if no relevant matters or work is ongoing in the area that the trainee is based in during this time, they may only be able to observe office-based elements of the role of inspectors. This is less useful for their learning and development.*

235. That led Nous to make a recommendation aimed at achieving greater consistency in this area of training. I endorse, and shall adopt as a **Recommendation** of this Report, what Nous said.

236. Nous noted that the use of inspectors to deliver the NITP, whilst of immense value to trainees because of the practical perspectives that inspectors could bring, placed very heavy workload pressure on inspectors. It concluded, from its interviews with past and present NITP participants and comments made in submissions to my Review, "*that workload pressures on the inspectors providing training were negatively affecting the education experience provided to participants*". That, Nous said, "*has the potential to reduce overall teaching quality*". I add that it has at least the "*potential*" to affect also the quality of the performance of the general "*inspector*" duties of those inspectors.

237. Those considerations led Nous to make another recommendation, which again I endorse and shall accept as a **Recommendation** of this report.

238. Nous considered the way in which trainees' performance of their assignment work was assessed. It concluded that there were areas of improvement, based on the apparent practice of allowing trainees multiple attempts to complete assessments. That carried the risk of allowing participants "*to understand how to pass assessments rather than ensuring they had learned sufficient content*". Nous made a recommendation to address this, which again I endorse and shall accept as a **Recommendation** of this Report.

239. Nous considered, and approved, the way in which the training material was revised from time to time.

240. Nous then considered ways in which the NITP could be improved. It said:

> *Ensuring the NITP is fit for purpose is a critical part of ensuring that the training program meets good practice standards. To date, SafeWork NSW has invested in monitoring student experience and ensuring that the program effectively contributes to driving learning by new inspectors. However, SafeWork NSW has not focused sufficiently on ensuring the NITP delivers the outcomes it is set up to achieve. A greater focus on ensuring that the program effectively sets inspectors up for success is required.*

241. Nous noted that there was no significant assessment or evaluation work undertaken to evaluate the NITP. It said that good training programs should be evaluated to assess their actual impact in achieving the outcomes that they were designed to produce. One particular problem that Nous perceived was "*inconsistencies in the practical training components of the NITP*" which had the potential to create dissimilar sets of skills and capabilities.

242. Accordingly, Nous made a recommendation for implementing a proper assessment framework. Again, that recommendation seems to me to be soundly based on the considerations discussed by Nous and to be one that I should endorse and accept as a **Recommendation** of this Report.

243. Nous then turned its attention to the training of HSRs and EPHs. It said that HSRs had a right to receive appropriate training (see section 72(1) of the 2011 Act), and that completion of an appropriate training course was a statutory precondition to obtaining an Entry Permit to carry out functions as an EPH.

244. Nous concluded that the HSR training was broadly aligned to relevant legislative and regulatory requirements, and was capable of equipping "*HSRs with the skills*

and knowledge to perform their role". Nous concluded, further, that the EPH training materials were well aligned to legislative requirements.

245. When examining the content and delivery of those training programs, Nous concluded that the most recent version of the training program, which appears to be about a year old, embedded good practice and was appropriate for the development of HSRs. It may be that complaints and submissions as to the quality of HSR training were directed to previous versions of the training materials; I do not know. That may however be an explanation of the apparent discrepancy between those complaints and Nous' approval of the current training material. For the avoidance of any confusion, I should make it clear that Nous expressly disavowed having reviewed any training materials other than the current ones.

246. As to EPH training, Nous noted that the training materials "*are of an acceptable quality, but could incorporate a more contemporary training design*". That, however, Nous understood would require SafeWork to work with SafeWork Australia, because Nous understood that the training materials are "*provided on a national level by SafeWork Australia*". Nous further understood it to be the case "*that the development and maintenance of appropriate EPH training materials is the responsibility of SafeWork Australia under the harmonised national work health and safety system*". Those materials have not been revised in any substantial way for over 10 years.

247. The comments provided by DCS/SafeWork on the draft report suggested that Nous was incorrect, or had been misinformed, as to the matters referred to in the preceding paragraph. Those comments stated that "*on 31 October* 2023*, SafeWork Australia confirmed that they are not responsible for the development or maintenance of training resources*". If that is the case, then, it would seem, SafeWork (NSW) is able to revise and update the relevant material to bring it to "*best practice*" levels in accordance with the recommendations made by Nous and adopted by me. I note, although it is of no present significance, that the observation made by Nous quoted at [246] above would need to be read subject to the same apparent disclaimer of responsibility by SafeWork Australia.

248. Nous concluded that the materials it had reviewed were somewhat aligned to its articulation of good practice, being clear, concise and well structured, but that they departed from good learning design in two ways. First of all, they were complex in content and there was insufficient time provided for training. And secondly, they did not provide a meaningful way of testing a trainee's ability to comprehend the

material. That led to a recommendation, which I endorse and accept, noting that according to the comment made by DCS/SafeWork, its implementation would not require SafeWork to consult with SafeWork Australia.

249. Nous then examined the way in which SafeWork assessed and approved the organisations that provided training for HSRs and EPHs. It found that the process was appropriate in principle and delivered effectively in practice, but that the impact of assessment on providers could be better performed. It made a recommendation to deal with that which I endorse and accept.

250. One point that troubled Nous was the limited oversight that SafeWork gave to the selected providers' delivery of training. It said:

> *SafeWork NSW has appropriate tools and powers to provide oversight over EPH and HSR training providers. However, it is not currently sufficiently well-resourced to provide detailed supervision of the delivery of EPH and HSR training by more than a handful of providers each year. Extending this supervision – either to more providers or to the outcomes obtained by students – may be desirable. However, it will require additional resources.*

251. The process of oversight was, as Nous accepted, "*resource intensive*". The result was that, with current staffing levels, it was only capable of application to "*a limited number of providers per year*". That led Nous to make another recommendation, which I endorse and accept.

252. The third topic Nous considered was training for staff involved in triage. Nous considered that there were limitations on that training, and that it "*should become more formalised and rigorous over time*".

253. The limitations arose from the absence of all but a limited quantity of formal training, with learning being transmitted by "*a system of coaching and mentoring from peers*". The training materials were limited, and too closely tied to existing triage materials. Nous said:

> *Good practice for training design suggests that tailored materials should be developed to support learning. This is because new starters to a role generally lack the full context necessary to understand it. Concepts should generally be introduced gradually and in a format that is designed to be easily understood and applied.*

254. Nous said that the materials used for training were not specifically designed for that purpose, and were in any event lacking in concise summaries and quick reference guides.

255. Nous accepted that training provided through a system of mentoring and "*buddying*" could be appropriate. However, self-evidently, "*training approaches of this design can vary significantly based on the staff member providing the mentoring or support*" and thus "*may not always produce consistent training outcomes*". Further, and again as Nous noted, it is an approach that is "*highly dependant [sic] on the availability of experienced staff…*".

256. Those conclusions led Nous to recommend an improvement for the preparation of formal training materials, and their regular revision. Given the importance of the triage process in the overall work performed by SafeWork, and the numerous complaints in submissions as to the adequacy of both the training of those who do triage work and the outcomes of their performance of that work, I consider that this is an essential recommendation that I therefore endorse and shall adopt as a **Recommendation** of this report.

257. The next matter considered by Nous was the extent to which SafeWork evaluated the outcomes of the training processes. It said that although senior leadership within SafeWork was confident that staff were capable and were performing their work appropriately, there was "*no way for SafeWork NSW to be certain that all staff providing training or coaching to new starters consistently work in line with required triage practice*". Nor, Nous thought, was there any assurance that staff are performing in line with required triage once trained.

258. This perceived gap between theory and practice gave rise, Nous said, to two risks. The first is that SafeWork could have no satisfaction that there was consistency in the way that triage work was performed from time to time. The other was that errors in training would perpetuate errors in practice, which would duplicate and reduplicate down the line. That led to another, recommendation, which I endorse and accept.

259. I set out the recommendations made by Nous in the training report:

Improvement Opportunity		Details
1.	**Seek to achieve greater consistency in mentoring and field work opportunities**	Inconsistent delivery of the field work component and variability in mentor supports detracts from the effectiveness of this training and has the potential to perpetuate poor practices. Into the future, SafeWork NSW should work to ensure that: • NITP mentors are selected based on their capability to effectively support mentees, as well as their willingness to engage actively and extensively to support the success of the NITP, • NITP mentors are selected based on their demonstrated history of embodying the ethics, values, attitudes, capabilities and adherence to procedure expected of inspectors at SafeWork NSW, • New inspectors are assigned to teams that have both the capacity to support the training elements required by the NITP and have sufficient work, of the right type, to support the development required by the NITP candidate at that stage of their training, and • New inspectors are supervised by sufficiently experienced staff with a history of delivering in line with the expected ethics, values, attitudes, capabilities and adherence to procedure expected of inspectors at SafeWork NSW.
2.	**Continue to focus on the workforce planning required to enable the best possible**	SafeWork NSW should continue to focus effort on workforce planning to enable the best possible teaching and

Improvement Opportunity		Details
	teaching and learning experience.	learning outcomes. Capacity planning should be considered to reduce risks associated with increasingly high workload of inspectors and ensuring students receive active engagement from their mentors and assessors. Although staff are managing workloads currently, there are risks associated with the current operating structure as the program has expanded considerably in recent years. SafeWork NSW RTO should consider alternate models of delivering training, such as receiving external support to facilitate components of the program to manage the workload of existing Inspectors involved in delivering the NITP.
3.	**SafeWork NSW RTO should review its assessment attempt approach to ensure it continues to meet good practice.**	Insights from previous and current NITP participants suggests an opportunity for rebalancing the assessment approach where there is a good mix of academic rigour, adult learning principles, and not being overly burdensome for either assessors or participants is achieved. The current assessment approach introduces the risk of participants relying on multiple resubmissions to complete assessments without initially investing adequate time for tasks. This potentially could reduce the ability of SafeWork NSW to understand if participants are meeting desired learning outcomes. SafeWork NSW should review the level of detail applied in providing feedback. This approach should have an emphasis on balancing opportunities to implement assessor feedback and academic rigour, while minimising excessive burden on assessors and participants. This will ultimately support more accurate critical assessments of participants against learning outcomes, aligning with good practice.
4.	**Fully implement a framework to assess the impact and outcomes the NITP is delivering and for sustaining**	Conducting an ongoing assessment of staff capabilities against the areas the NITP develops helps to:

Improvement Opportunity		Details
	organisational capability over time.	• Validate the impact and effect of the program • Ensure it continues to represent a valuable investment of resources • Drive consistency in organisational practice across SafeWork NSW by ensuring inspectors are regularly re-assessed in terms of their competency against the good practice standards of the NITP • Identify requirements for remedial or refresher training when gaps in staff knowledge are identified. • SafeWork NSW has developed a 'Health Check' program that assesses the performance of inspectors following the completion of the NITP. This program is designed to inform refresher training for inspectors as part of ongoing professional development through the Inspector Continuing Professional Development (ICPD) program. The 'Health Check' program does not yet amount to an ongoing evaluation and assessment of the performance of the NITP. Nor is it yet a full assessment of the capabilities and training requirements of inspectors – or of how effective the NITP was in building their initial capability. SafeWork should continue to develop and implement the Health Check program, and similar evaluation tools and approaches, to measure the impact, outcomes and efficacy of the NITP program more fully. This process should include the capture insights on the performance of the NITP, the knowledge and capability of recent graduates, and identify areas of further learning for Inspectors.

Improvement Opportunity		Details
		Lessons from this assessment process should be used to inform the design of the NITP as it evolves over time. They should also be used to design and to target remedial and refresher training to ensure consistent standards are maintained by staff across the organisation.
5.	**Institute formal assessment for HSR training participants**	A core part of the value of the HSR training program is the nature and extent of the skills and knowledge it provides to current and prospective health and safety representatives. At present, SafeWork NSW has no practical ability to test whether the HSR training program is meaningfully increasing the knowledge and capability of participants. Instituting a formal assessment task for the program, with appropriately anonymised results reported back to SafeWork NSW would help to address this gap. It would also enable a cycle of continuous improvement, where future changes to the program could be driven by trends in assessment data.
6.	**EPH training should be updated to reflect more contemporary training practices, however this may not be the responsibility of SafeWork NSW**	Current Entry Permit Holder training is adequate, but could be better aligned to good practice for contemporary training design. It should be expanded in scope and timeframes to enable a more comprehensive suite of information to be provided to prospective entry permit holders. In addition, formal assessment should be built into the training to ensure that prospective entry permit holders are assessed on the knowledge they acquire from the training. However, it is noted that the current suite of EPH training materials was developed by SafeWork Australia. Updates to these materials may be the responsibility of SafeWork Australia. It is also noted that SafeWork NSW is not currently resourced to make updates to the EPH training materials.

Improvement Opportunity		Details
7.	**SafeWork NSW's approval process for providers of EPH and HSR training should continue to be more focused review and continuous improvement process.**	SafeWork NSW's decisions to approve providers of EPH and HSR training are made in isolation from one another and are not subject to sufficient external oversight. SafeWork NSW should continue to implement a formal process of selecting a percentage of these decisions for review by a team or manager separate to the TACS team. In parallel, SafeWork NSW should also seek to continue to capture insights through collecting longitudinal data about the performance of providers approved to deliver training over time. Insights collected from multiple providers over time should be used to inform changes to the framework and criteria used by SafeWork NSW to approve providers, to ensure that lessons from actual experience are continually used to inform approval decisions.
8.	**Increase current oversight resources and consider an expansion to supervising student outcomes over time**	Maintaining appropriate oversight over the delivery of HSR and EPH training programs will require additional resources for SafeWork NSW. If it is determined by the independent review that greater or closer oversight over HSR and EPH training provision is required, SafeWork NSW would either have to deprioritise its supervision of other training programs or seek additional resources from government. As its supervision of other training programs is also important, additional resources are likely to be required. An expansion of the TPV Unit would allow for more EPH and HSR training providers to be reviewed each year.
9.	**Formal triage training materials should be prepared and then regularly refreshed**	Training materials should be prepared to support new starters when they join either the SWAS Contact Centre or Triage advisor teams. These materials should contain a summary of relevant triage procedures and standards. They should also be formatted in a way to support self-directed learning by either new starters or existing staff. These materials should be supported by designs for training sessions and

Improvement Opportunity		Details
		coaching to be delivered to new starters by existing staff. All of this material should be revisited and (where necessary) revised at least once every two years. Procedures should also exist to ensure that training materials always contain a current version of any triaging standards or frameworks that are updated on an annual basis (e.g., a list of high-profile focus areas for triage). These training materials can then be used to form the basis of a potential formal training program for new members of either the SWAS or Triage advisor teams.
10.	**Simple triage skills assessments should be administered for new starters post training and for existing staff before they deliver training**	A simple assessment tool should be developed to test the triage related skills and capabilities of staff at SafeWork NSW. This tool should be designed to present staff with relevant scenarios and problems that leverage their triage skills. It should then use multiple choice answers (or other similar, objective, tests) to establish their level of competency. A minimum score threshold should be established below which a staff member may be required to engage in refresher training for their triage skills. This assessment tool should be used to assess all new starters in the SWAS, Triage advisor and RCEU teams at a designated point in their first six months in the organisation. Further, the assessment tool should be used to test experienced staff prior to their delivery of triage training or coaching support to new starters. The assessment tool should also be used for inspectors moving into roles with supervisory responsibility over triaging decisions.

260. I adopt those recommendations and make each of them a **Recommendation** of this Report. I note, as to Nous's recommendation 6, DCS/SafeWork's clarification of the respective responsibilities of SafeWork and SafeWork Australia with the

revision and updating of EPH training material confirmed to be the responsibility of SafeWork. The table of Recommendations in Section 4 of this Report reflects this.

261. There are two further points that I wish to raise in relation to training. The first relates to the way in which new inspectors are set to work once they achieve their qualification. Some submissions to my Review suggested that although new inspectors might have received sufficient theoretical training, there was nonetheless a gap between a person's having the knowledge to undertake work as an inspector and the confidence to do it. As I understand it, the practical component of the NITP is intended to address this. However, it seems to me, there could well be value in formalising a system whereby once new inspectors commence to work, they are paired with an experienced inspector and work with that inspector for a period of time jointly to respond to notifications and to undertake the other, what might be called external or outward-facing, aspects of an inspector's duty.

262. Other submissions to my review have made the point that while some employers are easy to deal with and cooperative, there are others, particularly in areas such as the building and construction industry, who can be more difficult. That appears to apply (in the case of the building and construction industry) not so much to the large contractors, as to smaller operators and subcontractors. There will of course also be at least the potential for problems where there are linguistic or other barriers of communication between the inspector and the PCBU.

263. In my view, it would be extremely beneficial for new inspectors, for a period of time, to have the benefit of the experience and backing of a senior inspector when they undertake what might be called field work. I accept that this would be likely to produce further pressure on an already over-pressured workforce, but the solution, as I see it, is to reduce workforce pressure by expanding the number of people available to do the work. If new inspectors are given the confidence that they need to carry out their duties, it is more likely that they will remain employed and working as inspectors, and be able in their turn train, mentor and support others.

264. I therefore **Recommend** that SafeWork give consideration to instituting a formal process of assigning new inspectors to work, for a period of three to six months, in pairs with existing and experienced inspectors when performing those aspects of an inspector's functions that involve dealing with PCBUs over complaints and notifications, and their investigation.

265. The comments from DCS/SafeWork stated that there is a mentoring and supervision practice in place, and that new inspectors are supported through this process. I am not clear that this addresses specifically my Recommendation just set out. I understand that SafeWork has adopted a policy whereby inspectors participating in the NITP must undertake field activities or visits associated with a request for service or incident only under the direct supervision of an experienced inspector. However, my Recommendation goes further, because it is intended to apply to new inspectors for a period of time after they have completed the NITP.

266. There is a related point, which does not concern the NITP or post-training mentoring, but is convenient to mention here. It is that some submissions have perceived a need, on occasions, for inspectors to attend a worksite in pairs. That may be the case where, for example, the worksite is extremely volatile, or where there has been a death or serious injury on site and there is an imperative need to obtain and preserve evidence. The way and number in which inspectors should work in responding to notifications is highly fact-specific, and it is not feasible to lay down mandatory requirements. I would however hope that both the safety of inspectors and the likely amount of work to be done in the obtaining and preservation of evidence are factors that are always given the most careful consideration when sending inspectors to worksites. Having said that, I do not think that it is feasible for me to make a practical recommendation.

267. The second point relates to a submission made to me that training work should be separated from what might be called "*inspecting*" work. If this were intended to suggest that inspectors should not be involved in training, then it is not a suggestion that I endorse. The Nous report makes it clear that the involvement of inspectors with practical experience in the training process is, understandably, seen by trainees to have great value. It gives a practical perspective to the theoretical material with which trainees are instructed. If inspectors were not involved, and the only non-formal training experience were that of field work as already exists, it is in my view highly likely that graduates of the NITP would lack the practical skills necessary to enable them to perform what is always a challenging, and sometimes difficult, role.

268. I accept that the involvement of inspectors in the NITP places pressures on them, in relation to their performance of their duties as inspectors. Again, however, the solution appears to me to be to increase the number of inspectors, so that neither

training nor field work (not to mention the innumerable other duties of inspectors) are affected.

269. I do not endorse the suggestion that there should be a formal separation of training and inspecting. I do however think that consideration should be given to identifying the best method of delivering training, involving both dedicated and trained instructors and, where appropriate, inspectors, so that there is an appropriate balance of theory and practical leaning. I also think that, as was submitted, the education process could be much improved by the input of bodies such as FIWSAG. It is very important that trainees at all levels understand the appalling consequences that all too often follow from a breach of applicable standards and duties.

270. I therefore **Recommend** that SafeWork review all its educational functions, both internal and external, with a view to identifying and utilising the best possible combination of theoretical and practical learning, and that FIWSAG or some equivalent body should be enlisted, assuming its continuing willingness to do so, to have input into both the design and the delivery of internal and external training. That review should extend to a consideration of the desirability and content of on-the-job training, or continuing education, for all staff whose roles involve dealing with PCBUs, workers, unions, HSRs and members of the public in connection with complaints, referrals, requests for service, investigations, and prosecutions.

8.4 Reconciliation of submissions with findings in the Nous' Training Report

271. Consistently with what I have said elsewhere, I accept that the submissions made to my Review on the subject of SafeWork's educational functions reflect views genuinely and sincerely held by those making the submissions. Further, to a considerable extent, the burden of those submissions receives some support from the views expressed and conclusions reached in Nous' Training Report.

272. I am confident that if the recommendations as to training made in this Report are adopted and implemented, there should be a substantial improvement in the quality of training, with a commensurate improvement in the ability of SafeWork's staff to perform their functions efficiently in the various roles to which they are assigned.

273. I noted above a specific concern raised in submissions as to the asserted inadequate training of Customer Service Centre staff (DCS/SafeWork say in their comments that those staff should be described as *"SWNSW Advisory Service staff").* I am not sure of the extent to which that will be considered in the implementation of the recommendations I have made, but to avoid any confusion, I consider that the training programs to the instituted should give specific attention to equipping staff in the Customer Service Centre (or SWAS) to perform their roles in a way that facilitates their interactions with those submitting complaints, notifications, requests for service, or who otherwise, for whatever reason, contact SafeWork.

274. I therefore **Recommend** that when SafeWork reviews its educational functions in accordance with [270] above, it should ensure that the review extends to the content and delivery of training (including continuing education) of its Customer Service Centre / SWNSW Advisory Service Staff.

275. If the recommendations set out above are adopted and implemented, they should produce noticeable improvement in the training given to HSRs and EPHs.

276. I turn to external training. Nous did not examine specifically, as part of its work, the quality of the education programs provided to PCBUs and other workforce participants. However, the way in which those education programs are undertaken, and the work or other groups within which they are undertaken, are really matters to be determined by SafeWork as part of the regulatory priorities that its sets for itself from time to time. I do note the CFMEU's submission to the effect that in its area, building and construction, education seemed to be directed disproportionately to larger rather than to smaller PCBUs. That is understandable to an extent, because larger PCBUs more generally have larger numbers of people working on their building and construction sites. However, experience suggests that it is the smaller PCBUs in this field (and no doubt others) that require education. This is a matter that in my view SafeWork should consider when allocating its education priorities. I do not think it appropriate to make a formal recommendation to that effect because, as I have said, it is ultimately a matter for SafeWork to set its priorities and to monitor them from time to time to ensure that they meet both its and the wider community's needs.

9 Terms of Reference Part 3: Structure and organisational separation of SafeWork

277. What follows in the next eleven paragraphs outlines the previous structure of SafeWork and the problems that many of those who made submissions perceived to result from that structure. That structure has been superseded by the changes effective from 1 December 2023 already described. I include that material because it illustrates the importance of SafeWork's being independent of departmental control, and gives background to my consideration of and recommendations as to how that independence may best be achieved.

278. SafeWork was, up until 30 November 2023, part of the BRD within DCS. Its staff, budget and functions all sat within BRD/DCS. There were a number of other regulators similarly located within BRD, including Fair Trading, Subsidence Advisory NSW, the Office of the Registrar General, the Professional Standards Authority and the Long Service Corporation. The Deputy Secretary for BRD, who has had responsibility for overseeing all these regulators, has also held the role of Commissioner for Fair Trading.

279. As noted above when dealing with the comments of DCS/SafeWork, the structural arrangements have now changed. Those comments state:

> *The structure for SafeWork (NSW)* [just outlined] *was in place until 30 November 2023. From 1 December 2023 and operational separation of the three regulators that made up the Better Regulation Division … was implemented whereby they were set up as three independent regulatory identifies with the Department of Customer Service.*

280. As I understand it, that current structure, which is intended to be interim pending consideration of this Report, has the effect that some three of the regulators that were formerly co-located within the BRD are now separate agencies with their own staff but still located as agencies within DCS, and ultimately answerable to the secretary of DCS. It is not part of my Review to ask whether those arrangements are suitable for the other regulators, and the recommendations that I made below are intended to apply specifically and only to SafeWork.

281. As noted in my first Interim Report, a number of submissions made to my Review advanced the proposition that SafeWork's effective performance of its functions

was hampered by its having been at the time the submissions were made, in substance a unit within BRD within DCS. The essence of that structure was that SafeWork and other regulators in fields more or less remotely relevant to SafeWork's activities were grouped together in the BRD as part of, and with reporting responsibility to, DCS. They were, administratively, under the control of DCS. One consequence, as I understand it, was that SafeWork's inspectors may work on matters that fall within the province of another regulator that is located within the BRD.

282. How this operated in practice was explained by SafeWork in its submission to my Review as follows:

> *BRD operates within a collaborative regulatory model with a number of functional streams. Within BRD, some staff work for just one regulator, but some may work across a number of BRD regulators providing specialist services under a cost recovery model.*
>
> *Under the BRD structure, SafeWork NSW's functions are distributed across the functional streams that are accountable for the delivery of specific services across regulators. Our SafeWork NSW Inspectors and their teams have clearly defined roles within the structure…*

283. As a practical illustration of how this operated, the investigations and enforcement function of BRD covered investigations and enforcement across a number of regulators, including SafeWork. This meant that SafeWork staff worked alongside staff of other regulators within that function. There was not a dedicated "SafeWork" investigations and enforcement team as such; rather, a section which dealt with investigations and enforcement for a number of regulators. The recent restructuring developments include creating a dedicated "*operations stream*" and "*strategy and programs stream*" for SafeWork.

284. The problems which were perceived to arise from SafeWork's having been housed within DCS included a loss of identity, a loss of credibility, a reduced "*public face*", a blurring with other regulators within DCS, increased difficulty of access (including through the common DCS systems such as the phone service), and a less robust approach to the regulation of government agencies and other departments.

285. Submissions commented that:

> "*A key feature that is missing from SafeWork is an independent oversight board that should endorse [SafeWork's] strategy and deliverables…it should be made up of injured workers, unions, business organisations and safety professionals.*"
>
> "*…an independent oversight body should be established to set priorities, monitor behaviour, monitor performance of SafeWork and review work methods to ensure efficient service delivery.*"
>
> "*…SafeWork needs to be an authority like ICAC to allow the organisation to do the job…*"
>
> "*…remove SafeWork NSW from the Department of Customer Service cluster and be a separate identifiable regulator as has been done with Liquor and Gaming NSW; have an Inspector General or give the Ombudsman greater powers; establish a parliamentary committee (as has been done for workers' compensation); or a combination of the above suggestions*"
>
> "*…it is time for an overseeing body such as Parliamentary Committee, or for the Ombudsman to have further rights to oversee [SafeWork] to ensure its performance*"
>
> "*[SafeWork] must become an independent standalone government regulatory body with appropriate qualified and competent persons to provide oversight…*"
>
> "*the only way forward is to reinstate SafeWork NSW as a statutory authority immediately, with the appointment of a Board made up of industry and union representatives to oversee the functions of the regulator*"
>
> "*there is a need to guarantee and preserve the operational autonomy and independence of SafeWork NSW Inspectors. We would advocate the creation of an independent entity, similar to the Independent Commission Against Corruption for SafeWork NSW to facilitate this.*"
>
> "*One problem is lack of accountability. Since SafeWork was amalgamated into a mega-department, responsibility for oversight of the organisation's*

functions has been diluted such that SafeWork appears to have lost the will to regulate…"

"*an Oversight and Advisory Council should be established. The Council should receive a detailed quarterly report on SafeWork NSW activities and performance…The above report should be forwarded on behalf of the Council to the Minister, before being published online…Members of the Council should be appointed by the Minister…The Council should meet quarterly. For the first year it should meet monthly. The Minister should attend the Council annually…"*

"*[SafeWork should] establish a permanent tripartite council, with equal representation from [SafeWork], Employers and Unions NSW."*

"*…NSW currently does not have an advisory board or committee. We believe an independent WHS advisory board, commission or committee should be created, with wider representation beyond tripartite parties to include WHS experts, as is the case in jurisdictions such as WA, Queensland, and soon to be SA. An independent chair would help facilitate its operation, as occurs with NSW Resources WHS."*

"*…finally for SafeWork to be most effective, separating SafeWork from other NSW Government's service sectors and funding it appropriately to undertake both education and compliance functions is critical. SafeWork NSW has a unique function which should not be confused and conflated with other government functions."*

"*SafeWork's location in BRD in DCS is directly contributing to the inadequate WHS outcomes in NSW. SafeWork NSW should be a standalone Regulator. The Regulator should not be operating across different Divisions within a monolith Department… SafeWork NSW must be removed from the department of customer service and be made a stand-alone regulatory agency with appropriate board oversight including worker representatives…"*

"*…independent oversight, such as that provided by the Standing Committee of Law and Justice in the workers compensation system, is the only way to encourage SafeWork NSW to take its regulatory role seriously and to fulfil its functions effectively."*

> *"…ongoing oversight of the Regulator and removal of the Regulator from the Department of Customer Service. A tri-partite body with some [oversight] and input into the Regulator with an advisory role not dissimilar [to] the Nominal Insurer Advisory Committee (NIAC), consisting of unions, employer organisations and SafeWork NSW…removing SafeWork NSW from the Department of Customer Service. SafeWork NSW should then be a stand-alone entity. With parliamentary oversight. Something not dissimilar to the Standing Committee of Law and Justice which has oversight of the Workers Compensation system."*

286. As will be apparent from the extracts set out above, the submissions I received echo the comment made as long ago as 1981 by Commissioner Williams, referred to at [38] above and in my first Interim Report, when he expressed "*a strong view of the undesirability of administration becoming the responsibility of a subdivision or branch of some existing Government department*". Commissioner Williams recommended the establishment of a separate Commission with responsibility for regulation of occupational health and safety.

287. Submissions to my Review included a number of suggestions for alternative structures for SafeWork and for mechanisms of oversight, including a Board, a Council, a tri-partite body, a parliamentary committee, the Ombudsman, and/or a combination of some or all of these mechanisms.

288. While at the time of its submission to my Review dated 28 February 2023 SafeWork maintained that "*BRD's organisational structure is designed to ensure effective alignment of functions and operations*" and "*[t]he structure creates opportunities for collaboration and capability development that standalone regulators do not have access to*", by the time of the restructuring developments in October 2023, to which I refer at [53] and [277] above, SafeWork's position was that the approach of operating a so-called "*super-regulator*", incorporating multiple regulators, was not effective and should be abandoned.

9.1 Workforce and culture issues, including within the Inspectorate

289. A number of issues were raised in submissions as to the workplace culture of SafeWork, including within the Inspectorate.

290. The issues included:

a. **Numbers of inspectors**. Some submissions to my Review said there were not enough trained inspectors. I was told that the current number of inspectors does not meet the ILO standard of one per 10,000 workers in NSW. Further, I was told that the raw figures give an incorrect impression of the numbers of inspectors who are in fact working as inspectors, because staff at the director and manager levels have inspector authorities, but do not perform an inspector's role in an operational or front-line sense.

b. **Turnover**. A high turnover of staff was reported, including a "*revolving door*" of directors and increased instability across the regional inspectorate. An inspector said this creates turmoil, and a lack of continuity, which is demoralising' for staff.

c. **Recruitment and promotion**. Concern was expressed about nepotism and inappropriate recruiting, including inappropriate internal recruitment and a perception that external candidates are recruited without appropriate experience or qualifications. Inspectors reported inconsistent progression at inspector level. Some respondents expressed concern about inspectors' workplace mobility, including restrictions on progress or advancement, and consequent effects on inspector development.

d. **Micromanagement, bullying and burnout**. This included reports that new inspectors have been subjected to alienation, exclusion and other behaviour posing a psychosocial hazard and that there is a culture of "*mobbing*". An inspector said that inspectors of long-standing no longer know what their purpose is. It was reported that SafeWork's management is at burnout point. I was told that restrictions on moving among teams and on subsequent reassignment contributes to a feeling of burnout and inspectors' inability to progress. An inspector reported an "*adversarial*" culture.

e. **Workload**. I was told that inspectors' workload was too high. Higher level inspectors were reported to spend less time in the field, with lower-level inspectors being heavily tied up filling in databases.

f. **Support and conditions**. Some respondents expressed concern at the lack of support given to inspectors following fatalities and injuries, and during and after the hearing of prosecutions. Other submissions raised issues about

workplace conditions such as fatigue management, driving and unsuitable vehicles, working alone and in remote locations, and a lack of welfare checks.

g. **HSRs and work health and safety committee within SafeWork**. Some submissions expressed concerns about SafeWork's approach to the work health and safety aspects of its own workplace and workforce, including the internal work health and safety committee and SafeWork's attitude towards HSRs within its workplace.

291. SafeWork accepts that the numbers of inspectors employed does not, but should, meet the ILO standard and accordingly must be increased. It is less clear that SafeWork accepts that it is legitimate to count, towards the ILO standard of one inspector per 10,000 persons employed across the State, those who have qualifications to act as inspectors but do not in fact do so.

292. I accept that it is desirable for managers and directors to understand what it is that those whom they manage and supervise do, and that for SafeWork, managers and directors might be helped in this if they themselves are qualified as inspectors. I do not accept that it is appropriate to count such managers and directors as active inspectors, for the purposes of the ILO standard, if they do not work as inspectors.

9.1.1 Discussion

293. It appears to be accepted by all, including now DCS, that the current structure of locating all regulators within the BRD is undesirable. At the time of writing, SafeWork and two other regulators were broken out of BRD and set up as separate agencies, although still within DCS, with the head of each agency reporting directly to the Secretary of DCS. I understand that, at least in respect of SafeWork, further consideration of its structure and governance has been put on hold until the Minister has had an opportunity of considering this Report.

294. A number of those submissions to repeat, with a rare degree of unanimity, the essence of the concerns expressed by Commission TG Williams in 1981 (see at [38] of this Report). There is a need for SafeWork, or more broadly the workplace health and safety regulator however named, to be and to be perceived to be independent of the executive arm of government in this State. I do not think that the requisite degree of independence can be achieved for as long as SafeWork remains embedded within a department such as DCS. It is obvious that any department of which SafeWork is but a part will have policies and priorities that

may not always align with those of SafeWork. In those circumstances, there is a real risk that what is necessary for SafeWork to perform its functions independently and efficiently will be subordinated to the needs of other administrative areas within that department.

295. I have come to the conclusion that the optimal governance structure for SafeWork requires that it be established as an independent statutory corporation as for example the Environmental Protection Authority (**EPA**) is constituted under the *Protection of the Environment Administration Act 1991* (NSW) (**PEA Act**). So constituted, SafeWork would be free of departmental control. The model legislated for the EPA could be adapted fairly readily for SafeWork, with appropriate changes to meet the particular requirements of SafeWork and to reflect the very different roles of the two regulators.

296. There should be a board comprising representatives of employer and employee organisations with demonstrated interest and expertise in the field of workplace health and safety. The board should also include at least one person, independent of such organisations, who works and is expert in the field of workplace health and safety.

297. In addition, the board should include a representative from an organisation such as FIWSAG. FIWSAG, and other organisations with similar aims, represent people whose loved ones have been killed or seriously maimed in workplace incidents. They are able to bring unique insights to the regulation of workplace health and safety. They should be given a formal role in that process of regulation both because they can bring those insights to bear and so that people whose loved ones have been killed or injured at work know that their collective voice is being heard.

298. I make those **Recommendations** accordingly.

299. Although this may be getting to a level of detail that is beyond the scope of my Terms of Reference, I do believe that there is a need to ensure that the board is refreshed at regular intervals. This will help to stand in the way of a "*business as usual*" approach and will enable fresh ideas and fresh insights to be brought to bear on SafeWork's performance of its statutory functions.

300. That leaves for consideration the related questions: ministerial responsibility, and accountability. The model of the PEA Act suggests that there should be a responsible minister who should have limited powers to give directions of a general

nature and not in relation to specific matters (see section 13(1), (2) of the PEA Act). I do not think there should be an equivalent of section 13A, allowing the Minister in effect to assume and exercise functions of SafeWork.

301. I turn to accountability. Given the degree of independence that I recommend, it would be necessary for there to be effective oversight of SafeWork's operations. That, I think, could be achieved in two ways. The first is by a provision for reports to and scrutiny by a parliamentary committee: for example, the Standing Committee on Law and Justice. The second is by a provision for regular (biennial or triennial) reviews of the continuing operation of the amending legislation, with a view to ensuring that the objectives underlying the legislation and the performance of SafeWork as an independent regulator are satisfactory.

302. That necessarily raises the question of funding. Statutory independence does not of itself mean that government funding, if and where necessary, should cease. As I have noted above, SafeWork is presently funded, under section 35(2)(b) of the WIM Act, out of the Operational Fund which in turn derives contributions from the Insurance Fund and other insurers. In my view, that should continue. It is obvious that workers' compensation insurers (including particularly the Nominal Insurer, because of its preponderant market share) have a very strong interest in the effective operation of SafeWork or an equivalent organisation as a workplace health and safety regulator. Anything that helps to prevent or minimise workplace deaths and accidents is worthwhile, both for its own sake (which in my view should be the primary aim of any workplace health and safety regime and regulator) and to assist in keeping some control over the soaring costs of workers' compensation insurance. On this latter point, there is a complete alignment between the interests of SafeWork and the interests of the workers' compensation industry more generally.

9.2 Complaints as to alleged unlawful or undesirable conduct in the workplace

303. The former structure locating SafeWork within the BRD of DCS means that workforce complaints within SafeWork were dealt with, at least in the first instance, by the "People and Culture" (**P&C**) division of DCS. If the matter was referred as a workplace health and safety matter via SafeWork itself, the complaint was referred to the Resources Regulator. I received submissions as to the inappropriate or inadequate nature of these structures. As I understand it, that remains the

essence of the complaints handling process after the changes in structure effective from 1 December 2023. What was said about the process therefore remains relevant.

304. Some respondents expressed concern that P&C takes a narrow view of complaints made. Others expressed concern as to its conduct of investigations.

305. Other submissions expressed concern about the process of referring workplace conduct matters within SafeWork to the Resources Regulator. The concerns included that SafeWork "*triages*" matters and decides which ones will be referred. This was said to amount to a process, unique to SafeWork, of workers having to refer their workplace health and safety concerns to their employer before those concerns could be reviewed by the regulator. There was also concern that the Resources Regulator is not effective at assessing bullying and harassment matters. One inspector submitted that "*[f]or internal WHS matters, the workforce needs access to a truly independent WHS regulator with the same powers as SafeWork NSW.*"

306. Submissions to the Review raised individual cases of bullying and alleged unlawful or undesirable conduct in the workplace. The examination of specific cases does not fall within my Terms of Reference.

307. The comments from DCS/SafeWork on this topic stated:

> *If a matter is received through the internal complaints process and managed under the Positive and Productive Workplace Policy managed by PNC, an independent investigation is undertaken by an external agency. If the matter is referred through the SafeWork process available to any employee in New South Wales then the matter is referred to the Resources Regulator (rather than SafeWork which occurs for all other referral[s] to prevent a conflict of interest).*

308. If this were intended to suggest that the current process for handling complaints is both adequate and appropriate, then I do not agree.

309. DCS/SafeWork also commented that the NSW Resources Regulator has the same statutory powers as SafeWork. That may be so, but it is hardly to the point made in the submissions.

310. I do not regard the current structures for handling workplace complaints within SafeWork as satisfactory. The submissions outlined above show why this is so, as do the views of Nous to which I shall turn. Structural separation of SafeWork from DCS will, presumably, eliminate the role of P&C, but the remodelled SafeWork will have to develop its own system for handling such complaints, and for monitoring and reviewing the way in which those complaints are handled. Once such a system is developed and implemented, the need for what seems to be a clumsy structure involving the Resources Regulator should vanish.

311. It is beyond the scope of my Review to develop a specific, "*best practice*", workplace complaints handling structure. However, the comments and recommendations of Nous, which I next consider, provide valuable guidance as to the principles to be adopted.

9.2.1 Nous Group's report on SafeWork's complaints function

312. The third of the reports that Nous provided for my Review dealt with the question:

> *Are the Department and SafeWork NSW's current processes and practices appropriate to deliver effective and compliant outcomes for complainants and respondents? How can they be improved?*

313. Nous examined the processes set up by P&C and the way in which, over time, P&C had handled complaints. Nous' approach was methodologically similar to its approaches, described above, for its reports on the triage and IDMP processes and on training.

314. Nous identified what it regarded as "*the principles of a best practice internal workplace complaints and grievances function*", considered "*to what extent… [SafeWork's] existing processes and practices [were] aligned to best practice*", and then considered "*what are the areas for improvement*". To undertake that work, Nous considered a substantial volume of documentation provided by P&C, reviewed 12 sets of case files (one of those originally requested could not be found, so a substitute file was requested), and consulted with staff of both P&C and SafeWork. Nous also, of course, considered a number of sources in which best practice for handling workplace complaints and grievances were discussed, and looked at the statutory requirements imposed on SafeWork, as a New South Wales Government Agency, to deal with such grievances.

315. The statutory requirements are found in section 69 of the *Government Sector Employment Act 2013* (NSW) and in the Government Sector Conduct Rules. Nous concluded that the complaints and grievance processes set up for DCS by P&C were complaint with those legislative requirements.

316. A pervasive theme throughout this Nous report is that of change, or perhaps more accurately flux. Nous notes in several places that some of the relevant procedures and supporting systems are being updated. Thus, the processes that were considered by Nous may not reflect the processes in place when the issues raised in submissions to my Review occurred; and the processes considered by Nous may change as the updating process continues.

317. Nous noted, further, that there has been a significant turnover of staff within P&C. One consequence of that turnover of staff is that newly inducted staff members do not always have the benefit of being able to work alongside, and turn to for help, more experienced colleagues. Nous considered that this is a factor that contributes to perceived inconsistency of outcomes.

318. In very broad outline, the process that Nous understood to be followed when a complaint is received is to assess and triage it, with a view to directing the complainant to an appropriate grievance resolution pathway. There are three pathways: first, a one-on-one conversation with the complainant's manager; next (if the first pathway does not work), facilitated discussion; and finally (if neither works), external resolution.

319. Nous considered that "*the grievances and complaints process and systems applied to SafeWork NSW [by P&C] is* [sic] *generally conducted in alignment to good practice*" but that there were "*opportunities for improvement to strengthen the management of complaints*". As to that last point, Nous noted specifically "*a gap in processes to document and store complaint information and outcomes*" which, it said, "*limits the ability for end-to-end accountability and system reporting… to inform continuous improvement*". It also, as Nous noted, limited Nous's ability to assess and report on the efficiency of the complaints and grievances process.

320. The 12 case files assessed by Nous ranged in date from 2016 to 2022 (two from 2016, two for 2019) and one for each other year. It is concerning that, of the 12 case files assessed, five, in Nous' view, failed to demonstrate that good practice had been applied to the handling of the complaint. The problems were variously lack of documentation, lack of any documented resolution, delay due to under-

resourcing, lack of clarifying documentation, and lack of evidence of investigation. A study of the assessment findings suggests that the deficiencies in all cases but that of delay caused by under-resourcing were due to inadequate documentation – i.e., a failure on the part of the personnel handling the complaints to document clearly the process that had been followed and the result reached. This is of particular concern given that the improvements in process that Nous described do not appear to be directed at remedying deficiencies in performance of that nature. Having said that, I note that Nous has made recommendations, to which I shall turn, that, if applied, could help to remedy this particular problem.

321. At the level of principle, Nous, having assessed the current complaints handling process against the principles of good practice that it identified, found that the process "*is generally conducted in alignment to good practice*". There were, Nous thought, "*the foundations of an assessable and person centric system*", although "*poor access to information on the process may lead to poor outcomes*".

322. Nous considered that the accessibility of the grievance handling process was limited by both the difficulty of finding available materials and the lack of detailed and current information on the complaints handling process. Those conclusions gave rise to two recommendations, which I consider to be responsive to the difficulties identified by Nous, and that I endorse and propose to adopt as **Recommendations** of this Report.

323. Nous found that the existing processes demonstrated "*commitment to principles of both fairness and procedural fairness in* [their] *design and application*". The first point, fairness, relates to equality of treatment (specifically, all complaints being handled equally regardless of the identities of the complainant and the respondent). The second point, procedural fairness, is self-explanatory. Nous set out the elements of procedural fairness demonstrated by the existing processes as follows:

- *respondents are advised of the allegation and provided an opportunity to respond*
- *complainants and respondents are treated with respect throughout the process, with staff acknowledging their concerns and addressing them with sincerity*
- *complainants and respondents are communicated with throughout the process in a way that is suitable for the individuals involved*
- *communicate the reasons and supporting evidence for decisions to complainants and respondents*

- *allow participants the opportunity to respond to adverse information and decisions*
- *make lawful decisions that are independent of influence or bias*
- *conduct regular reviews of consistency.*

324. Nous' review of the processes as they are presently established and documented concluded that they followed principles of fair and equal treatment, and sought to embed those principles into the handling of workplace grievances. Nous said, further, that both from its review of the complaint handling files and from discussions with staff, it was able to conclude that the process had been applied in a fair way in individual cases.

325. Nous was concerned at the lack of evidence to demonstrate the efficiency of the complaints handling process. That was a systematic deficiency: the systems used did not provide guidance on timeframes; timeframes to outcomes were not communicated to complainants and respondents; and data as to resolution timeframes were not captured by the systems. Thus, although staff practice within P&C was to seek to resolve matters as quickly as possible, it could not always be shown that this had happened.

326. In addition, as one might expect, there were factors that could delay the speedy resolution of grievances that were beyond the control of P&C. They included the reference of matters to external examination, the return of matters to complainants or respondents or managers comment for further comment, and resourcing shortcomings in the P&C teams handling the complaints.

327. Nous made a recommendation intended to lead to the improvement of at least data collection, so that the efficiency of the complaints handling process could be assessed more thoroughly. I endorse that recommendation and shall adopt it as a **Recommendation** of this Report.

328. Confidentiality is of course an important aspect of grievance handling procedures. Nous reported that the processes in place maintained confidentiality, but that there was some room for improvement. It made a recommendation in support of this, which I endorse and shall adopt as a **Recommendation** of this Report.

329. One specific problem that Nous noted arose from anonymous complaints. Where a complaint is made anonymously (for example, through the DCS Integrity Hotline), it can be difficult both to contact the complainant to obtain further details where needed and to obtain sufficient information to identify a respondent and make the

respondent aware of the complaint, with sufficient information to enable the respondent to reply. Those difficulties inhibit the resolution of the complaint at all, and are likely to cause delay in achieving resolution. As Nous said:

> *There is a tension between the provision of anonymous complaint channels, procedural fairness, and effective investigation. Confidential reporting channels are a feature of good practice which exists in SafeWork's current process. Anonymous complaints should be investigated, as far as is reasonably practicable if they are assessed as having some substance. However, confidential channels can make the resolution process more difficult and, in some cases, not possible.*
>
> *One reviewed case file provides an example where an allegation of bullying was made against a manager. As the complaint was lodged through the DCS Integrity Hotline, there was no mechanism to speak to the complainant and understand the issue further, while the complainant had not responded to Core Integrity's enquiries. In addition, as P&C were unaware of the complainant's identity, their enquiries were restricted to minimise the risk of inadvertently exposing their identity. Documents provided to Nous indicate that this issue may not have been resolved. This presents a challenge for the Department in effectively addressing all matters it receives with appropriate seriousness and resources.*
>
> *There will always be an ongoing tension between providing channels for anonymous reporting of issues, and effective investigation of those issues. Complainants and staff must be clear on the implications of confidential reports and its limitations as a method to achieve outcomes. Further, clear guidance is required for P&C to address challenges of confidentiality where allegations arise such as the one described above.*

330. Nous made a recommendation seeking to improve the maintenance of confidentiality and its balancing with effective investigation. I endorse that recommendation and shall adopt it as a **Recommendation** of this Report.

331. Nous next considered the triaging of complaints. It concluded that the triage system was generally effective, having been updated and amended from time to time in response to changes in law or good practice. However, Nous considered that the material supporting the triage staff could be improved, and that if this were done, complaints could be more accurately directed to the appropriate resolution pathway.

332. An allied problem that Nous perceived was inconsistency of managers' people management skills to identify and support the most appropriate way for resolution of complaints. It appears that little training is provided, and that what little is provided is given only on induction when joining. There is no program of continuing, on-the-job, training to refresh and update the skills of managers in this area. Nous did note that SafeWork has "*recently invested in a new leadership training program 'Elevate'*." However, Nous said, "*it is not clear that complaint resolution is a focus of this program*". Further, at present, the program is focused on senior leaders and has not been yet extended to managers.

333. Another problem identified by Nous was "*that few managers [within SafeWork] are aware of their P&C contact*" and that such knowledge as there is tends to come from "*historical knowledge of the P&C Team*".

334. Nous considered the practices and systems that might assist in demonstrating accountability for complaints handling: that is to say, that might assist in demonstrating that complaints had been resolved in a timely and appropriate fashion. That was difficult, Nous said, because DCS "*does not currently have appropriate systems in place to ensure accountability for complaints and grievance processes. There is no single platform or tool that allows for case management of complaints and grievance processes*". Although work was under way to introduce those systems, there was not, as at October/November 2023 when Nous was considering the complaints handling process, any "*dedicated human resources record management or process management software tool*". Such tools as existed were informal, relying heavily on the knowledge of individual staff and, when those staff depart, on that knowledge being imparted on handover to incoming staff.

335. A new record-keeping and case management system is apparently being developed and implemented. That system was described to Nous "*as an internal 'minimum viable product' that would automate basic process management and record keeping*" with the expectation that additional features would be added over time. Nous considered that if this system were properly designed and implemented, "*it may support better outcomes*".

336. Against that background, Nous made a recommendation as to record-keeping which in my view is fully justified by the matters recounted in the Report. I endorse that recommendation and shall accept it as a **Recommendation** of this Report.

337. The last problem that Nous noted was that a lack of resources within the complaints handling process to support consistency of outcomes. Nous commented that "*current approaches are optimised around internal "self service" rather than the management of complaints by managers on behalf of staff*". Nous did note that it had been informed "*that processes, documentation and systems are currently being updated to support better outcomes from this approach*". It made a recommendation aimed at dealing with the problem of inconsistency. I endorse that recommendation and shall accept it as a **Recommendation** of this Report.

338. Nous made the following eight recommendations:

Opportunity	**Details**
1. Update the Positive and Productive Workplace Policy and accompanying intranet material	Undertake a complete review of the Positive and Productive Workplace Policy. This should include, in-depth consultation with SafeWork staff and Employee Reference Groups to under what users of the policy require. A revised policy should include key information on each step of the process, written in a clear and transparent way for all employees to be able to understand. An available contact should be provided for employees to clarify their understanding and provide further feedback.

Opportunity	Details
2. Invest in new processes and supports to ensure accessibility of complaints process for all SafeWork employees	The Department should take a user-centred approach to the review of complaints processes. This could include: working directly with Employee Reference Groups and other advocates who may represent vulnerable employee cohorts to obtain feedback on the existing information, processes and supports. Use behaviour insights from employee representatives to map the complaint journey from the perspective of employees and understand what accessibility reforms are required. Develop a 'lists of services' which can be made available to employees experiencing a complaints process. This list of services should include guidance on referral pathways to specialist services for people involved in a complaint, including people who are culturally and racially marginalised, people who identify as LGBTIQ+, or people with disability. Information about support options should be made clear and accessible on the DCS Intranet.
3. Better track delivery times for complaints and grievance issues	Over time, and especially once new systems are embedded, develop approaches for capturing data on the resolution of each stage of each complaint and grievance process. This should include time to complete each stage, as well as data on performance against other relevant KPIs. Draw on this data to analyse delivery timeframes, identify areas of potential delay, and drive process changes and resourcing changes to ensure rapid, effective, delivery of work to resolve complaint and grievance matters.

Opportunity	Details
4. Expand training for managers to identify and support the resolution of workplace grievances	Develop a mandatory training program for SafeWork managers to equip them with the skills to manage workplace conflict, have difficult conversations and to understand when and how to engage P&C. Review and update existing induction training for all staff to include detail on workplace conflict, unacceptable behaviour and how to manage grievances.
5. Consider clarifying how confidentiality is maintained and balanced against effective investigation of issues	Enhance the guidance for SafeWork employees and staff to make clear the value of confidentiality and to address potential gaps in maintaining confidentiality through current processes. Enhanced guidance should also provide clarity how confidentiality should be balanced with the need for administrative simplicity and a requirement that all complaints be effectively investigated and resolved.
6. Revise triaging tool to support more consistent decision-making to determine the appropriate pathway for complaint resolution	The Department should develop a new triaging tool which provides detailed guidance on the factors which may influence the severity of the case, or the required level of support. This new tool should be informed by an understanding of the different identities within the organisation, and how different power dynamics and relationships may play out in the context of conflict resolution. As part of the guidance, the Department and SafeWork should consider developing a risk assessment framework, with accompanying detail on the resulting triage, protocols, supports, and accommodations required. The triage tool and risk assessment framework could be incorporated into the new case management system. Once a triage system is implemented, monitor its use and the demand for different resolution pathways and invest in the appropriate resources to manage demand.

Opportunity	Details
7. Ensure record keeping and oversight is systematised, and automated where appropriate	Ensure that systems and processes are established to automate the collection and archiving of all documents related to each complaint or grievance matter managed by the People and Culture area. Using the record keeping and management system currently subject to implementation, ensure that all records generated as part of the resolution of a matter are linked to that matter and saved in a way that ensures that the People and Culture area meets appropriate record keeping requirements and can support all of its decisions with appropriate evidence.
8. Ensure greater consistency and support in the complaints and grievance handling work performed by the People & Culture team on behalf of SafeWork NSW	Improve current service delivery approaches to provide a more consistent and seamless suite of supports for SafeWork NSW staff and managers. This should include: increasing the consistency of knowledge of People & Culture staff engaging with the People & Culture team; improving the accessibility of the People & Culture team to SafeWork NSW staff and managers; and, reducing the manual effort required by SafeWork NSW staff and managers to progress complaints and grievance processes.

339. I adopt each of those recommendations and make it a **Recommendation** of this Report.

340. There is a further matter to be considered. As I have noted from time to time, it appears that the complaints handling process is undergoing considerable change. Nous was unable to consider the efficacy of those changes, because they are in some cases in complete and in others still in the process of implementation. In my view, it is essential that, when all those changes have been finalised and implemented, and after they have been given an opportunity to bed in, a further review of the complaints handling process be undertaken to see whether, and if so, to what extent, those changes affect any of the conclusions reached by Nous, and have worked to improve the quality and consistency of outcomes.

341. I therefore **Recommend** that within a period of 9 to 12 months from the delivery of this Report to the Minister and its publication, a further review be undertaken of

the complaints and grievance handling processes of SafeWork to identify whether the deficiencies in those processes identified in the Nous report have been rectified, and whether the complaints handling function has improved both as to efficiency and as to correctness and consistency of outcomes.

9.2.2 Reconciliation of submissions with findings in the Nous complaints report

342. There is some misalignment between the findings expressed in Nous's report and many of the complaints made or referred to in submissions to my Review. To some extent, I think, that can be explained on the basis that Nous was viewing the matter at a systems or procedural level, whereas the submissions reflected individuals' dissatisfaction with their particular complaints that were the particular subject-matter of their submissions.

343. There may be a related problem, in that as I have pointed out workplace issues are handled through the P&C Division of DCS. SafeWork, as an agency embedded within the BRD of DCS, will have its own interests and priorities. However, DCS as a "*super-agency*" or cluster agency, will have from time to time alternative and different priorities. It may very well be that some of the issues raised by SafeWork employees become subsumed within the wider issues and varying priorities peculiar to DCS as a whole.

344. I am not certain of the extent to which those differences can be accommodated within a single broad view. Regardless, it is essential that the complaints and grievances handling process, however it is set up, should offer both fairness and procedural fairness in the senses explained above; that the outcomes be transparent; and that the people who make them be accountable in that the reasons for their decisions can be seen to reflect and deal in an appropriate way with the complaint or grievance that was submitted.

10 Terms of Reference Part 4: A genuine voice for workers, their representatives and the families of injured and deceased workers

345. Part 4 of the Terms of Reference requires me to consider appropriate measures to ensure that workers and their representatives (including HSRs) and the families of injured and deceased workers have a genuine voice in the complaints, investigation and enforcement processes.

346. Consultation with families and injured workers is not a requirement of the 2011 Act. Section 164(2)(c) of the 2011 Act does however require inspectors, as soon as may be practicable after entry to a workplace or suspected workplace, to take all reasonable steps to notify any HSR for workers carrying out work for that business or undertaking at the workplace.

347. On this aspect of the Terms of Reference, I received submissions and heard directly from injured workers, their representatives (including unions), from people who have performed the role of HSRs, and from the families of injured and deceased workers. That last group included parents, spouses, partners and siblings of injured and deceased workers, including those who are members of FIWSAG and its co-chairs, and the Touched by Christopher Foundation.

348. I express particular gratitude to the injured workers and families who came forward to provide their experiences. I acknowledge the ongoing, painful and life-changing impact of their experiences of injury, and of the loss of partners, parents, and children in workplace incidents (to call them accidents is all too often a misnomer) that should have been avoidable. No-one should have to suffer serious injury, let alone death, for another's inattention to, or ignorance of, the fundamental importance of workplace health and safety. The whole community of this State is enriched by the willingness and ability of all those people, and the organisations they have formed, to make their suffering a force for improvement.

349. Four themes emerged from the individual and group stakeholder responses to this aspect of the Terms of Reference: communication, transparency (which I address together), input and support. I address those themes below after setting out some brief background about the creation of FIWSAG.

10.1 Family and Injured Workers Support and Advisory Group

350. FIWSAG was established in November 2020. It comprises people who have suffered a serious work-related incident or who have a family member who has died in a workplace-related incident. According to the FIWSAG page on the NSW Government website, FIWSAG:

a. Engages with affected persons through targeted and constructive consultation to improve service delivery;
b. Provides advice and makes recommendations to SafeWork about the support needs of affected persons;
c. Advocates for work health and safety in the community through actively contributing to the development and dissemination of work health and safety messages; and
d. Networks with others in similar circumstances and engages with people affected by serious workplace incidents.

351. SafeWork formally meets with FIWSAG quarterly, and additional meetings may be convened as required.

352. FIWSAG members who provided submissions to the Review described some frustration with progress of that consultation process in the first two years of its operation, but reported an improvement from October 2022. That coincided with a change of management at SafeWork and the involvement of the then head of SafeWork, Ms Natasha Mann, as a co-chair of the Group. SafeWork acknowledged these past concerns of FIWSAG and the more recent improvement in its submission to my Review.

353. In my view, that process of consultation should be continued. The families of deceased workers, and injured workers and their families, have a clear and extremely significant interest in knowing that SafeWork is functioning as an effective workplace health and safety regulator. There is much that they can add, in many areas, to SafeWork's performance of its functions: for example, in the tailoring of EUs to meet the precise circumstances of a workplace incident that resulting in death of serious injury.

354. I **Recommend** that when SafeWork is restructured, it formalise and continue with the process of regular meetings, at least quarterly and more often as circumstances require, with FIWSAG.

355. HSRs, of course, are another source of potentially extremely valuable information in this and in many other contexts.

356. I **Recommend** that when investigating a workplace incident and considering what action to take, SafeWork should wherever possible make contact with HSRs of the workforce of the PCBU at the location of the incident, and seek their input both as to evidence that may be available of an unsafe system of work and (where EUs are being considered) as to the precise terms of the EUs that may be negotiated with the PCBU.

357. I now turn to the themes that emerged from responses to this aspect of the Terms of Reference.

10.1.1 Communication and transparency

358. Injured workers and families emphasised in their submissions the need to improve communication and transparency during all stages of the investigation and prosecution processes.

359. One family member felt that there was "*a huge lack of transparency*" about workplace health and safety incidents and that they were "*only ever given basic information*". Another family member explained that the absence of a timeline or points of reference results in confusion and anxiety, because "*every milestone becomes an unpleasant surprise*". Another family member explained that it is "*often months*" between contacts from SafeWork. I was told that families would be assisted by an outline, at the outset, of the process to be followed in the investigation of the incident. It was suggested that a timeline, and an indication of possible outcomes, could be provided at the initial meeting between SafeWork and the family.

360. I was told that, once an investigation is commenced, families perceive that they receive minimal information, that they feel "*shut out*" of the process, and that in their experience they are often "*the last*" to be informed. One family member said that "*as a family member and first of kin, I had no visibility of the investigation process*". It was urged that "*there needs to be a way to keep families in the loop*". I received a similar account from an inspector about a family member's remaining unclear as to why an investigation had been finalised. Another family member said they had not been provided information or updates about the status of the investigation.

361. A family member explained that, when a decision is taken not to prosecute, or a decision is taken to prosecute certain entities but not others (for example, the PCBU but not its directors), they were frustrated about not receiving findings or reasons for the decision. Another family member commented that they would benefit from having significant decisions explained.

362. One submission commented that when a matter does proceed to prosecution, the family felt that they did not have an effective avenue to communicate with SafeWork during the prosecution. Where a PCBU enters a guilty plea, that pleas will often (if not always) be dealt with on the basis of facts agreed between the prosecutor and the defendant. In those circumstances, family members felt that they did not have the opportunity to know the full facts and evidence about what had happened to their loved ones.

363. Family members stressed in their submissions the need for empathetic communication, referring to the deep impact that information and decisions may have on affected family members, injured workers and their colleagues. The experience of going through the investigation and prosecution processes in connection with the death of their loved one was described by one family member as "*brutal*". Family members expressed frustration about the length of time taken by investigations and prosecutions, which they perceived to compound the problems described above. I was also told that some family members (for example parents who were not formal next of kin) felt that their relationship was not acknowledged to the same extent, and that it was more difficult for them to obtain information.

364. Submissions acknowledged that the position has improved somewhat through the work of SafeWork's family liaison officers and of FIWSAG. However, another submission expressed frustration that the family liaison officer's role appeared to be limited to dealing with families of deceased workers, and, in effect, that there is no equivalent role for liaison with injured workers or their families.

365. All those concerns may be acknowledged. Death is all too often brutal to the families of the deceased; and needless, avoidable death must be particularly so. Likewise, needless and avoidable injury. People want to know what happened. They want to know why. And they want to know what the consequences will be. They need to come to terms with what has happened; to its shattering impact on their lives and those of their families and friends.

366. Sometimes, those emotions and thoughts are directed at understanding and improvement. Sometimes, they are directed at punishment for those perceived to have been responsible. All those reactions are legitimate, and it is no part of my role to downplay their importance. But there are other very important considerations to be balanced. One submission referred to the importance of privacy and confidentiality of PCBUs and workers throughout the complaints, investigation and enforcement processes. That is important, as is the related necessity of avoiding any risk whatsoever of prejudicing any prosecution that my result from the incident.

367. There is no *a priori* formula to dictate how those considerations should be balanced. It requires an evaluative judgment which is intensely dependent on the particular facts of each case. Perhaps a better explanation of this at the outset of an investigation might help. But regardless, SafeWork, in conjunction with FIWSAG and others who might wish to have input based on experience, should develop and from time to time review guidelines for the way in which all those who have lost a loved one, or who have (or whose loved one has) suffered a significant workplace injury, are informed about the process to be followed and at least in broad outline of the way that process is evolving in the particular case.

10.1.2 Input

368. Family members expressed a desire for input into the investigative process. For example, it was suggested that family members may have evidence that would be of assistance to SafeWork. Inspectors also expressed concern that families are not included by SafeWork in the evidence gathering process.

369. Submissions from injured workers and family members expressed a desire to have input into the formulation of EUs and the programs and initiatives which may form part of them before they are finalised. It was suggested that this could make the outcomes of an EU more relevant and effective, and could also have the advantage that families and injured workers would "*have the chance to make a positive input thus feeling validated and heard*". A family member also expressed frustration about not having enough time to respond to a PCBU's application for an EU.

370. What I have said above as to the development of a structure for keeping workers and families informed is relevant here. I accept that families may have relevant information; and they should not be excluded as a potential source of evidence. Experience does however suggest that it is often the case that what someone who

is closely and personally involved thinks is highly relevant evidence is not always properly so described.

371. I do accept that families and workers should have input into the structure and content of EUs if these are being considered as an appropriate regulatory response in a particular case. In particular, a present or former employee of the PCBU involved may be able to offer valuable insights into the PCBU's likely ability or indeed their will to comply, and specifically into the terms that might be put forward.

10.1.3 Support

372. A submission by a family member called for a structured level of support and described their experiences of trauma, a lack of support and a feeling of frustration on the part of grieving families. I was told that the need for support extended to support for other workers of the PCBU involved in a work health and safety incident, given the "*ripple effect*" of health and safety incidents within a workplace. Those effects, it was said and I accept, may extend to mental health trauma. It was also suggested that inspectors need additional training on how to interview injured workers, taking into account mental health impacts, trauma. FIWSAG feels it could assist with this, and more generally families feel there are opportunities for collaboration and additional training both within SafeWork and for PCBUs.

10.2 Workers' representatives including HSRs

373. In relation to a genuine voice for worker representatives, including HSRs, submissions described a failure to contact worker representatives and a lack of support for HSRs.

374. I heard from unions that that they feel HSRs are very undervalued. Unions and inspectors reported experiences of HSRs not being contacted when inspectors attend workplaces, despite notification being required under section 164(2)(c) of the 2011 Act. The Fire Brigade Employee's Union of NSW (**FBEU**) reported that inspectors do not notify unions about when an inspector would be attending a site. Inspectors considered that not contacting HSRs was a missed opportunity to gather evidence to assess compliance and to verify what safety systems are in place at the workplace. An inspector submitted that to improve this, the WSMS system could be amended to require evidence or sign-off that workers and HSRs had been contacted by inspectors attending workplaces.

375. The SDA suggested that SafeWork should be more open and transparent with unions and HSRs about notices, throughout investigations and in the process of determining if a prosecution will be taken. According to the NSWNMA, SafeWork "*does not welcome or invite the expertise of Health and Safety Representatives or Unions during investigations, notwithstanding both have significant interest in making workplaces safer*".

376. An inspector described a lack of support for HSRs, despite HSRs being, in the inspector's view, one of the most beneficial parts of the legislation because of its provision for consultation between employees and PCBUs. Inspectors also described difficulties in having complaints by HSRs about non-compliance taken seriously, and suggested that SafeWork was not taking adequate compliance and enforcement action to protect HSRs in the exercise of their powers. More generally, unions felt that SafeWork has not made proactive efforts to engage with and assist HSRs, with the FBEU referring to a "*lack of institutional interest*" in developing HSRs.

377. Another submission stated that workers and worker representatives had not been kept informed adequately of the outcome of workplace attendances other than verbal feedback and general information, or of the progress and outcome once a matter has been referred to SafeWork. It was suggested in submissions by inspectors that providing more information would make the work of inspectors more transparent. The CFMEU stressed that direct contact with union officials is very important and gets matters addressed.

378. Other issues raised included an alleged lack of interest and commitment on the part of SafeWork to HSRs within the organisation; a perceived need for specific forums for workers and HSRs; the view that, where decisions are taken not to prosecute or to accept enforceable undertakings or other action, these should be transparently shared with the worker and/or union who raised the issue (if it were not reported anonymously); the view that inspectors should be required to provide copies of inspection reports and notices to the notifier of a matter, the relevant union and workplace HSRs; and difficulties for unions in pursuing prosecutions, due to not being notified within sufficient time of SafeWork's decisions.

379. I referred at [154] to [157] above to observations made by Nous in its Triage and IDMP Report as to the need to keep "*external stakeholders*" regularly informed. The submissions that I have received from a variety of sources, including FIWSAG and unions, emphasise the importance of this. The families of deceased and

injured workers, and of course the injured workers themselves, should be kept informed about the investigation into the incident that led to the death or injury. At the outset, they should be told of the investigative process that will be followed. Along the way, they should be kept informed of the progress of that process. And they should be informed of the outcome of the investigation.

380. I accept, of course, that where prosecution is being considered, care must be taken as to the form and content of those communications. It is essential not to jeopardise the success of any prosecution that may be instituted.

381. It is also essential, in my view, to explain to families and injured workers why, when it is the case, a prosecution is not undertaken. There will often be valid reasons for this, including that advice has been received that the evidence is unlikely to sustain a finding of guilt on the criminal standard. There may be other occasions when, although prosecution may have good prospects of resulting in a finding of guilty, other action is, nonetheless, seen to be more appropriate. Families and injured workers are entitled to have those matters conveyed and explained to them.

382. So too, in my view, are unions, at least where they have pushed for a prosecution. Sections 230 and 231 of the 2011 Act set out, in a somewhat convoluted way, when the secretary of an industrial organisation of employees may bring a prosecution for a Category 1 or Category 2 offence. Section 232 imposes a time limit for the bringing of a prosecution. If unions, in the circumstances postulated at the beginning of this paragraph, are not kept informed of the progress of an investigation, and in particular that it is not proposed to bring a prosecution, they may wish to consider the question for themselves. To do that, they need information, and they need it within time to avoid the operation of section 232.

383. One union submission called for inspectors' notes and reports to be made available to unions. I do not agree with that at the level of generality at which it was put. As I have said before, whatever is done in the way of keeping external stakeholders involved should not carry with it any risk of jeopardising a prosecution where one is contemplated. The premature disclosure of materials such as inspectors' notes and reports could do this. Of course, it would be a different matter if SafeWork had determined not to bring a prosecution. In that case, I would expect cooperation with a union that is interested in pursuing a prosecution to ensure that the union has all the information that is available to SafeWork to make a decision whether to spend its members resources in that fashion.

384. I **Recommend** that SafeWork develop, formalise and follow a procedure requiring it, when a workplace incident has resulted in the death of or serious injury to a worker:

a. To advise the family of that worker, and where applicable the injured worker, of the steps to be followed in the investigation of the incident;
b. To keep the family and the worker informed of progress of the investigation;
c. To inform the family and worker if a prosecution is to be taken and, if it is, to keep them informed of the progress and outcome of that prosecution;
d. To inform the family and worker, if a prosecution is not to be undertaken, of the reasons for that decision;
e. To consult the family and worker as to the terms of any EU that the PCBU may request and SafeWork may decide to consider; and
f. To offer the family and worker the opportunity to have input into the precise terms of that EU.

385. The comments from DCS/SafeWork stated the following:

> *SafeWork does not currently seek information relating to whether an injured or deceased worker is a member of a union. Implementing this recommendation will be dependent on the efficacy of making enquiries at the time of the incident response. All matters triaged as Category 1, 2, or 3, inclusive of contraventions of legislation or serious or dangerous incidents, are triaged for Inspector response. All responses to matters triaged for an administrative response are sent by email (with some by mail). The response is recorded in Workplace Services Management System with a date and time stamp. Regular reviews on all triaged matters have not identified failures to send the response. All matters triaged as Category 1 and 2 matters are transferred directly from the contact centre to an inspector. A similar process was in place in Workcover. Correction Incorrect unit name as the "customer contact centre" is the SWNSW Advisory Service (SWAS). Correction Incorrect unit name as the "call centre" is the SWNSW Advisory Service. "Customer contact centre staff" should be referred to as the SWNSW Advisory Service staff. Internal processes Triage is usually completed the same day of notification in accordance with SLA's and often within 2 hours of receiving a call. This paragraph seems to conflate the initial triage assessment process with other processes preceding a response.*

386. It is obvious that SafeWork cannot inform a union of the death of or serious injury to one of its members unless knows that the worker was, or is, a member of that union. However, if an attending inspector becomes aware of that fact, the relevant union should be informed.

387. I **Recommend** further where a worker who is killed or seriously injured in a workplace incident is a member of a trade union, and SafeWork is or becomes aware that the worker is or was a member of a union, SafeWork should also take, with all appropriate changes, steps in accordance with (a) to (f) above to inform and keep informed the relevant officials of that trade union of the progress and outcome of the investigation.

11 Conclusion

388. The maintenance of a rigorous system of workplace health and safety is a matter of fundamental importance in our society. As I have said earlier, workers have a right to go to work and return, as free from harm as the observation of reasonably practicable measures can ensure. Families have a right to see the safe return from work of their loved ones. Human lives and human suffering are not factors to be weighed against economic progress; they are fundamental rights that must be respected in efforts to achieve economic progress.

389. The social and economic justifications for those propositions cannot be doubted. Where workplace injuries and deaths occur, the financial costs are carried in part through the system of workers' compensation insurance. Those costs are borne in the first instance by employers, through the premiums that they pay. They are borne, thereafter, by society as a whole, because those costs are integers in the cost of goods or services that the employers produce. And to confine "justification" to economic analysis is to ignore the far greater human costs of workplace deaths and injuries, and to trivialise and demean, those who must perforce bear those costs.

390. A regulator such as SafeWork plays a key role in ensuring the maintenance of appropriate standards of workplace health and safety. It does this through its dual roles of regulator ("enforcer") and educator ("persuader"). To fulfil its functions effectively, SafeWork must be able to operate without fear or favour, indifferently to the status, positions in life and characteristics of workplace participants. And it must be funded adequately to enable it to do so, lest its activities be hindered by financial strictures.

391. The submissions made to this Report have identified clear examples where SafeWork has fallen down in the performance of its functions. Conversely, however, the reports prepared by Nous have given me confidence to say that, if the recommendations that are made in this Report are observed, there is good reason to believe that SafeWork can become once again the effective, independent and respected regulator that our society needs.

392. There are many dedicated and capable personnel working at SafeWork. They do their jobs because they believe in them. It is my hope that the recommendations

in this Report, once implemented, will give them pride in their work, and both the determination and the resources to perform it effectively.

Glossary

Abbreviations

Abbreviation	Term
BRD	Better Regulation Division
CDR	Compliance and Dispute Resolution
DCS	Department of Customer Service
EPH	Entry Permit Holder
EU	Enforceable Undertaking
FIWSAG	Family and Injured Workers Support and Advisory Group
HSR	Health and Safety Representative
IDMF	Investigation Decision Making Framework
IDMP	Investigation Decision Making Panel
IER [Directorate]	Investigations and Emergency Response Directorate
ILO	International Labour Organisation
KPI	Key Performance Indicator
L&D	Learning and Development
NITP	New Inspector Training Program
Nous	Nous Group
P&C	People and Culture
PCBUs	Persons conducting a business or undertaking
RCEU	Response Coordination and Enforceable Undertakings Unit
RFS	Requests for Service
RTO	Registered training organisation
SIRA	State Insurance Regulatory Authority
SIRP	Serious Incident Review Panel
SWAS	Safe Work Advisory Staff
TACS Team	Training Accreditation and Compliance Services Team
TPV Unit	Third Party Verification Unit
WHS	Work Health & Safety
WSMS	Workplace Services Management System

Other Terms

Term	Description
Administrative response	Following triage, if it is determined that an administrative response is appropriate, a letter will be sent to the PCBU.
Customer Service Centre	A central contact point where customers, inspectors and other stakeholders can contact SafeWork staff for information, to notify SafeWork NSW of an incident, to triage an incident, and to report harmful psychosocial behaviours.
Department of Customer Service (DCS)	The State Government Department housing individual agencies, offices, entities, and business units such as Service NSW, NSW Fair Trading, SafeWork NSW, Digital NSW, Revenue NSW, NSW Registry of Births, Deaths & Marriages and more.
Improvement Notice	A notice to a person requiring them to remedy a contravention of the WHS Act or prevent a likely contravention from occurring within a specified time.
Prohibition Notice	A direction, to a person who has control over the activity, prohibiting the carrying on of an activity that is occurring or may occur at a workplace that involves or will involve a serious risk to the health or safety of a person emanating from an immediate or imminent exposure to a hazard.
Inspector	Inspectors attend work sites following a complaint, incident, request for advice or as part of a targeted injury prevention program. They provide information or advice regarding WHS or workers compensation laws, guidance on how to reduce risk in the workplace, investigate or verify compliance with legislative obligations and issue notices or other instructions to ensure compliance with WHS obligations. The functions and powers of inspectors are set out in the *Work Health and Safety Act 2011* (NSW).
Inspector Response	The decision by the SafeWork Triage team to send an Inspector to a worksite in response to a request for service, complaint or notification of an incident.
Inspectorate	A body of inspectors.
Insurance and Care NSW (iCare)	Government agency acting for the Workers Compensation Nominal Insurer and providing services to other insurance and care schemes, including the NSW

	Self Insurance Corporation, which operates the Treasury Managed Fund, under which workers compensation cover is provided to NSW Government employees.
Investigation Decision Making Panel (IDMP)	The IDMP considers whether a matter will proceed to investigation and can refer a matter for investigation, refer a matter back for further information, reject a recommendation for investigation, or consider a response in place of or in addition to a full investigation.
Model Work Health & Safety Laws	The Model Work Health & Safety Laws comprise the model WHS Act, the model WHS Regulations and the model Codes of Practice.
Non-Inspector Response	The decision by the SafeWork Triage team not to send an Inspector to a worksite in response to a request for service, complaint or notification of an incident. An alternative response, such as an administrative response, may be undertaken instead.
Notifiable Incident	Under the *Work Health and Safety Act 2011* (NSW), a notifiable incident means the death of a person, a serious injury or illness of a person, or a dangerous incident.
NSW Legislative Council Standing Committee on Law and Justice	A committee established to inquire into and report on legal and constitutional issues in New South Wales, including law reform, parliamentary matters, criminal law, administrative law and the justice system, and matters concerned with industrial relations and fair trading.
Positive and Productive Workplace Policy	A Department of Customer Service policy to assist in resolving workplace conflict by providing information on preventing, identifying, and responding to workplace bullying.
Psychological safety	Ensuring work environments reduce the prevalence of psychological injury at workplaces, by focusing on mental health and wellbeing.
Psychosocial hazards	Aspects of work and situations that may cause a stress response which in turn can lead to psychological or physical harm. .
Requests for Service (RFS)	A request made by a customer or stakeholder for SafeWork NSW to respond to a complaint, incident, or hazard.
Resources Regulator	The NSW Resources Regulator regulates work health and safety at mines and petroleum sites and compliance and

	enforcement activities under the *Mining Act 1992* (NSW). The Resources Regulator sit within theMining, Exploration and Geoscience division within the Department of Regional NSW.
Right of Entry	The right of a WHS entry permit holder to enter a workplace to inquire into a suspected contravention of WHS laws.
SafeWork Australia	A national policy body that focuses on improving work health and safety and workers' compensation arrangements.
State Insurance Regulatory Authority (SIRA)	SIRA was created under part 3 of the *State Insurance and Care Governance Act 2015* (NSW). SIRA regulates motor accidents CTP insurance, workers compensation and the home building compensation scheme in NSW
Speak Up Save Lives Application	The Speak Up Save Lives Application is a means of reporting unsafe work circumstances, while giving users the choice to remain anonymous.
Triage	The assessment of matters that come to SafeWork's attention to determine the appropriate response.
WorkCover NSW	WorkCover NSW was replaced by three new agencies in 2015: iCare, SafeWork NSW, and SIRA.
Workers' Compensation	Monetary compensation paid by insurance to employees if they have been injured or become sick due to their work.