Triage and Decision Making Report

Independent Review of SafeWork NSW

5 December 2023

nous

Nous Group acknowledges Aboriginal and Torres Strait Islander peoples as the First Australians and the Traditional Custodians of country throughout Australia. We pay our respect to Elders past, present and emerging, who maintain their culture, country and spiritual connection to the land, sea and community.

This artwork was developed by Marcus Lee Design to reflect Nous Group's Reconciliation Action Plan and our aspirations for respectful and productive engagement with Aboriginal and Torres Strait Islander peoples and communities.

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Executive summary

SafeWork NSW is responsible for making regulatory decisions relating to work health and safety issues in NSW. This includes:

- Receiving and assessing information on 'Notifiable Events' from employers who have encountered work health and safety issues, as well as 'Requests for Service' from the public in relation to work health and safety issues.
- Making 'triage' decisions in respect of those Notifiable Events and Requests for Service to determine how to prioritise the scarce resources of SafeWork NSW's triage staff.
- Determining what matters it should subject to a full investigation through an investigation decision making process, administered by an Investigation Decision Making Panel (IDMP).

In 2023, the NSW Government commissioned an 'Independent Review' of SafeWork NSW. This is the first whole-of-organisation review conducted since SafeWork NSW was established in 2015.

The Hon. Robert McDougall KC is conducting the Independent Review into SafeWork NSW (the Review). The Review aims to examine SafeWork NSWs performance of its regulatory functions under the WHS Act. This report is prepared in support of the Review. It seeks to answer the following key questions related to SafeWork NSW's triage and IDMP process:

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

Triage processes at SafeWork NSW broadly align to good practice

Triage processes at SafeWork NSW are well documented, consistently applied, and drive appropriate individual outcomes. More could be done, however to ensure they are easy for new and existing triage staff to follow as well as ensuring that they are subject to appropriate review and oversight.

Triage staff are primarily within two teams, the SafeWork Advisory Services Team (SWAS) and Response Coordination and Enforceable Undertakings (RCEU) Team. The latter team consists of the Contact Centre and the Triage Advisors.

SafeWork NSW has established an effective and well documented triage process

The triage process at SafeWork NSW is comprehensively documented and aligned to good practice. This is reflected in the triage principles and related activities set out in triage guidance documents. It is also reflected in the systems that support triage. While the triage process is accurately and comprehensively documented, there is opportunity to make the guidance more accessible for existing and new triage staff. This could be done through preparing introductory materials, 'quick reference' guides, and making existing documents easier to follow.

Triage processes at SafeWork NSW align to relevant legislative and policy requirements

SafeWork NSW's approach to triage is appropriately grounded in relevant legislation and policy directions. The documented triage approach comprehensively responds to SafeWork NSW's legislative obligations as outlined in the WHS Act. It also incorporates national level policy direction. However, triage approaches should incorporate a more significant focus on the regulatory direction set by SafeWork NSW in response to legislative and policy imperatives.

Triage guidance and processes are followed effectively in practice

SafeWork NSW triage staff consistently follow their established triage process in practice. Contact Centre staff report working closely to guidance materials and making decisions in a consistent way. Senior leaders at the organisation also highlight efforts to ensure that staff involved in the triage process follow

established procedures. This is supported by a review of the systems used to undertake triage and the case files prepared on triaged matters.

As noted in a separate report provided to the Independent Review – focused on training at SafeWork NSW – triage practice could be improved by formalising and expanding the training provided to staff who perform triage activities on how to apply triage guidance in practice.

SafeWork NSW does not exercise sufficient oversight over triage decision-making

At present SafeWork NSW's oversight of its triage approach is not sufficiently robust. Review processes are informal and manual. The identification of gaps in approach and outcomes relies on the individual judgment of a small pool of expert triage staff. Further, responses to any identified gaps are generally similarly informal. Improving the nature and quality of the oversight of triage decision-making should be a key focus for SafeWork NSW into the future.

Investigation decision-making at SafeWork NSW generates appropriate outcomes, but could better consider regulatory strategy and better engage internal stakeholders

SafeWork NSW's investigation decision-making processes are clearly recorded and are followed in practice. This generally leads to good outcomes. However, decisions are not subject to significant oversight. This limits the lessons that SafeWork NSW staff can learn from the investigation decision-making process, as well as how quickly that process can be improved over time. Further, staff participating in supporting the decision-making process do not receive good feedback on their input, limiting their personal ability to improve their practice.

SafeWork NSW has detailed regulatory decision-making processes which align to good practice

SafeWork NSW has an established an investigation decision-making process that broadly aligns with good practice. This process is well documented with risk-based principles, guiding factors, and templates to enable consistent decision-making. The documents set out regular internal reviews and audits of decisions during the IDMP process to enable continuous improvement. The process also broadly aligns to legislative and policy requirements. There is an opportunity for documentation to be simplified to ensure the decision-making is clearly articulated and understood by staff.

Staff at SafeWork NSW follow established investigation decision-making approaches in practice, but more could be done to drive consistency in the decisions made

SafeWork NSW's actual delivery of the IDMP process appears to align with good practice. Inspectors and staff involved in the investigation decision-making process follow established procedures and utilise the existing tools such as templates. Decisions are consistent and staff are comfortable with the support they receive to work in a consistent way.

However, more could be done to ensure that decision-making is strategic and aligned to overall regulatory priorities. SafeWork NSW does not subject decision-making to significant oversight or review – instead relying on the expertise of SafeWork NSW staff to drive good outcomes. Over time, this has resulted in inconsistencies in the outcomes of the decision-making process – including an inconsistent consideration of strategic factors in decision-making. More should be done to improve the oversight of decisions, as well as to feed the results of any review process back into guidance for staff on how to make decisions.

Better support for staff involved in decision making would improve outcomes

Decision-making practice and the IDMP process could be improved through a formalised training program. Good practice suggests staff should be supported to effectively apply decision-making approaches through training. However, senior leaders and staff involved in the IDMP process largely 'learn on the job'. A lack of formal training may result in nuanced elements of the IDMP process and the documents that support it not being applied as effectively as possible.

Good regulatory practice suggests that stakeholders affected by a regulatory decision or process should receive clear, proactive, communications relating to that decision or process. SafeWork NSW effectively

communicates with external stakeholders in relation to IDMP decisions. However, it does not effectively engage with internal stakeholders regarding these same decisions. This drives dissatisfaction among the inspectors and other staff that support this process. It may also limit strategic decision-making by SafeWork NSW.

Summary of improvement opportunities

Improvement opportunities for SafeWork NSW's triage functions are presented in Table 1 below.

Table 1 | Improvement opportunities for triage

Recommendation	Details
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.
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.
Formalise the oversight and review of triage	SafeWork NSW should formalise the oversight and review of triage decisions and make process improvements from these insights. In doing so, SafeWork NSW

Recommendation	Details
decisions, as well as responses to challenges and issues identified as part of that review and oversight process	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 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.
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. 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.
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.

Improvement opportunities for SafeWork NSW's decision-making process are presented in Table 2 below.

Table 2 | Improvement opportunities for SafeWork NSW's decision-making process

Improvement opportunities	Details
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.
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 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.

Improvement opportunities	Details
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 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.
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: • 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.

Improvement opportunities	Details
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.

Background to the report

SafeWork NSW is a statutory body responsible for regulating workplace health and safety in New South Wales. It administers and enforces functions primarily under the *Work Health and Safety Act 2011 (NSW)* (WHS Act)[1] and offers the following services:[2]

- Advises on improving work health and safety
- Provides licences and registration for potentially dangerous work
- Investigates workplace incidents and enforces work health and safety laws in NSW.

In 2023 the NSW Government commissioned an organisation-wide Independent Review of SafeWork NSW. This is the first whole-of-organisation review conducted since SafeWork NSW was established in 2015.

The Hon. Robert McDougall KC is conducting the Independent Review into SafeWork NSW (the Review). The Review aims to examine SafeWork NSWs performance of its regulatory functions under the WHS Act in accordance with Terms of Reference set by the NSW Government.[3] An Interim Report was provided to the Minister in May 2023 and the Final Report will be provided in November 2023.

This document is designed to support the Review. It considers the current triage and Investigation and Decision Making Panel (IDMP) processes in SafeWork NSW. It directly responds to the scope of the Review in point (1) of the Terms of Reference. It is one of two documents prepared by Nous Group to support the Final Report for the Review. The second document reviews select training programs that SafeWork NSW provides for both internal and external delivery and responds to point (2) in the Terms of Reference for the Review.

This report details the outcomes of the review of the effectiveness of the current triage and IDMP processes in SafeWork NSW.

This report responds to the primary question: *Are SafeWork NSW's current Triage and IDMP processes and associated procedures effective? How can they be improved?*

In addressing this question for the triage process and IDMP processes, this review asked:

- **What does good practice look like for triage and IDMP processes**? This includes first understanding what the legislation,[4] SafeWork NSW policies and strategy. It then includes a consideration of good practice in triage and IDMP processes good practice to provide the basis for assessment of the effectiveness of SafeWork NSW processes.
- **To what extent do triage and IDMP processes align to good practice?** This includes an assessment of the triage and IDMP processes against good practice.
- **What happens in practice at SafeWork NSW?** This includes assessing whether the triage and IDMP processes are followed in practice as well as whether they align with good practice. This requires

[1] SafeWork NSW is also responsible for the administration of the *Explosives Act 2003 (NSW), Dangerous Goods (Road and Rail Transport) Act 2008 (NSW).* SafeWork NSW inspectors also have certain powers relevant to the compliance and enforcement under the *Work Health and Safety Regulation 2017* and Acts administered by the State Insurance Regulatory Authority (*Workers Compensation Act 1987 (NSW)* and the *Workplace Injury Management and Workers Compensation Act 1998 (NSW)*).
[2] SafeWork NSW, 'What we do', https://www.safework.nsw.gov.au/about-us/what-we-do
[3] NSW Government, Terms of Reference – Independent Review of SafeWork NSW, https://www.nsw.gov.au/departments-and-agencies/department-of-customer-service/publications-and-reports/terms-of-reference-independent-review-of-safework-nsw
[4] Nous is not commenting on the legislative scheme itself, but how well SafeWork NSW incorporate the legislation into its policies and practices.

understanding whether the processes are administered efficiently with appropriate inputs and supports to enable transparent, effective, and accountable decision-making.

- **What are the areas for improvement?** This includes understanding the strengths and issues with the current approach as well as opportunities for improvement.

Nous' methodology was based on an agreed review approach and analytical framework.

Nous followed fives key steps in preparing the report. These are set out in in Table 3.

Table 3 | Nous' methodology

Step	Activities by Nous
Agree on review approach and understand the triage and IDMP processes.	• Worked with the Review to agree on the key questions that this report will answer. • Requested data from both SafeWork NSW and the Review. • Reviewed extensive documentation on the triage and IDMP processes provided by SafeWork NSW against the agreed key questions for this report to understand each process.
Developed analytical frameworks and assessed the intended triage and IDMP processes.	• Generate insights on SafeWork NSW's triage and IDMP processes as they are articulated within the documentation. • Researched and developed good practice frameworks for regulatory triage and decision-making against which to assess SafeWork NSW's current practice.
Developed understanding of the triage and IDMP processes in practice.	• Consulted with SafeWork NSW staff (as outlined in the paragraph below) to reflect on their experience with either process. • Reviewed anonymised submissions made to the Review related to the triage and IDMP processes. • Reviewed a sample of triage and IDMP decisions made in 2023. • Generate insights on SafeWork NSW's triage and IDMP processes in practice on the basis of stakeholder consultations, review of submissions, and review of sample decisions.
Assessed against the analytical framework and socialised findings.	• Assess the triage and IDMP processes as documented and in practice against the good practice framework. • Socialise improvement opportunities with the Review and SafeWork NSW.
Draft and finalise the report.	• Consolidate findings in a draft report and test factual matters with SafeWork NSW. • Finalise the report and provide to the Review.

Nous collected insight from a broad range of sources in preparing this report.

Nous engaged with staff in both the triage and IDMP functions at SafeWork NSW:

- In relation to the triage function, Nous engaged with the SafeWork NSW directors and managers across both the SWAS and RCEU Teams. Nous also consulted with inspectors within RCEU and Triage Advisors in SWAS. Input on the Contact Centre within SWAS was sourced from Triage Advisors, who had each formerly worked as Contact Centre staff.
- In relation to the IDMP process, Nous engaged with directors who make up the membership of the IDMP. Nous also engaged with senior staff who support the process. Nous also consulted with inspectors who had experience of making submissions to the IDMP, and with the responses of the IDMP to those submissions.

Nous conducted an extensive review of documents provided by SafeWork NSW and the Review. This included a review of:

- Legislative requirements as outlined in the WHS Act.
- Documentation on policy, procedures, and guidance material for the triage and IDMP process.
- Extracts from anonymised submissions to the Review about the triage or IDMP process (collated by the Review Team).
- Thematic summary of issues raised related to the triage or IDMP process within SafeWork NSW (compiled by the Review Team).
- Sample of submission made to the IDMP in August and September 2023 and the corresponding meeting minutes.
- Sample of notifiable incidents and requests for service received by SafeWork NSW in September 2023 as recorded within data entry reports, the WSMS incident report, and screenshots of the information in WSMS.
- PDF extracts from spreadsheets used to review triage decisions.

Part 1: Triage

1 Background to Triage at SafeWork NSW

1.1 SafeWork NSW's Triage approach

SafeWork NSW applies a triage approach to all 'notified events'[5] reported to the regulator. SafeWork NSW receives two types of notified events which include:

- 'notified incidents' – the death, serious injury or illness, or dangerous incident of a person,[6] which a PBCU is required to report; and
- 'request for service' (RFS) which is a request for regulator response to a work health and safety issue, advisory request, and matters for which SafeWork NSW has a statutory obligation to respond.[7]

In the first instance, SafeWork NSW discerns which notified events it receives are within its jurisdiction, whether SafeWork NSW has a duty to respond, and if there is enough information to proceed to the next step.

If the notified event meets these requirements, they are assessed on their criticality. Critical events are all notifiable incidents, high-profile RFS, and statutory requests.[8] Non-critical events are non-notifiable incidents, non-critical RFS, and events received after hours.[9] This determines which teams is responsible for triaging the notified event. Triage is then conducted to prioritise and allocate the matter to the appropriate area of SafeWork NSW to take action.

Given the volume of work health and safety incidents, it is necessary for SafeWork NSW to prioritise these matters. To do so, SafeWork NSW applies a triage framework that aims to ensures that all events are responded to in a way that is proportionate to the risk they present and that resources are used efficiently.

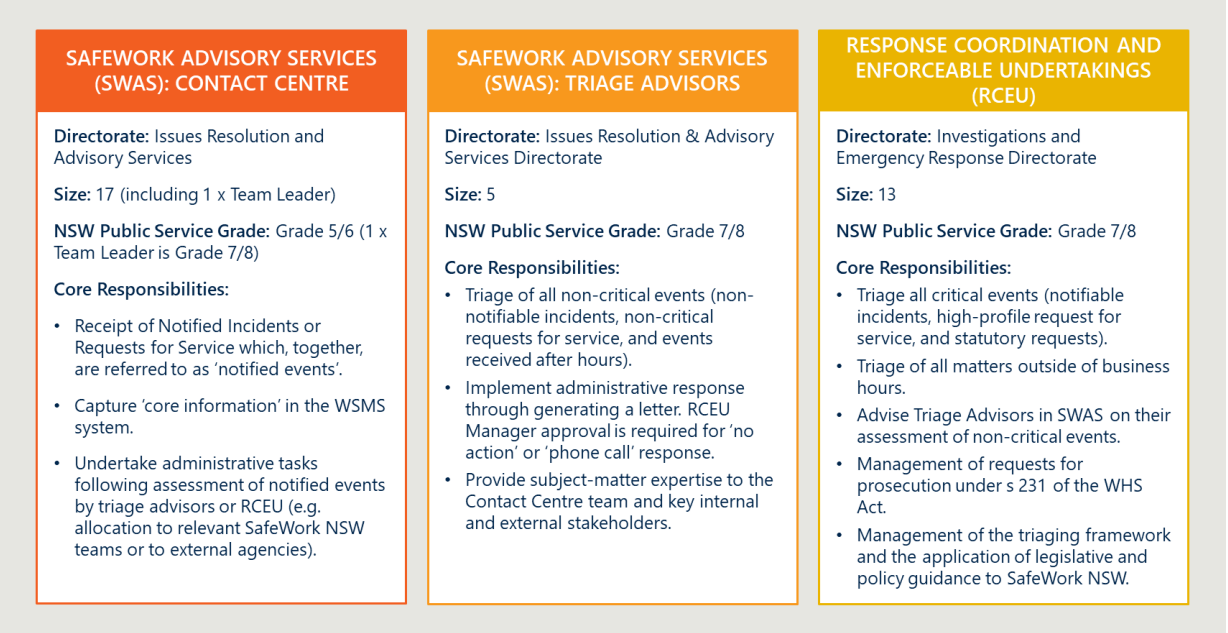
The triage process is performed by two teams and three 'groups'.

The SafeWork Advisory Services Team (SWAS) and Response Coordination and Enforceable Undertakings (RCEU) Team are primarily responsible for the triage process. Both teams are located in separate Directorates within SafeWork NSW.

The SWAS comprises two sub teams – the Contact Centre and Triage Advisors. Each plays a different role in the triage process. These roles are outlined in Figure 1. The Contact Centre is focused on collecting information from the general public, employees and PCBUs and supporting regulatory decision making by inspectors in the RCEU. The Triage Advisor team make independent triage decisions, albeit ones generally relating to lower priority matters.

[5] 'Notified events' are all notifiable incidents and Requests for Service that SafeWork NSW receives as outlined in SafeWork NSW, Framework Management of Notified Events Procedure', 2022, pg. 9.
[6] S 35 WHS ACT
[7] SafeWork NSW Framework for the Management of Notified Events Procedure, 20222, pg.5.
[8] SafeWork NSW, Framework for the Management of Notified Events Procedure, 2022, pg. 9.
[9] SafeWork NSW, Framework for the Management of Notified Events Procedure, 2022, pg. 9.

Figure 1 | SafeWork NSW groups within the triage process[10]



There is a clear triage process for SafeWork NSW to follow.

Nous understands the triage process based on a document review and interviews with SafeWork NSW staff. SafeWork NSW's triage process starts with the intake of incident reports via phoneline, website, email and the Speak Up app..

The way in which SafeWork NSW receives incident reports determines their initial allocation within triage groups. RFS received via the Speak Up App are directly allocated to the Triage Advisors. All other RFS and notified incidents are received by the Contact Centre.

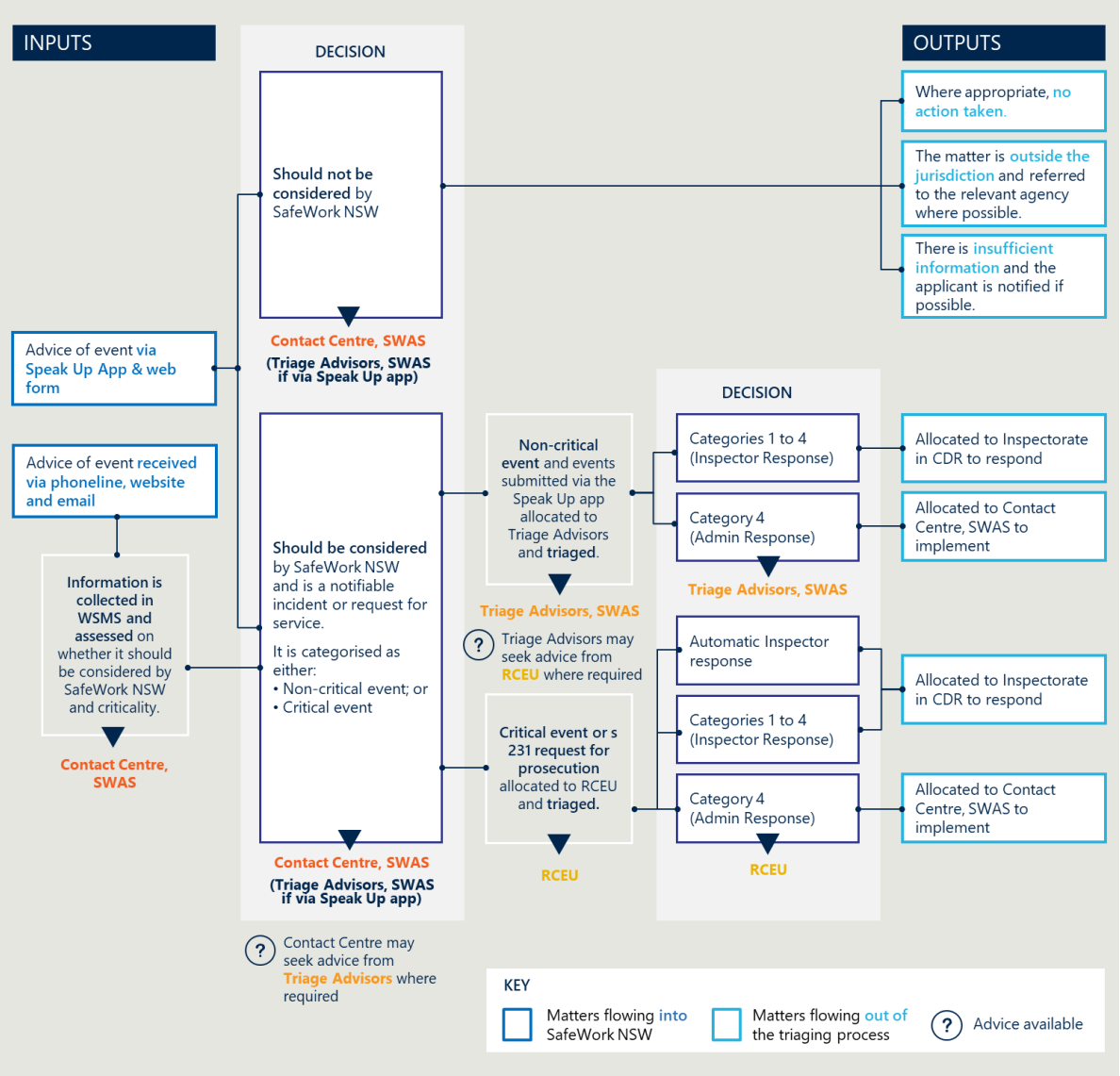
Incident reports are assessed on whether they are within scope for SafeWork NSW and whether they are 'critical'. They are within scope if the incident reports are notified events, that is a notified incident under the *WHS Act*, or a RFS. Events are critical if they are notifiable incidents, high-profile RFS, and statutory requests. Critical events are allocated to RCEU and non-critical events to Triage Advisors to be triaged. At this stage some critical events may receive an 'automatic inspector response' where the matter will be referred directly to an inspector to respond to the matter.[11]

Triage Advisors and RCEU are responsible for triaging notified events. Triage occurs in accordance with the national Triage Decision Making Model[12], Response Categorisation Matrix[13] and High Profile Event Matrix.[14] This usually results in either an inspector or administrative response. Notified incidents or RFS requiring an inspector response are referred on to the appropriate Compliance and Dispute Resolution (CDR) branch or, an administrative response is implemented by Triage Advisors or Contact Centre staff on behalf of the RCEU.

SafeWork NSW's standard, business hours, triage process is summarised at Figure 2. Further detail on this process and the afterhours process is set out at Appendix A.

[10] SafeWork NSW, Framework for the Management of Notified Events Procedure, 2022, pg. 9.
[11] An automatic inspector response may be triggered by events that pose a significant risk for community concern, require a statutory response or diminish work health and safety efforts (SafeWork NSW, Framework Management of Notified Events, 2022, pg. 17).
[12] National Triage Decision Making Model, as interpreted by SafeWork NSW's Framework for the Management of Notified Events Procedure, 2022, pg. 15-16.
[13] SafeWork NSW, Response Categorisation - Operating Protocol, 2022.
[14] SafeWork NSW, High Profile Event Matrix, 2023.

Figure 2 | Triage process flow during business hours*



**The RCEU is responsible for the operational and triage aspects of the process outside of business hours.*

1.2 Good practice principles for triage

Good practice principles for triage exist across many regulators. Nous has worked to support a broad range of Australian regulators, to review and enhance their triage practice. As a result of this work, Nous has identified a range of good practice principles that we commonly observe as features of effective triage approaches.

These principles are set out at Table 4. This material has been prepared with reference to:

- The publicly available material on the triage approaches and processes of the following regulators:
    - Workplace Health and Safety Queensland, Electrical Safety Office Queensland[15]
    - NSW Environment Protection Authority[16]
    - WorkSafe Victoria.[17]
- Reports and analysis summarising good practice, including:
    - Ten Principles of Good Business Process Management[18]
    - Commonwealth Ombudsman: Better Practice Complaints Handling[19]
    - Previous Nous reports and analysis.

These principles are presented along with a set of features that Nous considers would indicate whether the principle has been met. As part of our analysis of the triage approach at SafeWork NSW, we have considered whether these principles are in place in the triage approach used. To the extent they are, we are more likely to conclude that the triage approach is appropriate and less likely to suggest improvement opportunities.

Table 4 | Principles identified in good practice triage approaches

Practice principle	Explanation	Features establishing the principle has been met
Decisions are made in line with clear rules and standards.	Triage is ultimately a process of categorisation and risk prioritisation. This is most effective where there are clear guidelines for decision-making – including: clear regulatory objectives and purposes; alignment to relevant rules and standards; and an outcomes focus.	• **Clearly articulated objective** – The regulatory objective sought as part of the triage process is clearly understood and clearly articulated. All people involved in the triage process pursue this goal as part of their work. • **Alignment to relevant rules**– The legislative, policy and other relevant standards that apply to the regulator are a core consideration in the triage process. All triage decisions are made in support of those rules and standards being met. • **Risk-based principles are applied** – The risk of harm from relevant behaviour is a key consideration in making triage decisions. The agency makes considered choices about where to focus its effort, based on this risk. With these choices informing triage decisions in a consistent way, based on a risk framework.
Decisions are made in a consistent way,	Triage should not be an arbitrary process. All triage decisions must be made in line with a clear set of rules and standards, known and	• **Consistent decision-making –** Decisions are made in line with an established triage decision-making framework, which is applied consistently each time.

[15] Queensland Government, Compliance Monitoring and Enforcement Policy, 2018, https://www.worksafe.qld.gov.au/__data/assets/pdf_file/0016/22174/compliance-monitoring-enforcement-policy.pdf.
[16] Environment Protection Authority, Regulatory Strategy 2021-2024, 2021.
[17] C Noone, M Donnan, Butcher, Independent Review of Occupational Health and Safety Compliance and Enforcement in Victoria, 2016.
[18] JV Brocke, T Schmiedel, J Recker, P Trkman, W Mertens, S Viaene, Ten Principles of Good Business Process Management, Business Process Management Journal, 2014, 20. 10. 1108/BPMJ-06-2013-0074.
[19] Commonwealth Ombudsman, Better Practice Complaints Handling, 2023.

Practice principle	Explanation	Features establishing the principle has been met
with consistent outcomes.	expressed in advance. The information required to make a triage decision must also be specified in advance, along with clear standards for sources of information and their value.	• **Consistent documentation –** Materials to support this consistent triage decision-making process are developed, available to triage staff, and easy to understand and follow in a consistent way. • **Intelligence led –** Triage decision-making is informed by clear insights, from agreed sources, captured and analysed in a consistent way. Where more information is required to make a decision, there are clear processes and mechanisms that are followed to collect that information.
Delivery is efficient, effective and aligned to established standards.	Triage decisions must be made in line with the rules, standards and approaches an organisation establishes. The best approach *in theory* must be delivered effectively *in practice*. This delivery must also be efficient, and effective. Any effective triage process must effectively engage with internal stakeholders, on a regular basis, where appropriate.	• **Alignment to established standards** – The triage process, as delivered, must align with the law, relevant policies and standards, and with the objectives set by the agency. It must also deliver outcomes that are acceptable to the community and other stakeholders. • **Alignment to established materials** – The triage process, as delivered, must align with the decision-making approach and decision-making materials established by the agency. • **Efficient** – Staff using the triage approach established, must make decisions quickly and efficiently, using only the information set out in relevant frameworks, and making decisions when relevant information is available. Rapid decision-making, with a direction to use a higher risk classification in cases of uncertainty, should be preferred over approaches that pursue absolute certainty before a triage decision is made.
All processes are fair, transparent and subject to oversight.	Triage decisions must be made fairly, transparently and without bias. The same triage decision should always be made, given a sufficiently similar set of facts. Decision makers should only consider relevant information, and never consider irrelevant information, in making triage decisions. Decision-making processes should be subject to regular oversight and review.	• **Transparent decision-making** – The method for how triage decisions are made, along with the rules and standards against which they are made, should be available. Similarly, the rationale for any decision made should be recorded, and made available where appropriate. • **Fairness** – Decision makers should only consider relevant factors and should never consider irrelevant factors. Decisions should be free of bias. • **Accountability** – Triage decision-making processes should be subject to oversight and review. Effort should be invested in ensuring that decision-making standards and practices are followed at all times. Trend data should be analysed to surface systemic bias or other issues. • **Continuous improvement** – In parallel to accountability and oversight, triage decision-making should be subject to regular outcome and process reviews. Processes and approaches should be continuously improved over time. Feedback should

Practice principle	Explanation	Features establishing the principle has been met
		be provided to internal sources to improve on functions that input into triage decisions.
Triage staff are appropriately equipped and supported.	SafeWork NSW staff who make triage decisions must be sufficiently skilled, equipped and enabled to work effectively to make appropriate decisions. This includes ensuring that they have the right personal capabilities, resources and capacity. It also includes ensuring they are appropriately supported and enabled by managers and leaders. It requires ensuring they feel confident making difficult decisions, and that the organisation will 'back' their calls where appropriate procedures have been followed.	• **Appropriate ways of working** – Triage staff are trained and supported to work in a risk-based way, be outcomes focused, and collaborate across teams. • **Appropriate capability** – The organisation regularly tests the capability of triage staff to deliver in line with the principles outlined above, to the extent that gaps are identified, training and support is provided. The agency makes regular investments in the quality and capability of staff. • **Staff decisions are trusted** – Decisions are not subject to multiple levels of oversight, generally staff triage decisions are accepted as made, unless there is a good reason for them to be reviewed and changed. • **Leaders enable effective work** – The leadership culture and approach of the agency supports staff to make decisions effectively, and to feel confident that they will be supported if their decisions are challenged.

2 SafeWork NSW has established an effective and well documented triage process.

The triage process at SafeWork NSW is comprehensively documented and aligned to good practice. This is reflected in the triage principles and related activities set out in triage guidance documents. It is also reflected in the systems that support triage. While the triage process is accurately and comprehensively documented, there is opportunity to make the guidance more accessible for existing and new triage staff.

Good practice principles for triage suggest that organisations should clearly document a process where triage decisions are:

- **Made in line with clear rules and standards** – Triage decisions are made in line with a shared understanding of a clearly articulated objective. The process to make these decisions should be guided by risk-based principles for SafeWork NSW to prioritise its efforts towards with the most risk and harm involved. The process, decision-making, and objective should be to meet the requirements articulated in legislative, policy, and other standards for triage at SafeWork NSW.
- **Made in a consistent way, with consistent outcomes** –Triage decisions should be made in line with an established triage decision-making framework. The framework should be made available to triage staff and be easy to understand such that they are able to apply it consistently to make decisions. The decisions should be informed by the right inputs and clear insights and in its absence, there are processes to collect this information.
- **Fair, transparent and subject to oversight** – Triage decisions should be made by reference to clear rules and standards that are made available to staff and with a clear rationale communicated to internal and external stakeholders where appropriate. Decisions should be informed by relevant factors only that are free of bias. There should be oversight and review to ensure processes are followed consistently and to a high standard and not subject to underlying biases. There should also be reviews on the decision, the output of which is communicated back to internal teams that contributed during the triage process. This oversight and regular process reviews should contribute to continuous improvement.

SafeWork NSW processes are broadly in line with good practice with some room for improvement, as set out below.

2.1 SafeWork NSW's triage process aligns to good practice.

SafeWork NSW's documented triage processes appears to align with good practice. Triage processes and rules are aligned to appropriate standards. The triage approach encourages consistent and fair decisions.

2.1.1 Triage rules and standards are clear and embed a fit-for-purpose approach.

SafeWork NSW has set clear principles for triage. High level principles are articulated in SafeWork NSW's 'Framework: Management of Notified Events Procedure'. This document provides general guidance to SWAS Contact Centre staff, Triage Advisors and inspectors in making triage decisions. More specific guidance is provided in SafeWork NSW's Triage Principles guidance document. This offers more specific and focused guidance for staff in making triage decisions that result in administrative responses. Each of these frameworks aligns to good practice.

General triage principles align to good practice.

The Framework Management of Notified Events Procedure establishes seven triage principles: consistency; constructiveness; transparency; accountability; proportionality; responsiveness; and, targeted.[20] These principles are supported by an explanation of their intent.

These principles align with indicators of good practice triage. They establish clear standards against which triage staff can make consistent decisions. The principles encourage proportionality and targeted effort, ensuring that risk-based decision-making sits at the heart of triage practice. This places contemporary regulatory practice at the heart of SafeWork NSW's triage practice. [21]

The good practice approaches established by general principles are supported and embedded in more detailed guidelines. In line with good practice, this detailed guidance specifies that triage staff should:

- Adopt a risk-based approach to triage. Specifically, through using the High-Profile Event matrix and Response Categorisation of Events to ensure that each notified event receives a timely response that is appropriate for the risk and harm it relates to.
- Collect data accurately using the Event Classification Schema. This encourages consistent and accurate reporting to identify emerging work health and safety issues within industry sectors and across NSW.
- Apply the same rules to ensure consistency of decision-making in triage. For example, through using the Triage Principles to inform how to triage Category 4 – Administrative Response.
- Ensure decisions being made by inspectors are fair through their use of guidance such as Incidents Triaged for inspector response and Requests for Service – Field and Non-Field Response

Each of these aspects of the guidance offered directly connects with aspects of Nous' good practice framework, set out at Table 4 above.

[20] SafeWork NSW, Framework Management of Notified Events Procedure, 2022, pg. 7.
[21] The Framework states that, "These principles acknowledge that in order for regulators to be effective they need to ensure that their resources are targeted toward the areas of greatest need and the strategies used will achieve constructive outcomes." SafeWork NSW, Framework Management of Notified Events procedure, 2022, pg. 7.

2.1.2 The triage approach encourages consistent and fair decisions.

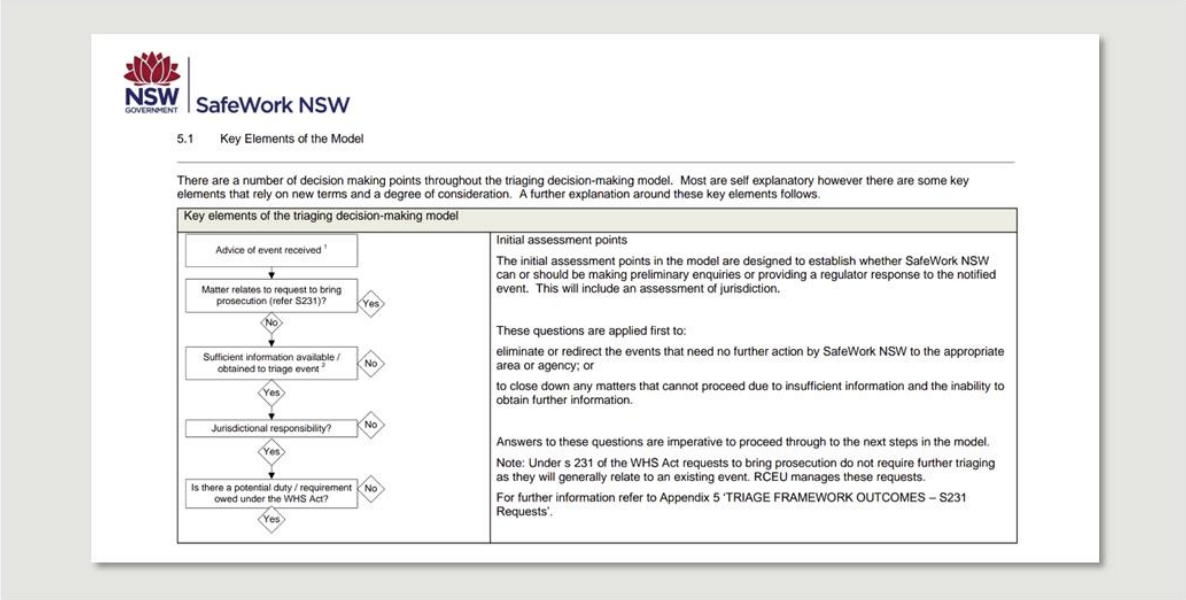
Effective triage practice sees decisions being made in line with an established framework, which is applied consistently each time. The RCEU team and Triage Advisors making triage decisions should have a clear sense of what information to draw on, and how to use it. Tools and frameworks should encourage the use of the right insights, and the drawing of appropriate conclusions from those insights. Support structures should also be in place to enable triage staff to test emerging conclusions before decisions are made.

SafeWork NSW's triage approach is established in a way that encourages consistent, fair decision-making. The triage process is documented end-to-end and available to SWAS Contact Centre staff, Triage Advisors and inspectors to guide them through the process. This end-to-end guidance is supported by numerous tools, such as guidelines, templates and systems, that encourage consistent decision-making throughout the process. Informal peer support and formal managerial support is also available to guide staff in making decisions. Fairness and objectivity are embedded into the process through tools that support unbiased and well evidenced decision-making.

The triage process is comprehensively documented.

Triage guidance documents, as is provided to staff in SWAS and RCEU teams, outline a clear, end-to-end process for triage. This process is primarily articulated in the Framework Management of Notified Events Procedure.[22] The framework incorporates the National Triage Decision Making Model, a nationally consistent guidance document which provides a flow chart and other visualisations to aid decision-making.[23] It also provides detailed explanations of how staff should work at each stage of the triage process and defines key decision-making standards. Sample extracts from this document are set out at Figure 3 and Figure 4.Figure 3 and Figure 4.

Figure 3 | Flow chart extract from Framework Management of Notified Events Procedure[24]



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5.1 Key Elements of the Model

There are a number of decision making points throughout the triaging decision-making model. Most are self explanatory however there are some key elements that rely on new terms and a degree of consideration. A further explanation around these key elements follows.

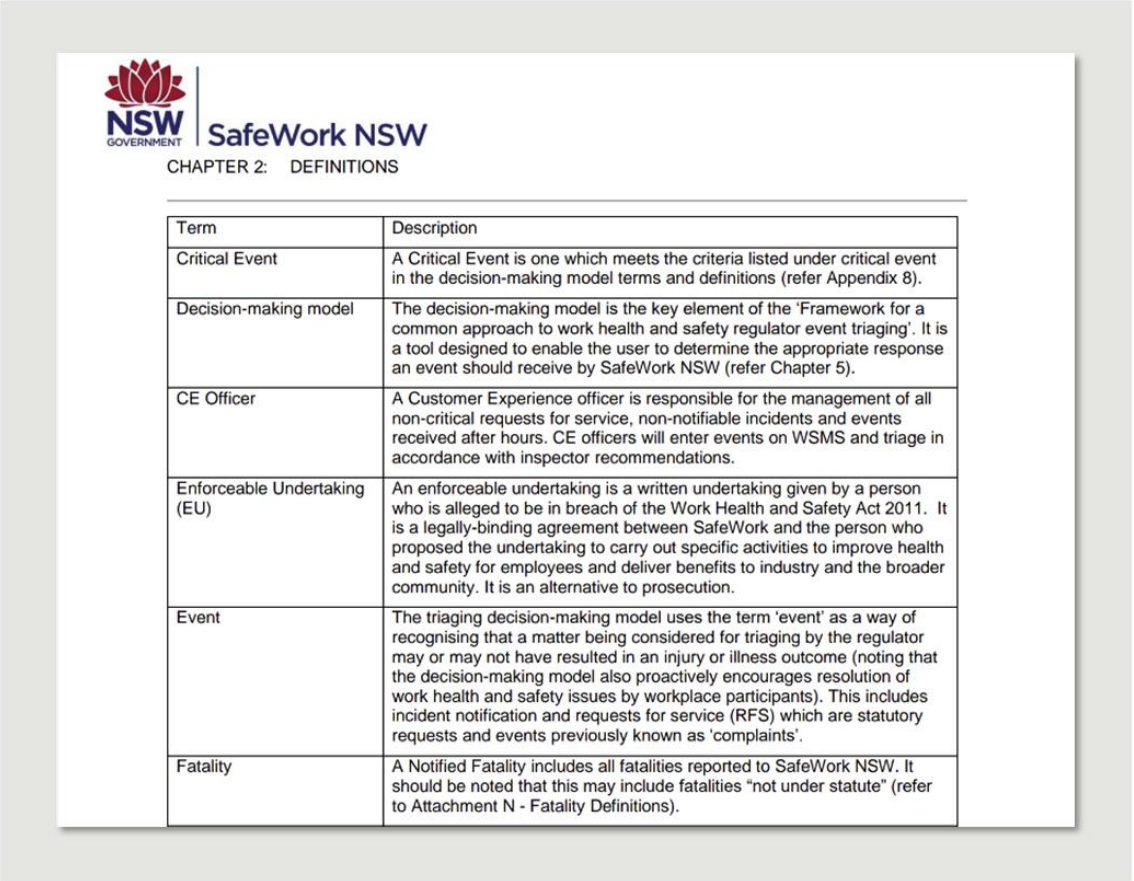
Key elements of the triaging decision-making model	
Advice of event received [1] ↓ Matter relates to request to bring prosecution (refer S231)? — Yes ↓ No Sufficient information available / obtained to triage event [2] — No ↓ Yes Jurisdictional responsibility? — No ↓ Yes Is there a potential duty / requirement owed under the WHS Act? — No ↓ Yes	Initial assessment points The initial assessment points in the model are designed to establish whether SafeWork NSW can or should be making preliminary enquiries or providing a regulator response to the notified event. This will include an assessment of jurisdiction. These questions are applied first to: eliminate or redirect the events that need no further action by SafeWork NSW to the appropriate area or agency; or to close down any matters that cannot proceed due to insufficient information and the inability to obtain further information. Answers to these questions are imperative to proceed through to the next steps in the model. Note: Under s 231 of the WHS Act requests to bring prosecution do not require further triaging as they will generally relate to an existing event. RCEU manages these requests. For further information refer to Appendix 5 'TRIAGE FRAMEWORK OUTCOMES – S231 Requests'.

[22] SafeWork NSW, Framework Management of Notified Event Procedure, 2022. For a full list of documents that outline the triage process, refer to Appendix C.

[23] SafeWork NSW, Framework Management of Notified Events Procedure, 2022, pg. 15.

[24] SafeWork NSW, Framework Management of Notified Events Procedure, 2022, pg. 16.

Figure 4 | Definitions extract from Framework Management of Notified Events Procedure[25]



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CHAPTER 2: DEFINITIONS

Term	Description
Critical Event	A Critical Event is one which meets the criteria listed under critical event in the decision-making model terms and definitions (refer Appendix 8).
Decision-making model	The decision-making model is the key element of the 'Framework for a common approach to work health and safety regulator event triaging'. It is a tool designed to enable the user to determine the appropriate response an event should receive by SafeWork NSW (refer Chapter 5).
CE Officer	A Customer Experience officer is responsible for the management of all non-critical requests for service, non-notifiable incidents and events received after hours. CE officers will enter events on WSMS and triage in accordance with inspector recommendations.
Enforceable Undertaking (EU)	An enforceable undertaking is a written undertaking given by a person who is alleged to be in breach of the Work Health and Safety Act 2011. It is a legally-binding agreement between SafeWork and the person who proposed the undertaking to carry out specific activities to improve health and safety for employees and deliver benefits to industry and the broader community. It is an alternative to prosecution.
Event	The triaging decision-making model uses the term 'event' as a way of recognising that a matter being considered for triaging by the regulator may or may not have resulted in an injury or illness outcome (noting that the decision-making model also proactively encourages resolution of work health and safety issues by workplace participants). This includes incident notification and requests for service (RFS) which are statutory requests and events previously known as 'complaints'.
Fatality	A Notified Fatality includes all fatalities reported to SafeWork NSW. It should be noted that this may include fatalities "not under statute" (refer to Attachment N - Fatality Definitions).

The triage process encourages consistency.

SafeWork NSW staff are encouraged to follow the triage process and make consistent decisions through tools and support from colleagues. Tools, such as guidelines and systems, have been made to complement the documented triage process above. They add additional context to certain points in the process and enable staff to follow the process more easily. When staff are still unsure, they are encouraged to seek further clarity from colleagues who have more technical knowledge. This aligns to good practice as it shows that SafeWork NSW has set up structures to guide staff in consistent decision-making.

SafeWork NSW staff are supported in applying the core triage process through numerous tools that enable consistent decision-making. These tools include guidelines, templates, protocols and systems. Table 5 provides an example of some of these tools.

Table 5 l Triage tools to promote consistent decision-making

Tool	Description
Event Classification Schema Interpretive Guide	This document provides information on the classification of hazards and issues through the triage process. It helps to ensure the consistency and accuracy of event triage by providing a description, explanation and example of categorised events. This also helps to develop business insights to identify emerging priority issues through the correct classification of Notified Incidents or RFS.

[25] SafeWork NSW, Framework Management of Notified Events Procedure, 2022, pg. 4.

Tool	Description
SafeWork NSW Operating Protocol	This document provides instruction to triage teams on how to appropriately handle the receipt, communication and response to fatalities, serious incidents and high-profile matters. This insures that for priority matters, there is a clear process to ensure a timely response by SafeWork NSW.
High Profile Event (HPE) matrix	This is a live document and enables regulatory priorities, trends in work health and safety incidents and matters of concern to the community to be highlighted as priority areas when triage. The document gives detailed instructions of how to triage the matter, usually eliciting a timelier and more involved response by SafeWork NSW.
Workplace Services Management System	The WSMS is the software SafeWork NSW use to record and store triage information. It has been specifically set up to align with the process flow of the National Triage Decision Making Model, as adopted by SafeWork NSW. In supporting the end-to-end process, the system is designed to ensure all users collect the correct information to make triage decisions and follow the correct triage process.[26]

Engagement with SafeWork NSW staff involved in the triage process highlights that these tools are effective in supporting their work. Directors, managers and Triage Advisors have spoken to the utility of the tools and frameworks provided to staff in supporting effective triage decision-making. Triage Advisors consistently report that the WSMS system, while functional, is outdated and negatively affects efficiency. Nous' review of these tools supports the conclusion that although their length and outdated technology poses challenges for users, they represent an effective suite of supports for appropriate triage decision-making.

SWAS Contact Centre staff, Triage Advisors and inspectors also have access to peer and manager guidance throughout the triage process. Procedures exist to ensure staff are supported by managers and other leaders in making triage decisions when they are unsure of what action to take. For example, staff in the Contact Centre work closely with inspectors in the RCEU when escalating matters for Triage. SWAS Triage Advisors also have the option to seek input and advice from inspectors and managers in the RCEU unit at any point during the triage process. Consultations with staff in the SWAS and RCEU teams have praised the collegiate culture within and across the teams as well as the willingness of managers to provide support and advise on complex matters.

Processes and guidance support staff to make fair and unbiased triage decisions.

Triage decisions at SafeWork NSW align with good practice in terms of fairness and a lack of bias. Good practice suggests that triage decisions should be made in a transparent manner, with a consideration of only relevant factors, and free from any personal or organisational bias. Triage decisions at SafeWork NSW are made based on appropriate information and insights. Mechanisms are also in place to ensure that assessor bias is effectively managed. This suggests a good practice approach is followed.

SafeWork NSW has established procedures and systems to ensure triage decisions are informed assessments based on reasonable insights. Detailed guidance is provided in the triage documents developed by SafeWork NSW on evidentiary and other information standards required for decisions.[27] These documents outline extensive procedures for triage staff to follow in collecting insights ahead of decision-making. The WSMS also embeds these requirements in the questions and criteria it requires

[26] Analysis of screen shots of the WSMS confirm that it follows the questions asked within the National Triage Decision Making model in a simple way, ensuring that intake of Notified Events is done consistently and correctly.
[27] SafeWork NSW, Incidents Triaged for Inspector Response document, 2020, pg.3-7; SafeWork NSW, Request for Service – Field and Non-Field Response, 2020, pg. 3-6.

triage staff to complete before progressing a decision. This supports decision-making which draws on the right insights.

Procedures have also been established to reduce the possibility of bias. Inspectors who perform triage are not able to allocate themselves onto the triage or inspection of a particular notified incident or RFS. This is managed by SWAS and the WSMS and remains outside the role of inspector's who perform triage. When a notified event has been received and logged in WSMS, the system locks the file down so that only SWAS can access it. Direct involvement by inspectors or others in the triage process is also discouraged through organisational processes[28] and directions from managers and other senior staff.

2.2 The triage process is accurately documented but could be made more user-friendly for staff.

The documents outlining SafeWork NSW's triage process could be made more user friendly. Triage documentation is long and text heavy. SWAS Contact Centre staff, Triage Advisors and inspectors using it are also required to reference multiple different documents at various stages throughout the triage process. SafeWork NSW staff at all levels have commented on the material not being easily digestible for new staff and that it does not support rapid onboarding. To align with good practice, SafeWork NSW should update, or create new materials, outlining the process to be more easily used and understood by triage staff.

Good practice for triage requires that there is a consistent source of information on triage approaches that is user-friendly for staff. This information must be consistent with the practice that the organisation expects of staff. It also requires that information is presented in an accessible format. In combination, comprehensive and accessible information enables effective triage by ensuring that staff can work in a consistent way.

The triage process is comprehensively documented but it is not easy to follow for staff who perform triage related activities. Most documents are long and detailed. For example, the Framework Management of Notified Events Procedure is intended as a 'day to day' guide for triage work but has over 40 dense pages of text (excluding appendices). This core document is also supported by 11 other guidance documents, such as those outlined in Table 5 above. This does not allow users to quickly locate information as they must refer between documents when making triage decisions. SafeWork NSW staff highlight that this creates inefficiencies through the time taken referring to multiple documents for direction.

SafeWork NSW staff indicated in interviews that these challenges are particularly acute for new starters. In several interviews, Triage Advisors and senior staff across RCEU and SWAS commented that it could take some staff multiple months to get comfortable with using existing materials. Challenges are compounded by the lack of any introductory material that can be used to facilitate learning. Directors and managers at SafeWork NSW highlight that the current documentation available is not well suited to the rapid onboarding of new staff.

[28] SafeWork NSW, Incidents Triaged for Inspector Response, 2020, pg.2-3; SafeWork NSW, Request for Service – Field and Non-Field Response, 2020, pg. 2-3.

Improvement opportunity 1: Ensure triage documentation is better tailored to the needs of users.

Materials outlining the triage process should be updated to ensure they can be more easily used and understood by staff. This will allow SafeWork NSW to be better placed in periods of staff turnover and help staff who perform triage related activities to 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 also update current documents to include simple and clear signposting for how to it should be read and used. This should include sequencing guidance and 'quick reference' guides.
- SafeWork NSW should also establish checklists and procedure documents for triage. These should be designed to ensure that there is an easy way for staff to 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.

3 SafeWork NSW has aligned its triage approach to relevant legislative and policy requirements.

SafeWork NSW's triage approach meets good practice as it closely aligns to relevant legislative requirements and policy directions. Good practice suggests that triage decisions should be made in line with relevant legislative and policy guidance. The documented triage approach comprehensively responds to SafeWork NSW's legislative obligations as outlined in the WHS Act. It also incorporates national level policy direction. However, triage approaches should incorporate a more significant focus on the regulatory direction set by SafeWork NSW in response to legislative and policy imperatives.

To note, Nous are not commenting on the legislative scheme itself, but how well SafeWork NSW incorporate the legislation into its policies and practices.

3.1 SafeWork NSW's triage approach is grounded in its enabling legislation.

SafeWork NSW is responsible under the WHS Act to promote the health and safety of people in the workplace. The triage approach applied by SafeWork NSW directly relates to this legislative objective. It also responds to the SafeWork NSW's specific roles and powers under the WHS Act.

SafeWork NSW's primary assessment framework, the Response Categorisation Matrix, is informed by the duties, powers, and functions conferred by the WHS Act. This categorisation enables triage officers to apply the legislative framework through an assessment of jurisdiction, identification of contraventions under the Act, assessment of the level of risk and harm, and requirements for inspector responses.

Table 6 provides a summary of how SafeWork NSW's triage approach responds to the legislative requirements in the WHS Act through the Response Categorisation Matrix.

Table 6 | Application of the WHS Act to SafeWork NSW's triage process

Legislative requirements	Corresponding element of SafeWork NSW's triage approach
SafeWork NSW has the power to do all things necessary or convenient to ensure the health and safety of persons at a workplace through the exercise of its functions in s 152 of the WHS Act.	The Response Categorisation Matrix allows for a range of responses by the regulator to exercise its functions under s 152 from providing information and advice, to requiring compliance with the Act. This is through requiring inspector attendance (Categories 1 and 2), inspector response (Category 3), and administrative response (Category 4).
The matter must be related to a duty under the WHS Act. The primary duty of care under the Act is established by s 19 on persons conducting a business or undertaking. Additional health and safety duties are imposed by Part 2, Division 2, 3 and 4.	The triage process requires identifying whether the WHS Act applies to the notified event. Where it is within the WHS Act, the event will be triaged as part of Categories 1 to 4 of the Response Categorisation Matrix. Where the WHS Act does not or may not apply, Categories 5 or 6 of the Response Categorisation Matrix may be applied: • Category 5: Insufficient information to triage an event – triage officers make efforts to obtain the necessary information. • Category 6: Not under statute – the event may be referred to another regulator or areas of SafeWork NSW for further action.

Legislative requirements	Corresponding element of SafeWork NSW's triage approach
Triage officers must have regard to what is 'reasonably practicable' for workplace participants in ensuring health and safety (per s 18) when determining contraventions and the appropriate response by SafeWork NSW.	Categories 1 to 4 of the Response Categorisation Matrix are informed by the level of risk and degree of harm from the event. Both these factors are also used to determine what is 'reasonably practical' for duty holders to ensure health and safety in the workplace.
Inspectors must respond to notifiable incidents[29] to preserve the site (s 39).	The Response Categorisation Matrix requires inspector action in relation to notifiable incidents, which involves serious injury or illness and dangerous incidents, through: • Category 1: Critical priority – Inspector action within 24 hours of the event being notified. The immediate area where the incident occurred must be preserved in all cases. • Category 2: High priority – Inspector action within three days of the event being notified. The immediate area where the incident occurred must be preserved in some cases.
Inspectors are required for statutory responses (ss 54, 56, 82, 89, 99, 100, 141).	The Response Categorisation Matrix recognises statutory responses within Category 1 and 2. These specify the circumstances in which inspectors will respond, along with the timeframes in which they will do so.

3.2 SafeWork NSW's triage approach also responds to relevant policy directions.

SafeWork NSW's triage approach responds to national policy on effective work health and safety practices. SafeWork NSW has incorporated directions from SafeWork Australia as part of its adoption of a harmonised national framework. This suggests that SafeWork NSW's triage approach aligns to good practice.

National standards have been established for triage by work health and safety regulators.

In 2008, the Council of Australia Governments committed to the harmonisation of work health and safety laws. The aim was to improve work health and safety, provide consistent protection for Australia workers and reduce the regulatory burden[30]. WorkSafe Australia was created out of this agreement to develop a national policy relating to work health and safety, and workers compensation. This was completed by SafeWork Australia in 2011 and enacted in NSW in the WHS Act, which came into effect on January 1, 2012.

Governments recognised the need for these laws to be complemented by a nationally consistent approach to implementation and administration, and compliance and enforcement. These approaches are outlined in the national Framework for a Common Approach to Work Health and Safety Regulator Event Triaging (the National Framework) and the National Compliance and Enforcement Policy (NCEP).

The National Framework establishes a national approach to the triage of notifiable events. This includes a Triage Decision Making Model, along with explanatory materials (including descriptions of events) that can be used to support triage decision-making. These key materials are supported by a suite of other

[29] Per s 35 of the WHS Act, notifiable incidents are defined as the death, serious injury or illness, or dangerous incident of a person

[30] SafeWork Australia, National Compliance and Enforcement Policy, 2020, pg.1.

documents that regulators can (but are not required) to draw on to support triage.[31] These include: a service charter; a set of core information to be collected during the data entry of Notified Incidents and RFS; an Incident Information Release to advise the public of a serious incident; guidance for the management of events which receive an administrative response action; and, principles surrounding the management of site preservation requirements.

The NCEP also provides guidance for SafeWork NSW's practice. The NCEP promotes a nationally consistent approach to compliance and enforcement of work health and safety laws. It encourages regulators to apply key principles to guide all work health and safety compliance and enforcement activities, including triage. These principles, as described in Appendix B, are consistency, constructiveness, transparency, accountability, proportionality, responsiveness and targeted.

SafeWork NSW has incorporated this national guidance on good practice into its triage approach.

SafeWork NSW has successfully aligned its triage approach to the requirements outlined above. SafeWork NSW has explicitly implemented the key elements of the National Framework and NCEP into its triage processes and procedures.

SafeWork NSW has completely adopted the Triage Decision-Making model to guide triage. It has also incorporated the decision-making flow it outlines into the design of the WSMS tool used by SafeWork NSW staff to make and record triage decisions. The Framework Management of Notified Events Procedure also draws on the event definitions set by the National Framework to ensure events are understood in line with the national understanding.

In addition, SafeWork NSW has closely aligned the triage process to guidance within the NCEP. SafeWork NSW has adopted the NCEP Principles within Chapter 3.2 of the SafeWork NSW Framework Management of Notified Events Procedure, as discussed above.in 2.1.1. They are also reflected more broadly in SafeWork NSW's overall risk-based triage approach. SafeWork NSW applies the compliance and other tools specified in the NCEP. Senior triage staff at SafeWork NSW referenced the NCEP and its principles in consultations with Nous, highlighting that they form the basis of decision-making approaches and tools within the organisation.

Further discussion of this alignment is set out at Appendix D.

3.3 SafeWork NSW could better integrate its own regulatory priorities into its triage activities.

SafeWork NSW sets its regulatory direction in line with legislation and policy. However, it could better integrate this regulatory direction into its triage approach.

SafeWork NSW has effectively set regulatory priorities, which incorporate guidance from the Department of Communities and the wider NSW Government. The triage approach set by SafeWork NSW has been revisited with a view to ensuring that it incorporates these priorities however, triage documentation and approaches could further evolve to ensure this material is better embedded.

SafeWork NSW has established, and regularly revisits, regulatory priorities.

SafeWork NSW consistently seeks to align its work to critical priorities for effective work health and safety regulation. The organisation recognises that it must align its activity to government policy, as well as to emerging trends in work health and safety risk. In response, SafeWork NSW develops and maintains regulatory priorities.

[31] The National Framework states that, 'regulators will adapt these elements as is considered necessary to meet their internal infrastructure and operating arrangements'. This is found at National Compliance and Enforcement Policy, SafeWork Australia, pg.3.

SafeWork NSW revisits its regulatory priorities each year[32]. This is done to ensure its work aligns to current and emerging risks and challenges to safe workplaces. SafeWork NSW sets these priorities drawing on its own internal data, the expertise of its staff, input from external sources (e.g., academic research) and policy input from the Department of Customer Service and the wider NSW Government. This approach to setting regulatory priorities aligns with good practice.

SafeWork NSW also seeks to align its regulatory focus to particular groups of workers and employees. These groups are chosen through a similar process as the regulatory priorities, where SafeWork NSW draws on internal data, the expertise of staff, input from external sources and policy input from the wider NSW government. Its regulatory prioritisation activities seek to ensure that workers have an equal expectation of safety in the workplace, regardless of the nature of their work or their background. For example, SafeWork NSW places special emphasis and increased focus on workers from vulnerable backgrounds. This includes: young workers; workers from culturally and linguistically diverse backgrounds; and Aboriginal people.[33]

The regulatory priorities set by SafeWork NSW through this process are set out in Appendix E.

Triage documents and approaches do not sufficiently align to SafeWork NSW's regulatory priorities.

SafeWork NSW has not yet completely aligned its triage processes to its regulatory priorities. This means that regulatory priorities are not appropriately prioritised as part of triage. As these priorities are grounded in information that should generally inform triage decision-making, this may result in instances where good practice is not followed.

SafeWork NSW has sought to incorporate the NSW Regulatory Priorities 2023 into the triage process. This has primarily been through implementing a way to flag these matters in the WSMS.[34] Based on a review of files related to 20 Notified Incidents and RFS cases, it appears that this has been implemented. This will allow SafeWork NSW to capture data and identify trends on the regulatory priorities.

However, process documents, such as Framework Management of Notified Events Procedure or the Triaging Principles do not explicitly refer back to the SafeWork NSW Regulatory Priorities or refer to the vulnerable cohorts mentioned. Triage Advisors also highlight that the regulatory priorities of SafeWork NSW are not always a reference point for them in making triage decisions.

Improvement opportunity 2: SafeWork NSW should better embed regulatory priorities into the triage process.

SafeWork NSW should regularly revisit its triage process to ensure it aligns to 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:

- Updating triage process documents, guidelines and templates 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 PCBUs.
- Systems, including WSMS, should continue to be updated to ensure they support and enable the integration of regulatory priorities into the triage process.

[32] SafeWork NSW, SafeWork NSW Submission to the Independent Review of SafeWork NSW, 2023, pg. 9.
[33] SafeWork NSW 2023, SafeWork NSW Regulatory Priorities 2023, https://www.safework.nsw.gov.au/about-us/safework-nsw-regulatory-priorities-2023.
[34] SafeWork NSW, Regulatory Priority Dashboard, 2023.

SafeWork NSW must communicate these changes effectively to triage staff in RCEU and SWAS, 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.

4 Triage approaches in practice broadly align with good practice, however oversight could improve

SafeWork NSW's actual delivery of triage processes appears to align with good practice. Established processes are closely followed and delivered in a way that aligns with the law and policy standards. Work is efficient and effective. In addition, decisions are broadly consistent with the facts of the Notifiable Events they relate to.

Good practice suggests that triage approaches should involve:

- **Decisions being made in a consistent way with consistent outcomes** – Triage decisions should be made in line with an established triage decision-making framework, applied consistently each time. Triage decisions should be informed by clear insights from appropriate sources.
- **Delivery of triage processes is efficient, effective and aligned to established standards** – The triage process, as delivered, should align with the decision-making approach and materials already established. The process, as delivered, should also align with the law.
- **All processes are fair, transparent and subject to oversight** – Processes supporting triage decisions should be transparent, fair and accountable to enable continuous oversight and review.

As outlined in Section 3 above, SafeWork NSW's triage approach appears to align with good practice. Section 3 also highlights that the approach appears to align with the requirements of relevant legislative and policy standards. Therefore, if SafeWork NSW staff deliver triage approaches in line with their established process, and do so efficiently, effectively and consistently, these decisions are likely to align with good practice. As set out below, this appears to be the case in practice.

4.1 Triage occurs in line with documented processes but could deliver greater consistency in outcomes

SafeWork NSW staff generally apply the organisation's processes in practice. This has been observed through consultations with staff all levels within RCEU and SWAS, and a review of a sample of triage decisions made by SafeWork NSW staff. Ensuring that the decisions made by the triage team are correct both in process and in terms of the outcomes they deliver should remain a focus for SafeWork NSW.

4.1.1 SafeWork NSW leaders report staff adhering strictly to triage processes.

SafeWork NSW staff report that the documented triage processes are generally followed in practice. Senior leaders, managers, inspectors, and Triage Advisors in the organisation were unanimous in their assessment that the triage process as outlined in Section 2 above are followed in practice. They highlighted their perspective that triage documents provided to their teams contain the correct information and are formatted in a way that suggests the process has been followed. They also highlighted that the WSMS, and other process tools, guide staff to follow the process each time.

Managers and senior leaders responsible for triage processes highlighted that triage processes are generally followed in practice. They reported that SWAS Contact Centre staff, Triage Advisors and inspectors who perform triage are generally encouraged to follow the process. They also reported that the intra-team engagement between triage staff as they do their work is focused on ensuring the process is followed. However, it was noted in these conversations, as well as those with inspectors, that triage decisions may not be followed in practice, as discussed further in Section 4.1.2.

RCEU team inspectors and SWAS Triage Advisor staff highlight that they generally follow the triage process in practice. When consulted about triage training and the focus on triage as part of the New Inspector Training Program, inspectors highlighted that staff are provided with a clear understanding of what good triage looks like at SafeWork NSW. These same inspectors highlighted that in their experience, and in practice, triage approaches are generally followed by Triage Advisors. Triage Advisors confirmed this during consultations. They noted that the tools and systems in place enable them to directly follow the triage process and that when unsure of a decision, get advice from peers, managers and the RCEU team.

4.1.2 A review of actual practice highlights that triage processes are generally followed

A sample review of triaged matters shows that processes are consistently followed. This demonstrates alignment to good practice. However, SafeWork NSW staff and data highlight that there is sometimes dissatisfaction with the conclusions reached during the triage process.

To determine alignment to the triage process in practice, Nous reviewed nine notified incident and ten RFS reports. This set was selected at random, being 19 reports received in sequence on a single day. This was done to avoid potential bias in sampling. These samples included the initial data entry report, the WSMS triage report and a screenshot of the WSMS triage flow.

Triage processes are closely followed in practice.

All examples highlighted the expected triage approach being followed in practice. All notified events reported in to SafeWork NSW were assessed for their eligibility to be triaged by the regulator based on whether they are within the jurisdiction of SafeWork NSW, whether the matter relates to a duty under the WHS Act and whether there is sufficient information to triage the matter. Further rules were then applied to determine how these notified events should be triaged in line with SafeWork NSW's Framework Management of Notified Events Procedure and supporting triage documents. All details were recorded in the WSMS.

Despite the small sample size, sequential sampling from a random day should eliminate any selection bias for these examples. Matters were processed by a number of different staff members each of whom were allocated the matter at random This sample also eliminates any selection bias of the work of a particularly diligent staff member.

The review indicated that expected processes are followed but did highlight a few limitations. A selection of the strengths and weaknesses observed is highlighted in Table 7.

Table 7 I Strengths and weaknesses observed of random triage samples

Strengths	Weaknesses
• Each sample had complete hazard codes. • Descriptions of the events were detailed in most cases. • Priority issues that aligned with SafeWork NSW's Regulatory Priorities 2023 were noted. • When triaged Category 6 – Not under statue, details were given of which regulator it had been referred to. • There is evidence of efforts to gather further information. • There is evidence of the application of the High Profile Event (HPE) matrix and	• Not all samples provided detailed reasons for triage decisions in the WSMS comments section or the Issues and Actions section of the Inspector Report on the WSMS Incident Report. • Notified Incidents were more likely to lack consistent detail under the Issues and Actions sections of the Inspector Report on the WSMS Incident Report.

Strengths	Weaknesses
SafeWork NSW Regulatory Priorities 2023 for a case involving harmful substances. • For RFS, most gave reasons for decisions made in the WSMS comments section or Issues and Actions section of the inspector's report.	

Triage decisions are not always supported by inspectors..

Even though documented triage processes are consistently followed, staff at SafeWork NSW are not always satisfied with the triage decision. In interviews, senior SafeWork NSW leaders highlighted that triage decisions may be subject to informal reviews based on resourcing pressure. Formal requests for review are relatively rare but when triggered, result in a change of triage decision in approximately three quarters of cases.

In consultations, senior leaders and managers confirmed challenges in the correct categorisation of triaged matters. These staff highlighted that while triage decisions are generally made in line with established processes, these processes do not appropriately consider organisational factors (including resourcing). As a result, they indicated that there are instances where an inspector assigned to work on a triaged matter may 're-triage' it back to Category 4 – Administrative Response, with this being done to manage emerging facts and resourcing pressures.

Data on informal 're-triage' is not collected and therefore was not available for the preparation of this report. However, submissions to the Independent Review noted the inefficiencies caused by 're-triage', as matters would then be returned to SWAS Contact Centre or Triage Advisors. Submissions made to the Independent Review include suggestions that if matters are returned to the RCEU or SWAS, staff members in those teams may be subject to criticism. The practice of re-triage does not align to best practice. It may lead to decisions being made that do not follow expected practices or standards.

Note: The full impact of informal re-triage should be better understood by SafeWork NSW. Work to collect relevant data on this issue is encouraged. However, insufficient information is available to make a formal improvement opportunity on this point.

4.2 SafeWork NSW does not exercise sufficient oversight over the quality of triage decision-making.

At present SafeWork NSW's oversight of its triage approach is not sufficiently robust. Review processes are informal and manual. The identification of gaps in approach and outcomes relies on the individual judgment of a small pool of expert staff. Further, responses to any identified gaps are generally similarly informal. Improving the nature and quality of the oversight of triage decision-making should be a key focus for SafeWork NSW into the future.

Good practice suggests triage must be subject to appropriate oversight. To ensure decision-making is accountable, an organisation engaged in triage must monitor how triage decisions are made. They must also review the quality of the decisions made, ensuring their alignment against appropriate practices and standards. To the extent that gaps are identified between the quality of decision-making expected, and its quality in practice, continuous improvement activities must support a rapid uplift in triage quality.

Regulators demonstrating good practice in their oversight of triage approaches tend to have the following attributes:[35]

- Detailed data is captured by the regulator on the rationale for decisions made, along with how that rationale aligns to decision-making frameworks and practices.
- Triage decisions made are subject to a random sampling process to determine which should be subject to review.
- Sampled triage decisions are subject to a formal, documented, review process that tests specific features of the decisions made and the process that supported it being made.
- Data is captured as a result of this review process. This data is subject to analysis to establish common flaws or gaps in triage approaches.
- Where flaws or gaps are identified, remedial action is planned and delivered by the regulator. This generally includes process and system updates, as well as tailored training for triage staff.

4.2.1 Triage processes are subject to informal oversight.

Oversight approaches are relatively informal and are not clearly documented. Triage process documents outline some requirements for managers to review triage decisions. However, instructions on review and reporting are not detailed and do not always outline what exactly should be done and how often.[36] Further, it is not clear how the insights from existing reviews are communicated or how often. This suggests that the success of reviews rely on the experience and expertise of either the inspectors or managers involved. Senior SafeWork NSW leaders interviewed about these review processes noted that the lack of a formal review process was an issue and that it would be best practice to formalise this approach.

Five current forms of oversight over triage have been described in consultations with SafeWork NSW staff and process documentation. These are outlined in Table 8.

[35] Commonwealth Ombudsman, Better Practice Complaints Handling, 2023, pg. 17.
[36] SafeWork NSW, Triage Principles, 2021; SafeWork NSW, BRD Service Level Agreement 2022 – Appendix 1, 2022; SafeWork NSW, RCEU Monthly Report – Procedures.

Table 8 | Forms of triage review and their limitations

Type of review	Description	Limitations
Informal inspector review [37]	From time to time, an inspector receiving a triage decision may question whether it was made correctly. As a result, they may choose to raise this issue with the triage manager. This will result in the triage decision being reviewed through a discussion between the manager and inspector. Opportunities for improvement identified either by inspectors or as part of the review process are captured in a shared spreadsheet for further action.	• It is not a formal, documented process therefore it is unclear when or how often they are conducted or how to implement the outcomes of the review processes. • The inspector's decision to review the categorisation after it has been allocated may be based on resourcing constraints of the team or the broader Inspectorate, rather than the most appropriate triage outcome. • There is little formal accountability over decisions made by an inspector or the manager they engage with.
Requested WSMS event review[38]	Triage Advisors in SWAS and team members in the RCEU can request to have their triage decisions overlooked by the RCEU Manager. This is an informal process where after the manager has reviewed, they will sit down with the staff member to discuss changes to a decision, if any. Outcomes of this process are recorded in a spreadsheet for record keeping which is owned and managed by the RCEU Manager.	• The review process relies on the capacity, capability, and knowledge of one individual (the RCEU Manager). This can be an issue if this person is not available. • There is little formal accountability to test the triage decisions of one manager through different perspectives (e.g., shared responsibility with senior inspectors to respond to WSMS event reviews with managerial review)
Periodic manager 'spot check' review [39]	On a semi-regular basis, managers responsible for the triage process will select triage processes completed by SWAS staff for a 'spot check' review. It is estimated by SafeWork NSW staff that between 10 and 20 percent of triage decisions categorised as a 1, 2 or 3 on the triage scale are subject to a 'spot check'. This review involves a manager comparing the decision against their knowledge of the required decision-making process to determine if the decision was made correctly. Insights from this process are captured in a shared spreadsheet for further action.	• This is not a formal process with set standards for how many matters should be reviewed. • There is little evidence to verify this process is occurs consistently or whether it leads to consistent oversight outcomes.
Review of all Category 4 triage outcomes[40]	This review is conducted by the RCEU team and involves the review of all Category 4 triage outcomes. This review occurs before a matter can be closed in WSMS.	• This process is not clearly documented and therefore it is unclear what events are subject to this e.g., RFS or notified incidents, and when this is conducted.

[37] SafeWork NSW, Triage Principles, 2021; Stakeholder consultations.
[38] SafeWork NSW, 2023 Register of Requested WSMS Event Reviews, 2023; Stakeholder consultations.
[39] Stakeholder consultations
[40] SafeWork NSW staff representatives

Type of review	Description	Limitations
Verification of Category 4 decisions[41]	Up to 20% of Category 4 decisions allocated to an administrative response are subject to a verification process through an inspector visit.	• Matters selected for the verification visit are generally based on recommendations in the WSMS rather than at random.

4.2.2 Current oversight approaches produce only a limited effect on improving triage practice.

The scope of current oversight is limited and data is not collected consistently. Current approaches result in a relatively small and inconsistent sample of triage decisions being subject to review. This limits the value of oversight as it does not seek to ensure a random sampling or sufficient coverage of all different types of triage decisions or matters. Similarly, data collection from oversight is relatively limited. There is no consistent framework for data capture. This makes it difficult to compare the outcomes from one review against another, or to identify trends in triage decisions.

Current oversight is manual and relies on the capacity of individual staff. Decisions to review matters are not triggered automatically via WSMS. This means that it requires a proactive decision from a Triage Advisor to flag a decision for review and an inspector or manager to manually review a triage outcome. Managers interviewed indicate that they seek to review matters on a regular basis and take the time to talk through reviewed triage decisions with staff. They did acknowledge however, that their individual capacity at any given time influences the frequency of these reviews.

Only limited actionable insights are produced by the review process. Data is not captured in sufficient detail or depth to allow for trend analysis or an objective assessment of challenges. While the perspectives of individual staff on potential triage gaps or challenges are recorded, albeit informally, this information is then not formally reported or escalated. In the absence of sharing these insights widely, there appears to lead to a lack of structure and consistency in how triage issues are responded to and therefore, it is unclear what changes have been made in response to insights gathered.

Improvement opportunity 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 ensure that process improvements are made from these insights. This will ensure that the right processes are being followed and that when they are followed, the right outcomes are being achieved. In doing so, SafeWork NSW will align with best practice on accountability of decisions and foster a culture of continuous improvement.

To ensure that processes are being followed, and that the right outcomes are being achieved, SafeWork NSW should more clearly outline what reporting is expected of senior team 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.

[41] SafeWork NSW, SafeWork Submission to the Independent Review of SafeWork NSW, 2023, pg.18; Stakeholder consultations.

- 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 that there is a mechanism in place to 're-triage' decisions that are identified as incorrect by 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, triage managers should introduce process improvements to ensure that processes maximise efficiency and are relevant to current work health and safety priorities and trends. This will ensure SafeWork NSW are meeting best practice triage in that decisions are more consistent, there is transparency in the process, triage staff in SWAS and RCEU are accountable for their decisions, and staff are making better decisions through process improvements.

5 Triage work could be better supported through training and organisational structure.

There is opportunity for SafeWork NSW to better support their staff and the triage function as a whole. The fragmented structure of the triage function spread across two directorates does not support effective ways of working between teams. Information flows are not smooth, ways of working are not optimised and there is a lack of effective oversight of the three groups in relation to each other. The lack of formalised training, for new staff and ongoing development, leaves SafeWork NSW at risk of experienced staff turnover and not achieving their agile regulatory priorities. To align to best practise more closely and fully enable their staff, SafeWork NSW should consider co-locating the triage function under one directorate and formalising training for new staff and ongoing development.

Good practice for triage requires an ability for staff to work efficiently and effectively by being appropriately equipped and supported in their jobs. In part this is achieved where organisational structures support the rapid, accurate flow of information, and instructions between all staff involved in triage. It is also achieved through staff being appropriately supported through training and ongoing development to gain the information and insight they need to perform effectively.

5.1 The organisational structure applied for triage could evolve to support more efficient and effective triage outcomes.

Triage outcomes at SafeWork NSW could be improved through the integration of disparate functions performing triage work. Currently, triage effort is spread between three groups of staff – each performing different aspects of the process. These groups have separate reporting lines. Managers and senior leaders highlight challenges in managing triage because of this structure. Examples from other organisations also suggest that disparate triage structures create challenges. Integrating these teams would bring triage at SafeWork NSW closer to good practice.

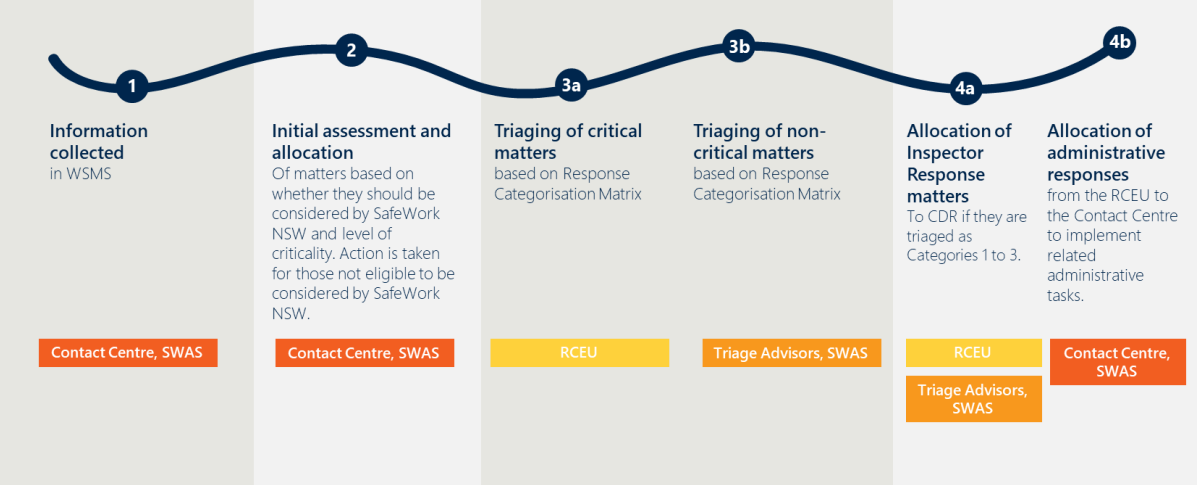
SafeWork NSW's triage function is made up of three groups.

Triage at SafeWork NSW is performed by three distinct groups within two teams. These groups are:

- Contact Centre team in SWAS who sit within the Issues Resolution and Advisory Services Directorate and support inspectors to make decisions
- Triage Advisor team in SWAS who also sit within the Issues Resolution and Advisory Services Directorate
- (RCEU team who sit within the Investigations and Emergency Response (IER) Directorate.

The structure of the three groups is outlined Section 1.1, Table 4 and the flow of information and actions between them is outlined at a high-level in Figure 5.

Figure 5 I Triage Function Information Flow



The current structure does not effectively enable triage teams.

The disjointed triage structure disrupts the smooth flow of information between teams. Staff have highlighted that information and insights do not always move effectively between the three groups involved in triage. In particular, Triage Advisors and senior leaders have both outlined that information on required improvements to triage practice is often 'trapped' within the Triage Advisor and RCEU groups. For example, Triage Advisors and the RCEU meet monthly to discuss approaches to triage, but information does not flow on to staff in the SWAS Contact Centre. This may mean that the different triage groups are not aligned on trends emerging in internal reviews or NSW work health and safety more broadly.

A review of case files highlights other challenges in the flow of information. Information provided at formal handover points between teams is relatively limited, as discussed in Section 4.1. Generally, only basic information on decision rationale is recorded, and only the notes and data expressly required by the WSMS are included. Exchanges between triage groups are informal but they are encouraged to discuss triage decisions and may help to fill contextual holes in understanding why certain decisions have been made.

Oversight and management of triage teams is similarly disjointed. The manager of SWAS, which consists of the Contact Centre and Triage Advisors, report to the Director of the Issues Resolution and Advisory Services Directorate, while the RCEU team reports to the Director of the IER Directorate. Both directors, as well as managers in their teams, highlight that this creates the risk of directions being given that cause these teams to work at crossed purposes.

Each senior leader engaged as part of this review highlighted that integrating SWAS and the RCEU under a single directorate would result in improved outcomes. This is due to the frequency with which information flows between all teams to enable effective decision-making. During consultations, SafeWork NSW triage staff at all levels highlighted the synergies between RCEU and Triage Advisors as two groups that perform the triage function for SafeWork NSW or implement administrative activities for the same triaged matter.

Proximity for both groups can enable better information sharing and accountability on how to triage consistently. Further, the Contact Centre is responsible for collecting, recording, and reporting core information directly to RCEU to enable them to triage effectively. Proximity for these groups can better equip the Contact Centre with feedback to ensure it can support RCEU in its triage function. Co-locating both teams in the organisational structure creates efficiencies in decision-making and the potential for better oversight by RCEU as the owners of the triage process.

Other similar regulators generally co-locate intake, triage and oversight. Good practice regulators considered as part of this review – including the NDIS Quality and Safeguards Commission - co-locate their intake and triage functions. This is done to ensure that staff in these teams cooperate most effectively. It is also done to ensure that appropriate cross-training occurs within these teams. Changes to

triage practice can also be flowed out more quickly in these organisations given the administrative proximity of teams involved in triage.

Improvement opportunity 4: Consolidate the two teams 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 be reactive to process improvement. This will align SafeWork NSW with best practice triage to ensure that staff are appropriately equipped and supported to work at their best.

Co-locating the triage function will enable the reactiveness of new ideas and implementation of 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. Combing triage to sit 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.

Consolidating the three groups of staff who perform triage functions under one directorate will meet best practice in ensuring that appropriate ways of working are enabled. Better ways of working between staff will allow them to better meet SafeWork NSW's legislative, policy and strategic outcomes and put SafeWork NSW in line with other best practice regulators who co-locate their intake and triage functions.

5.2 Improved training for triage staff could drive more consistent triage outcomes.

Note: Training for triage staff is the focus of a separate report, also provided to the independent review. However, this section is included in this report for the sake of completeness.

Improved training for triage staff would enable triage staff to work more effectively throughout their whole tenure. A lack of formalised training for SWAS staff means they are not enabled to be effective and efficient early in their role. SWAS staff may pick up incorrect behaviours and do not have quality training materials to build foundational knowledge and reference back to. Further, the capability of staff who perform triage related activities is not continually developed, with limited refresher training offered. This does not align with best practice which encourages workplaces to continually invest in building staff capability, particularly at the start of their career.

There is a lack of formal training for new starters in SWAS.

Training for new staff is not formal. The triage training for Contact Centre staff and Triage Advisors relies on an informal onboarding process. This training has been developed in an environment where staff join infrequently and often transfer from roles or organisations that have provided them with transferable skills. As a result, formal training is not extensive. Existing triage guidance materials are generally repurposed as ad-hoc training materials. In consultation, Triage Advisors noted the lack of formal training for their role and the Contact Centre but acknowledged that for the breadth of work, it would be hard to create a formal training program that encompasses the entirety of the roles.

Most learning for Contact Centre staff and Triage Advisors occurs on the job. A new Contact Centre employee or Triage Advisor will be paired with a senior staff member, who will work alongside the new employee to teach them the tools, considerations, and processes for triage. Further support may also be provided by the RCEU team. This mentoring support allows new starters to learn from staff who have technical knowledge and industry experience. Engagement with managers and Triage Advisors have highlighted that this approach provides the right skills for Triage Advisors but that there are some gaps in Contact Centre Staff knowledge.

Contact Centre training does not equip staff with sufficient knowledge of the triage process. Contact Centre staff play an important role in collecting, formatting and presenting information to the RCEU and Triage Advisors, but they do not receive formal training on triage decision-making or WHS laws. This places increased burden on the expertise of Triage Advisors or RCEU staff who are points of escalation when dealing with more complex matters. Submissions into the review also indicated that Contact Centre staff should be upskilled on WHS law to ensure they are providing an appropriate regulatory response for notified events.

The on-the-job training approach is labour intensive and difficult to scale. While on-the-job training provides SWAS staff with the correct skills, managers and triage advisors have highlighted that this approach is slow and resource intensive in how it builds staff capability. High staff turnover may result in SafeWork NSW not being able to keep pace with training needs or they may lose their ability to train new staff if experienced staff leave. Both of these outcomes are a risk as SafeWork NSW do not currently have a contingency plan in place.

With most of the training taking place on the job, staff are dependent on the approach of those that they learn from. This can lead to potential inconsistencies and makes SWAS staff dependent on inspectors for guidance, rather than their own process materials. For example, the review of sample triage decisions reveals that over 100 corrections were made to SWAS incident notifications logged in WSMS from 1 September 2023 to 14 September 2023 for smaller errors such as the wrong hazard category or triage decisions being incorrectly formatted. While this can be corrected and is routinely picked up, it is inefficient. The accuracy and quality of triage decisions decrease, which creates a greater burden on the reviewer and may result in re-triage occurring at a later stage, as reported in Section 4.1.2.

Staff do not receive targeted, ongoing training.

SafeWork NSW staff who perform triage activities do not receive formal ongoing development training. At present, the capability of Contact Centre staff, Triage Advisors and inspectors who perform triage is not continually developed to achieve more efficient and effective regulatory outcomes. Staff appear to receive only limited refresher training, particularly around changing regulatory priorities. This does not align with best practice, which recommends that staff capability is continually developed throughout their employment.

Triage processes are static and are not subject to continuous improvement based on outcomes data. In consultations, SafeWork NSW managers recognised the need to better utilise the data that is collected throughout triage to draw out insights and make improvements to the triage process more regularly.

It is unclear what refresher training staff receive for SafeWork NSW's changing regulatory priorities. To better align to the SafeWork NSW Regulatory Priorities 2023 and ensure a risk-based triage approach is taken, the HPE matrix is updated as well as the WSMS to better capture data on the regulatory priorities. It is unclear however, how staff receive ongoing training to ensure they are aware of these changes and know how to enact them. This does not effectively enable staff to meet their regulatory priorities. Creating ongoing refresher training must become a priority as SafeWork NSW's regulatory priorities now change year on year. Processes must be in place to adapt and align triage to achieve agile regulatory outcomes.

Formalisation of training for triage staff will reduce risks associated with turnover and inconsistency between staff providing training. It will also ensure that established staff have sufficient reference points to refresh their skills.

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.*

Part 2: Decision-making

6 Background to decision-making in SafeWork NSW

6.1 SafeWork NSW's IDMP process

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:

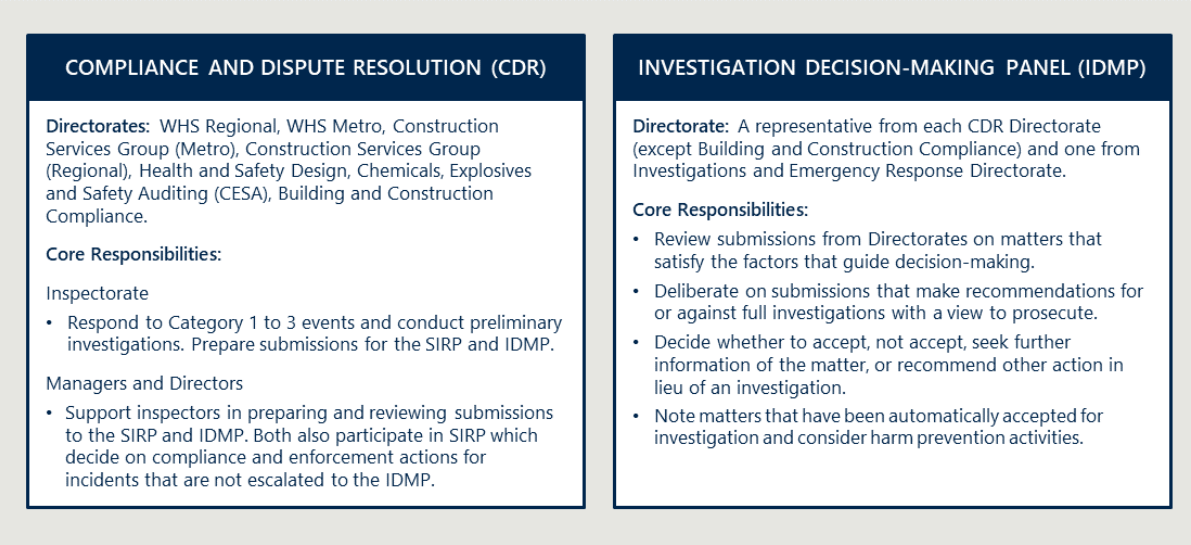
- SIRP: identifying which matters should be escalated to the IDMP and in the alternate, which notices should be issued to ensure compliance amongst duty holders.
- IDMP: who review, deliberate on, and decide which matters require a full investigation with a view to prosecution.

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.

The IDMP process is primarily conducted within Compliance and Dispute Resolution (CDR).

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.

Figure 6 | SafeWork NSW IDMP process roles and responsibilities

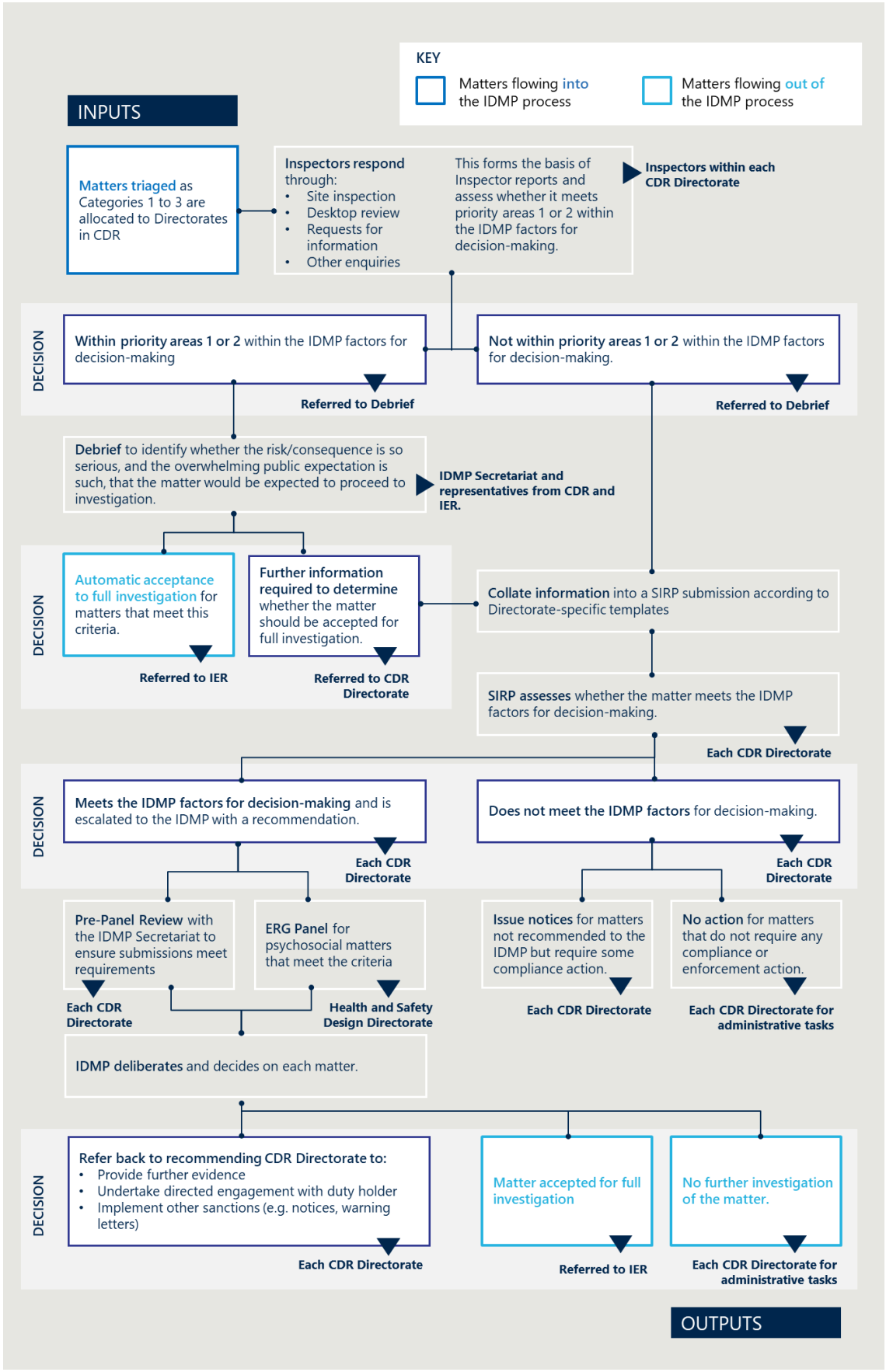


There is a clear IDMP process for SafeWork NSW to follow.

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. The IDMP factors for decision-making can be found in the Investigation Decision Making Framework (IDMF) extracted in Appendix G.

A detailed explanation of the IDMP process illustrated below can be found in Appendix F. In the diagram ERG refers to the Evidence Review Group, IER refers to the Investigations and Emergency Response Directorate and SIRP refers to Serious Incident Review Panel.

Figure 7 | SafeWork NSW IDMP decision-making process map



6.2 Good practice principles for Decision-Making

Good practice principles for regulatory decision making are well established in the literature and in the work of Australian regulators. Nous has worked to support a broad range of Australian regulators, at the state and Commonwealth levels, to review and enhance their regulatory practice. As a result of this work, Nous has identified a range of good practice principles that we commonly observe as features of high performing regulators and their decision-making approaches. These principles are set out at Table 9. For the purposes of this project, these principles have been refined by reference to:

- The publicly available material on the decision-making approaches and processes of the following regulators:
    - Environment Protection Authority (EPA) NSW[42]
    - WorkSafe New Zealand[43]
    - WorkSafe Victoria[44]
- Reports and analysis summarising good practice, including:
    - ACECQA National Quality Framework[45]
    - Ten Principles of Good Business Process Management[46]
    - Nous' experience working with regulators on decision making.

These principles are presented along with a set of features that Nous considers would indicate whether the principle has been met. As part of our analysis of the regulatory decision-making approach at SafeWork NSW, we have considered whether these principles are in place and are consistently followed. To the extent they are, we are more likely to conclude that the decision-making approach is appropriate and less likely to suggest improvement opportunities.

Table 9 | Good practice principles for regulatory decision-making

Good Practice principle	Explanation	Features establishing the principle has been met
Regulatory decisions are made in line with clear processes.	Regulators must exercise their powers in line with clear guidelines and standards – and towards a clear regulatory objective. This ensures that staff have clear guidance for decision-making. It also enables regulated parties to understand likely outcomes up-front.	• **Clearly articulated objective** – The regulatory objective sought by the agency is clearly understood and clearly articulated. All people involved in regulatory decision-making pursue this objective as part of their work. • **Consistent documentation –** Materials to support regulatory decision-making process are developed, available to staff, and easy to understand and follow in a consistent way.

[42] Environment Protection Authority, Regulatory Strategy 2021-2024, 2021.
[43] WorkSafe New Zealand, 2018, Enforcement Decision-making Model, 2018, https://worksafe.govt.nz/dmsdocument/1031-enforcement-decision-making-model.
[44] C Noone, M Donnan, Butcher, Independent Review of Occupational Health and Safety Compliance and Enforcement in Victoria, 2016.
[45] Australian Children's Education and Care Quality Authority (ACEQA), The National Quality Framework, 2023, https://www.acecqa.gov.au/national-quality-framework/guide-nqf/section-5-regulatory-authority-powers/15-good-regulatory-practice.
[46] JV Brocke, T Schmiedel, J Recker, P Trkman, W Mertens, S Viaene, Ten Principles of Good Business Process Management, Business Process Management Journal, 2014, 20. 10. 1108/BPMJ-06-2013-0074.

Good Practice principle	Explanation	Features establishing the principle has been met
Regulatory decisions are made in a consistent way.	Exercises of regulatory power should drive and support changes in behaviour by regulated parties. This will occur when decision-making is predictable and where particular behaviours or outcomes will result in consistent outcomes. To ensure consistency, regulators should draw on established sources of information and insight, apply risk-based principles of decision making in determining focus areas based on that information, and ensure all decision making is made consistently, in line with an established framework and principles.	• **Intelligence led –** Regulatory decision-making is informed by clear insights, from agreed sources, captured and analysed in a consistent way. Where more information is required to make a decision, there are clear processes and mechanisms that are followed to collect that insight. • **Risk-based principles are applied** – The risk of harm is a key consideration in making regulatory decisions. The agency makes considered choices about where to focus its effort, based on risk. With these choices informing regulatory decisions in a consistent way, based on a risk framework. • **Consistent decision-making –** Decisions are made in line with an established regulatory decision-making framework, which is applied consistently each time. Similar sets of facts and circumstances should generate similar regulatory decisions.
Regulatory decisions are always within powers.	Regulators cannot exceed their legislative mandate in making decisions. They should also ensure that all decisions align to policy directions and other guidance provided by Government and by their portfolio department. Decision making processes, and the decisions made pursuant to those processes, must therefore align to relevant laws and standards.	• **Alignment to relevant laws** – The legislative standards that apply to the regulator are the primary consideration in any decision-making. All regulatory decisions are made in support of the purpose of the agency's enabling legislation being met. • **Alignment to policy settings and standards** – Regulatory decision-making must also align to relevant government policies and standards, and with the objectives set by the agency. It must also deliver outcomes that are acceptable to the community and other stakeholders.
Regulatory decisions are sufficiently strategic in focus	Regulators have limited resources. As such, regulatory decision-making activities must seek to prioritise the focus and effort of the regulator. This prioritisation must be driven by the overarching regulatory objectives and strategy of the organisation, and by reference to the objectives of its enabling legislation.	• **Individual decisions are made by reference to strategic goals** – Each individual decision made by the regulator to pursue or not to pursue particular actions is informed by both: the individual circumstances of the matter subject to the decision; and the broader strategic objectives that will be pursued or met as a result of the decision. • **System level impacts are considered** – The effect of a given decision on the whole system subject to regulation – including stakeholders beyond the stakeholders directly affected by the decision – should be considered. With a focus on ensuring any system level effects align to the regulator's strategic objectives.
Regulatory decision-making	Regulatory decision-making must align *in practice* to the approach	• **Alignment to established materials** – The triage process, as delivered, must align with the decision-

Good Practice principle	Explanation	Features establishing the principle has been met
is efficient and effective	outlined in the guidance materials the agency has established (or follows). This delivery must also be efficient, and effective. With continuous improvement efforts ensuring that the right outcomes are delivered in the right way.	making approach and decision-making materials established by the agency. • **Efficient** – Staff using the decision-making approach established, must make decisions quickly and efficiently, using only the information set out in relevant frameworks, and making decisions when relevant information is available. Rapid decision-making, with a direction to use a higher risk clarification in cases of uncertainty, should be preferred over approaches that pursue absolute certainty before a triage decision is made. • **Continuous improvement** – Regulatory decision-making should be subject to regular process reviews. Processes and approaches should be continuously tested and improved over time.
All processes are fair, transparent and subject to oversight.	Regulatory decisions must be made fairly, transparently and without bias. The same decision should generally be made, given a sufficiently similar set of facts. Decision-makers should only consider relevant considerations, and never consider irrelevant considerations, in making regulatory decisions. Finally, decision-making processes should be subject to regular oversight and review.	• **Transparent decision-making** – The method for how decisions are made, along with the rules and standards against which they are made, should be available. Similarly, the rationale for any decision made should be recorded, and made available where appropriate. • **Fairness** – Decision-makers should only consider relevant factors, and should never consider irrelevant factors. Decisions should be free of bias. • **Accountability** – The regulatory decision-making processes should be subject to oversight and review. Effort should be invested in ensuring that decision-making standards and practices are followed, to a high standard, at all times. Trend data should be analysed to surface systemic bias or other issues.
Staff are appropriately equipped and supported.	The staff used by an agency to make regulatory decisions must be sufficiently skilled, equipped and enabled to work effectively, as well as to make appropriate decisions. This includes ensuring that they have the right personal capabilities, resources and capacity. It also includes ensuring that they are appropriately supported and enabled by managers and leaders. Finally, it requires ensuring they feel confident making difficult decisions, and that the organisation will 'back' their calls, providing appropriate procedures have been followed.	• **Appropriate ways of working** – Staff are trained and supported to work in a risk-based manner, be outcomes focused, and collaborate across teams. • **Appropriate capability** – The organisation regularly tests the capability of staff to deliver in line with the principles outlined above, to the extent that gaps are identified, training and support is provided. The agency makes regular investments in the quality and capability of staff. • **Staff decisions are trusted** – Decisions are not subject to multiple levels of oversight, generally staff decisions are accepted as made, unless there is a good reason for them to be reviewed and changed. • **Leaders enable effective work** – The leadership culture and approach of the agency promotes staff to make decisions effectively, and to feel confident

Good Practice principle	Explanation	Features establishing the principle has been met
		that they will be supported if their decisions are challenged.
People with a stake in the process are kept informed.	Regulatory decisions can have a significant decision on a range of stakeholders. Within an organisation, they can affect resourcing decisions and subsequent regulatory decision-making. Outside an organisation, they can be confronting for complainants and their supporters, or raise issues or matters that other organisations or individuals must deal with. As such, any effective regulatory decision-making process must effectively engage with stakeholders, on a regular basis, where appropriate.	• **Feedback must be provided to internal sources of input for regulatory decisions** – The decision-making team must work to ensure the Contact Centre, intake staff and other 'data collection and collation' functions have feedback on the regulatory decisions that are made. This should be done with a view to ensuring that information is better captured and summarised with each iteration of the process. • **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. • **Other agencies or organisations who may be affected by the decision or who need to know about the circumstances resulting in the decision should be engaged** – Outreach to other third parties who need information relating to the decision should occur as early as possible.

7 SafeWork NSW has an established decision-making process.

SafeWork NSW has an established an investigation decision-making process that broadly aligns with good practice. The process describes the role of an IDMP as well as the roles of different SafeWork NSW staff in supporting the IDMP.

This process is well documented with risk-based principles, guiding factors, and templates to enable consistent decision-making. The documents set out regular internal reviews and audits of decisions during the IDMP process to enable continuous improvement. The process also broadly aligns to legislative and policy requirements. There is an opportunity for documentation to be simplified to ensure the decision-making is clearly articulated and understood by staff.

7.1 SafeWork NSW has detailed decision-making processes and procedures which are aligned to good practice.

The IDMP process provides clear guidance for how the IDMP, and other staff that support the IDMP, should work. This aligns to good practice as it establishes a clear, tailored, framework for decision-making. The core IDMP process is well documented and supported by clear templates and guidance material. This guidance encourages appropriate regulatory decision outlining clear criteria and factors for consideration.

Guidance and templates are structured to support evidence-based decision-making and application of risk-based principles. However, these materials could be edited to be more accessible, or supported with higher level reference materials.

The core IDMP process is well documented and aligned to good practice.

The core IDMP process is outlined in a suite of key documents, all of which are made available to SafeWork NSW staff. A clear outline of the IDMP process is set out in the Investigation Decision Making Framework (IDMF). The IDMF outlines the guiding principles, and establishes the steps, that staff should follow to enable appropriate decision-making. It provides guidance to IDMP members on how they should consider evidence and make decisions. It also includes detailed guidance on how other staff at SafeWork NSW should brief and support the IDMP.

A range of other materials support the IDMF and provide supplemental guidance to staff:

- The IDMP Terms of Reference (ToR) provides further guidance on how the IDMP should make decisions. It sets out the requirements for the IDMP, including the role and makeup of panel members. It also specifies what the IDMP must consider as part of their deliberations in the decision-making process.
- The IDMP Submission template is a structured form outlining what information should be featured for IDMP members to inform their decisions. All cases brought to the panel must be submitted using the provided template and reference the guiding principles outlined in the IDMF[47] to inform their recommendation stated in the submission.
- Directorate specific SIRP templates outline the procedure directorates should follow in determining which matters go to IDMP. Templates provide clear guidance that enables staff to closely follow the process as they structure submissions and signpost the requirements of the process.

Together, these key documents outline a suite of guidance materials on regulatory decision-making that effectively and accurately guide the work of SafeWork NSW staff. They establish that staff should make

[47] SafeWork NSW, Investigation Decision Making Framework, 2022, pg. 6-7: 'Factors guiding investigation decision making'.

decisions in line with a clear purpose[48]. They also ensure that staff are directed to make decisions which are proportionate, risk-based, consistent, transparent and accountable. These materials support good regulatory governance by ensuring that there is a clear structure for the IDMP process and for decision-making. Finally, these materials encourage intelligence led decision-making, with a balanced consideration of factors relating to the individual matter at hand and the strategic direction of SafeWork NSW. Each of these elements represents a core part of good regulatory decision-making practice.

Available guidance encourages appropriate regulatory decision-making.

SafeWork NSW has established appropriate guidance for regulatory decision-making as part of the IDMP process. The IDMF outlines key factors for investigation decision-making. These factors are also reflected in the templates and supporting materials to encourage and enable appropriate regulatory decision-making by the IDMP.

The decision-making factors[49] outlined for use by the IDMP include:

- **Jurisdiction** – this factor refers to the scope of SafeWork NSW's work by ensuring that decisions are deliberated within the appropriate jurisdiction. This aligns to best practice by ensuring regulatory decision-making is within SafeWork NSW's powers.
- **Priority Areas** – nine areas have been identified to provide guidance on how areas of investigation should be prioritised consistently, in alignment with the NCEP and SafeWork NSW Prosecution Guidelines (see Appendix G). These priority areas are applied throughout the decision-making process as they are reflected in the SIRP guidance and IDMP Submission Template.
- **Guiding Principles** – there are 14 guiding factors that allow staff to apply appropriate risk-based responses, by establishing standards to clearly identify which matters should be investigated. These also appear in conjunction with the priority areas in the SIRP generic process template and the IDMP Submission template (see Appendix G).

Together these factors align to best practice as they enable decision-making at SafeWork NSW to be made within powers and in line with clear processes. The consideration of jurisdiction in decision-making ensures that limited resources are being effectively utilised to address matters that are within the scope of SafeWork NSW's regulatory requirements and support SafeWork NSW's regulatory functions. Alignment of priority areas and guiding principles to other guidelines supports consistent decision-making against a shared set of standards. Regulatory objectives are clearly articulated through the factors expressed in the IDMF. These objectives are further embedded within the process through guiding documentation. This supports their consistent adoption across different decision-making processes in practice.

Decision-making under the IDMP process is evidence based and applies risk-based principles for determining outcomes.

The IDMP process, and supporting materials, encourage staff to work in a consistent and risk-based manner. SafeWork NSW has created templates to guide staff through each stage of the decision-making process, directing how decisions should be prioritised against criteria.

The SafeWork NSW decision-making process uses risk-based principles to prioritise matters and apply proportionate responses. In investigation decision-making, risk is considered in the categorisation of matters against the Priority Areas and Guiding Factors impacting decision-making. Risk-based decision-making means that matters of the greatest severity or potential risk can be prioritised to proportionately allocate the limited resources of SafeWork NSW.

Evidence and risk-based principles are embedded into documentation outlining and supporting the primary IDMP process. Supporting documents available provides accurate guidance on the evidence required and how risk-based principles should be applied for submissions to the IDMP. For example:

[48] SafeWork NSW, Investigation Decision Making Framework, 2022, pg. 1: 'Purpose'.
[49] SafeWork NSW, Investigation Decision Making Framework, 2022, pg. 6-7: 'Factors guiding investigation decision making'.

- Pre-IDMP, when determining whether a serious incident should be escalated for further investigation, the generic SIRP template considers the factors of Target Areas and Guiding Principles.
- The IDMP Submission Templates require key reasons for a recommendation to be evidenced, with specific reference to priority focus areas and decision-making factors for SafeWork NSW.
- The IDMP Meeting Agenda and Minutes are structured to make specific reference to and record 'Factors considered' when an outcome is deliberated.

The consideration of the factors guiding decision-making is consistently embedded throughout the IDMP process, as evidenced above. This aligns with best practice as the risk of harm is clearly a key consideration in making regulatory decisions. Clear documentation and closely followed processes enable staff to consistently apply these principles.

The SIRP is documented but has some level of inconsistency.

Documentation available to staff embeds appropriate risk-based practice at an IDMP level, however guidance across directorates at the SIRP level could be clearer. The SIRP serves two primary purposes in SafeWork NSW's decision-making process. It is an exercise of SafeWork NSW's regulatory toolkit, and it is also a key input into the IDMP. Directorate-specific documentation of the SIRP can lead to inconsistencies in decision-making outcomes. This limitation has been acknowledged in the IDMF, in a previous review[50] of the process and through engagement with directors.

Directorate-specific documentation of the SIRP undermines SafeWork NSW's ability for consistent decision-making. It is currently geared towards being an input for the IDMP as each directorate conducts their SIRP in alignment to the IDMF's principles and guiding factors. However, this serves only one of its core purposes and can lead to inconsistencies for lower-level decision-making. For matters that don't meet the criteria for escalation to the IDMP, there is no consistent way to determine how other compliance and enforcement mechanisms will be used by SafeWork NSW.

Documents reviewed by Nous have identified the risk of inconsistency:

- **The IDMF**[51] – makes explicit reference to the difference in potential outcomes reached, by stating: "given there may be different directorate-specific priorities, there is potential for differing opinions about whether investigation is to be recommended."
- **2022 Internal Review of the IDMP**[52] – recommends the consideration and implementation of a "single, consistent best-practice approach to decisions as to whether matters should progress to the IDMP." It also identifies the importance of establishing clear criteria to enable consistency in lower-level decision-making.

SafeWork NSW staff have also provided insights as to areas where this could be improved.

- **Inconsistency across lower-level decision-making** – directors expressed concern that the current decision-making process isn't sufficiently guiding decision-making on lower-levels when deliberating on the use of compliance and enforcement actions. It was said that more guidance was needed for determining when one enforcement (e.g., penalty notice) would be issued over another (e.g., prohibition notice). The absence of guiding factors or priority areas to guide staff in making these decisions was also noted.
- **Establishing universal committees to address decisions below the IDMP level** – not all matters require escalation to the IDMP level. Other agencies have adopted universal 'enforcement' committees

[50] SafeWork NSW, Review of SafeWork NSW Investigations Decision Making Panel, 2022.
[51] SafeWork NSW, Investigation Decision Making Framework, 2022, pg. 12.
[52] SafeWork NSW, Review of SafeWork NSW Investigations Decision Making Panel, 2022, pg. 31: Recommendation 15: "Conduct a review of the Serious Incident Review Processes (SIRPs) or equivalents in place across CDR directorates with a view to putting in place a single, consistent best-practice approach to decisions as to whether matters should progress to the IDMP. The criteria applied and the decision-making mechanism should be consistent across directorates, though it may still be appropriate for the process to vary in minor respects such as frequency of meetings for directorates with a lower volume of matters. The review should consider the criteria that are applied at SIRP's, and by managers and/or inspectors when making a decision as to whether to submit a matter to the SIRP."

to address decisions that require lower-level compliance and enforcement activities. A SafeWork NSW director indicated that has already been implemented in the Constructions directorate, where Regional and Metro are conducting SIRPs as one body. It was also noted that analysis would be useful in determining whether adopting a universal approach to SIRP across different directorates would be successful in light of their differing areas.

At present, matters that don't meet the criteria for pursuing with a view to prosecution are at risk of inconsistencies. This is because lower-level decision-making lacks clearly established criteria to guide decision-making at the directorate level. If adopted by SafeWork NSW, a universally applied approach could more directly align to the structure of the IDMP as a governing body in decision-making that has broadly been accepted as effective and consistent.

Documentation refers to continuous improvement for stages of the decision-making process.

The IDMP process documents support consistent decision-making and appropriate process improvement for specific stages of the process. However, a process to ensure individual decisions and quality assurance of those decisions is lacking. To align with best practice SafeWork NSW should establish clearer measures to evaluate improvements for decision-making itself, in addition to current reflections on the process.

Supporting documents promote the continuous improvement of stages of the IDMP process. SafeWork NSW has established mechanisms to ensure continuous improvement for the decision-making process which are embedded in supporting documentation. This is seen in:

- **IDMP guidance documents support ongoing iteration of the decision-making process –** The IDMP ToR[53] set an expectation that panel members will rotate their role in alignment with the IDMF. This contributes to effective and efficient processes that seek continuous improvement by consistently inviting new perspectives to the decision-making process.
- **On a directorate level, yearly audits are conducted to establish a feedback loop –** An internal audit of reports through Panel Logs and Directorate Logs are collated at the end of each calendar year. A feedback loop is then established when the Directorate Logs are sent to the Safety Management Audit Team for review. This process is recorded in guidance documents[54]. It seeks to generate insights that inform future decision-making and promote the consistent review and improvement of the decision-making process.
- **Consistent improvement opportunities are reflected in the cyclical reviews of core documentation** – The IDMF, IDMP ToR and SafeWork NSW Prosecution Guidelines all set out that regular reviews will be conducted at specified intervals, if not requested earlier. Recording this as a consistent practice in the IDMP documents instils a level of accountability to the process which encourages consistent reflection on opportunities to improve the effectiveness of decision-making at SafeWork, and its alignment to regulatory requirements in light of emerging strategic priorities.

However, the extent of guidance is limited to specific procedures within IDMP and not of decisions itself. The IDMF requires an annual audit of SIRP decisions. Senior SafeWork NSW leaders have also referred to spot checks for file handovers post IDMP decisions. However, as will be further examined in Section 8.1.4, there is little in the way of quality assurance for the IDMP process in its entirety to assess the efficiency, effectiveness, and appropriateness of the processes and inputs into decisions.

Good practice requires clear measures against which organisations can evaluate their processes to drive continuous improvements. This is as it can establish a shared understanding of measures against which SafeWork NSW can evaluate its IDMP process to drive continuous improvement end-to-through spotting gaps and design solutions. In the absence of overarching and clear guidance of the IDMP process, it is difficult for SafeWork NSW to conduct quality assurance to assess consistency in decision-making.

[53] SafeWork NSW, IDMP Terms of Reference, 2022, pg. 2: "SafeWork NSW Directors will convene the Panel on a rotating basis for a period of 2 years, coinciding with the review schedule for the IDMF."
[54] SafeWork NSW, SIRP Generic Process Template, 2023, pg. 5; SafeWork NSW, Investigation Decision Making Framework, 2022, pg. 10.

7.2 The IDMP process aligns with relevant legislation and government policy.

The IDMP process, and the materials that document it, align with the standards and direction set by relevant legislation and government policy. The process supports SafeWork NSW in meeting relevant aspects of the WHS Act as the primary governing legislation. It also supports the agency in meeting the policy directions and standards set for it.

Alignment to the WHS Act is a key focus of the IDMP process.

Decisions about the exercise of SafeWork NSW's legislative powers sit at the heart of the IDMP process. The WHS Act provides SafeWork NSW with powers relating to the investigation of notifiable events. The IDMP process supports the organisation to do so. The IDMF is aligned to ensure that SafeWork NSW takes up investigations that help it to secure the health and safety of workers in NSW. The links between legislation and the IDMP process are set out at Table 10.

Table 10 | Application of the WHS Act to SafeWork NSW's decision-making process

Legislative requirements	Corresponding element of SafeWork's IDMP process
SafeWork NSW must administer and exercise its functions to secure the health and safety of workers and workplaces (ss 3 and 152 WHS Act)	The IDMP process enables SafeWork NSW to implement compliance and enforcement measures to ensure duty holders meet their requirements under the WHS Act. This is through issuing notices within the SIRP and decisions to investigate matters further with a view to prosecute within IDMP. The IDMP also enables SafeWork NSW to prioritise the most matters to have the maximum impact in protecting workers against harm and minimising risk, per s 3 of the WHS Act. This is through: • Automatically accepting priority areas 1 and 2 for 'full investigation' based on their level of seriousness. • Enabling directorates to take enforcement decisions for less serious and non-priority matters through SIRP. • Requiring IDMP to consider its decision for 'full investigation' by reference to priority areas and guiding factors to target resources and efforts.
The WHS Act confers power on SafeWork NSW's inspectors to obtain information and investigate events (ss 155, 160(e) and (f))	The preliminary investigation by inspectors (following the triage decision to allocate matters to inspector response) informs the IDMP process and the ability to make intelligence-led decisions. Inspectors exercise their powers to investigate notifiable events. Their initial exercise of powers is directed by the triage process (as described in Section 1 above). Subsequent exercises of their powers to conduct a preliminary investigation are governed by the IDMP process. Decisions regarding whether this exercise of powers should occur are made in line with s 155 of the WHS Act, that is, whether SafeWork NSW has reasonable grounds to believe that a person is capable of giving evidence or providing relevant documents.
The WHS Act s160(d) and Part 10 empowers inspectors to take enforcement measures through issuing notices.	CDR directorates may decide to take enforcement action as part of the SIRP. As a result, less serious and non-priority matters are addressed by SafeWork NSW through improvement, non-disturbance, prohibition, and penalty notices in accordance with Part 10 of the WHS Act. This enables the IDMP to focus its efforts on the most harmful and risky notifiable events.
The WHS Act confers on SafeWork NSW the power to	The IDMP process enables SafeWork NSW to bring legal proceedings through referring matters for investigation with a view to prosecute. This is through:

Legislative requirements	Corresponding element of SafeWork's IDMP process
bring legal proceedings for an offence under the Act (s 230).	• Automatic acceptance for full investigation with a view to prosecute. • Recommendation by the IDMP for full investigation with a view to prosecute. • Review of the available evidence for psychological matters to determine the merits of a full investigation with a view to prosecute. Matters that are undergo a 'full investigation' by IER may be referred to DCS Legal to begin legal proceedings.

The IDMP process embeds national work health and safety policy standards.

As established in Section 3.2, SafeWork NSW closely align their processes to the requirements of the National Enforcement and Compliance Policy (NCEP) established by SafeWork Australia. The IDMP process guides decision makers to focus on the priority areas for investigation outlined in the NCEP. The IDMP process also incorporates the key factors the NCEP outlines for investigation decision-making. This aligns to best practice as there is strong alignment to policy settings and standards through the adoption of these factors into the IDMF.

The NCEP outlines six priority areas[55] that should be the focus of investigations. These include fatalities or serious injuries, ongoing non-compliance and a failure to notify regulators of incidents. The eight Target Areas outlined in the SIRP[56] procedure document closely adhere to the priority areas outlined in the NCEP. This means these factors inform the inputs to the IDMP from an early stage. There is also significant alignment between the NCEP priority areas and the nine Priority Areas for decision-making outlined in the IDMF. The IDMP priority areas include the addition of a strategic perspective (number nine, as seen in Appendix G). This inclusion nods to a basic consideration of strategic factors laid out in broader policy standards.

The NCEP also outlines seven factors[57] that should be considered in making investigation decisions. These include the severity and scale of harm, risk factors for the duty holder and the wider strategic relevance of the event under consideration. The generic SIRP procedure outlines 11 guiding principles[58] as factors guiding the decision to investigate. The IDMP process has embedded the NCEP's factors into decision-making criteria established within the IDMF. Specifically, the IDMF outlines 14 factors to guide the decision to investigate priority areas[59], which again closely align to the seven factors outlined in NCEP. The IDMF has a larger set of guiding factors than the NCEP due to the addition of considerations that are in direct alignment with the IDMP's purpose, legislative objectives and specified factors that may impact further investigations with a view to prosecution.

The IDMP process could focus more expressly on delivering SafeWork NSW's regulatory priorities.

SafeWork NSW's own strategic direction as a regulator is not sufficiently embedded in the IDMP process. This does not align to best practice as the deliberations and decisions of the IDMP are not adequately drawing on strategic considerations to inform their decisions.

To be a good practice regulator – and to align with the National Framework (as referenced in Section 3.2) – SafeWork NSW must investigate in line with its strategic enforcement priorities. Features of good practice state this should be reflected in the decision-making process and accompanying documentation.

[55] SafeWork Australia, National Compliance and Enforcement Policy, 2020, pg. 5: Section 5 Monitoring and compliance – 'Priority areas for investigation'.
[56] SafeWork NSW, SIRP Generic Process Template, 2023, pg. 9: Appendix C – 'Factors for guiding decision making.'
[57] SafeWork Australia, National Compliance and Enforcement Policy, 2020, pg. 4-5: Section 5 Monitoring and compliance – 'Factors determining which matters to investigate'.
[58] SafeWork NSW, SIRP Generic Process Template, 2023, pg. 9: Appendix C – 'Factors for guiding decision making.'
[59] SafeWork NSW, Investigation Decision Making Framework, 2022, pg. 7: Factor 3 – 'Guiding Principles'.

SafeWork NSW sets these priorities on an annual basis. However, the process does not adequately ensure that they are a focus of the deliberations and decisions of the IDMP.

SafeWork NSW most recently refreshed its strategic priorities in 2023 (as outlined in Appendix E). The IDMF indicates, at Priority Area 9, that the IDMP should have regard to 'new priorities' in making regulatory decisions (see Appendix G for the full list of Priority Areas). 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.

7.3 IDMP process documentation could be tailored to be more accessible to staff.

The documentation supporting the IDMP process is comprehensive but not user friendly. When read together, the documents contain the information staff require to make good decisions. However, the materials are dense and difficult to digest, other than for experienced staff within CDR. Quality assurance becomes difficult in the absence of an overarching document to outline core process in a central source. Simplifying these materials, or providing summary documents, would support better decision-making.

When read together, the suite of documents available to support the IDMP process comprehensively describe how decisions should be made. However, the existence of multiple guidelines and processes across the IDMP process means that inspectors and other staff within CDR need to consult multiple documents to understand it in sufficient detail. This may influence the ability for consistent decision-making and alignment to best practice.

Good practice suggests that the materials supporting regulatory processes should be formatted for ease of understanding. This is because they need to be relied on by staff – including new starters – to shape their understanding of how regulatory processes should function.

Clear materials are also a requirement for consistent and effective processes. Regardless of their experience level, staff will often need to have reference to guidance material to confirm their understanding of key aspects of, or standards within, a decision-making process. Similarly, the evaluation of compliance with a process requires that process to be clearly defined and easily amenable to external scrutiny – even by a non-expert. Clear guidance documents are a key aspect of the 'reference' materials required for both confirming understanding and assuring compliance.

Documentation is not formatted for ease of understanding.

There is no single document that succinctly outlines the end-to-end process. Instead, each stage of the IDMP process is governed by different sets of guidelines, frameworks, processes and procedures that frequently cross-reference each other. These documents must be considered together to understand the end-to-end IDMP process in sufficient detail. As a result, staff are required to consult a range of resources to understand the IDMP process.

Materials are not formatted in a way that enables staff to quickly understand IDMP practice and the IDMP process. New starters at SafeWork, or staff members seeking to refresh their understanding of the IDMP process, do not have accessible, comprehensive, reference materials. For a staff member to understand the IDMP process, they must conduct a detailed review of at least four technical, text heavy, documents.[60] These include the IDM Policy (Framework doc), Close the Loop (CTL) Procedures, WSMS Extraction Process and the Serious Incident Review Form (SIRF).

[60] The four core documents to understand IDMP are: Investigation Decision Making Framework, IDMP Submission Template, IDMP Terms of Reference, SafeWork NSW Prosecution Guidelines. In addition, the core documents to understand SIRP are: the SIRP Generic Process Template, and the directorate-specific templates created.

The difficulty experienced by staff in understanding and applying IDMP process guidance is supported in feedback provided by SafeWork NSW staff. Directors highlight that the nature of the materials available means that tenure within SafeWork NSW and participation in the IDMP process is the most effective way for staff to understand the IDMP process and system. Training and document review are not seen by current inspectors as an effective way for new starters to build an understanding of the IDMP process. The existing materials are also not viewed as an efficient or effective way for existing staff to confirm or refresh their understanding of the IDMP process.

Improvement opportunity 5: Documentation supporting the IDMP process should be simplified.

Documentation supporting the 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 on any level, in particular new starters, to easily follow through the decision-making.
- **SafeWork NSW should incorporate more appropriate formats, such as process maps as visual aids.** To counter the weight of textually verbose 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[61].

[61] SafeWork NSW, Review of SafeWork NSW Investigations Decision Making Panel, 2022, pg. 31: Recommendation 13 – "Clarify how the IDMP fits in with other processes and policies across SafeWork NSW, including developing a diagram or decision-tree that is available to all SafeWork NSW staff."

8 Decision-making activities broadly align with established processes and good practice.

SafeWork NSW's actual delivery of the IDMP process appears to align with good practice. Staff follow established processes and utilise the existing tools such as templates. However, more could be done to ensure that decision-making is strategic and aligned to overall regulatory priorities. Introducing greater emphasis on a strategic focus in their decision-making process will enable SafeWork NSW to better meet good practice according to the framework in Table 9.

Good practice suggests that decision-making should involve:

- Regulatory decisions are made in line with clear processes – Decisions within IDMP should be made by reference to a clearly articulated objective that is understood by all those involved in the process. Documentation in support of this should be consistent across directorates and easy to apply.
- Regulatory decisions are made in a consistent way – SafeWork NSW should draw on the agreed and right sources of information and insights. Decisions should be made according to an established framework in which risk-based principles are embedded.
- Regulatory decisions are sufficiently strategic in focus – Decisions should be made by reference to individual circumstances of a matter and broader strategic objectives. In doing so, system level impacts should be considered.
- Regulatory decision-making is efficient and effective – Decisions should be aligned to established processes such that the process of decision-making is efficient. Regular process reviews ensure that the tools that enable decision-making are continuously improved.

8.1 Delivery of the IDMP process closely aligns to established processes and approaches.

The delivery of the IDMP process in practice closely aligns to established processes and approaches. Staff involved in the process highlight that they follow relevant guidance material closely. Staff also confirm using established briefing and decision-making templates. A review of process materials and outputs suggests that staff are correct in indicating that the documented IDMP process is followed.

8.1.1 Staff indicate that the documented IDMP process is followed closely in practice.

SafeWork NSW leaders and staff consulted all indicated that the IDMP process is closely followed. Staff demonstrated a clear understanding of the importance of closely following processes in practice. This reflects good practice as these insights are indications that the established IDMP process is consistently followed and implemented in practice. Staff are adopting the intelligence-led and risk-based approach that is laid out in the IDMF.

Numerous SafeWork NSW staff reported that the documented IDMP process is strictly adhered to in practice. Nous consulted with four IDMP panel members, the IDMP secretariat, select inspectors and staff members who have observed the process. Statements made by each of these participants about the nature of the process followed were consistent with one another, despite being interviewed separately. Inspectors agreed that the process is generally followed, noting the significant improvement from previous decision-making processes. The current IDMP process was noted to be more transparent and based on a consistent set of factors in practice, which contribute to producing appropriate outcomes.

SafeWork NSW directors and inspectors engaged understood the importance of following the process closely. In consultations with staff supporting the IDMP process, each highlighted an understanding that the IDMP process reflected legislative and other requirements that were important to follow. They recognised that a failure to follow the process could undermine SafeWork NSW's ability to meet its legislative and regulatory responsibilities.

8.1.2 Staff indicate that generally the correct inputs are being used to make decisions.

Staff within CDR and the IDMP have agreed that the correct inputs are being used to make decisions but have concerns for the lack of strategic and legal perspectives. Consultations with inspectors indicated that process templates and guiding documents were key tools in preparing submissions for the IDMP and the broader decision-making process. Staff contributing to the IDMP process reflected, however, that there is less weight on strategic considerations in the decision-making process. The absence of legal perspectives noted through stakeholder engagements may impact the effectiveness of decision-making.

SafeWork NSW staff involved in supporting the IDMP process identified the use of established templates and tools as a key way of ensuring the process was followed. Secretariat and manager grade staff highlighted that the briefing templates and decision-making frameworks were always used to brief and support the Panel and its deliberations. IDMP Panel members reported being briefed in a consistent way, using the established tools and frameworks.

Inspectors reflected that their submissions provide the IDMP with the right inputs to make decisions. Current processes are primarily governed by the IDMP guiding principles and factors. These are consistent across all directorates to guide the quality of submissions recommended from the SIRP to IDMP. These are supported by forms that are clear and consistent between SIRP and IDMP to ensure consistency of decisions for investigations with a view to prosecute at all levels of the IDMP. However, it was noted that the current Submission Template did not encourage the inclusion of various formats of evidence which may help to substantiate a case. Deliberations on the panel may be more clearly informed through the addition of CCTV footage or other multimedia evidence that represents the circumstances of a matter. Written detail and images may not always serve to clearly communicate the rationale for a recommendation to the panel.

Inspectors have reflected that there is an opportunity for them to be more involved. Inspectors mentioned that technical input into decision-making on the IDMP is limited where matters are complex and specific, with a tendency to engage with cases that involve familiar circumstances. It was indicated that cases, similar to those previously pursued and in which Directors have strong expertise, can be favoured as they appear to have a clearly articulated precedent to guide how they will be handled. The shift in the role of inspectors and the subsequent reduction in their involvement of a matter means that there is opportunity for them to build and contribute their expertise in areas that the current panel members may be lacking.

Additional sources of insight, including strategic priorities and legal requirements, are not used as frequently as part of decision-making. This means that decisions are not made with all the right inputs. Senior SafeWork NSW staff expressed that there was a need for strategic or legal perspectives given the potential for legally enforceable outcomes that can shape the work health and safety landscape of NSW. A review of the sample IDMP meeting minutes showed, however, that there was limited and inconsistent consideration of strategic priorities or legal requirements as a key reason for its decisions. This is reflected in submissions to the Review with references to a "limited understanding of the WHS legislation" and discontent over the objective factors that guide IDMP decisions. The need for greater consideration of strategic priorities and legal requirements in decision-making are further explored in Sections 8.2.2 and 8.2.3 respectively.

8.1.3 A review of decision-making materials and outcomes highlights that established practices are followed and defined tools are used.

Nous reviewed a sample of IDMP decisions and meeting minutes. SafeWork NSW provided submission samples and IDMP meeting minutes and agendas from August and September 2023. The submissions were reviewed in alignment with the respective minutes to compare the content of submissions with the outcomes recorded.

From the review, Nous identified these conclusions:

- **Nous reviewed a sample of 18 submissions to the IDMP and found that the process was applied in practice.** The items listed in the IDMP minutes and agenda items documents show alignment with the process for deliberation as laid out in the IDMF. As Section 6.1 outlines, auto-acceptance bypasses IDMP, however the IDMF states that it should be verbally reported at the next IDMP meeting. This practice is reflected in the sample as multiple matters in which item eight note the verbal reports to the panel for the cases of auto-acceptance. A risk-based lens is shown to be applied to decision-making as fatality matters are separated from and discussed before non-fatality matters.
- **Submissions consistently referred back to the same decision-making principles and factors.** The content of all 18 submissions closely aligned to the requirements set out in the IDMF and other IDMP process documentation. Each submission clearly identified the Priority Area and Guiding Factors that are applicable to the matter. All submissions also included additional information to support decision-making in line with IDMF guidance. This was attached through labelled photographs and diagrams as well as detailed factual reports.
- **A review of Panel minutes relating to the discussion of submissions highlighted robust debate.** This discussion did not always result in the recommendation in the panel being followed. Of the 18 submissions considered, three resulted in an outcome at the IDMP that differed to the recommendation put forward to the Panel.
- **Panel minutes highlighted a degree of discussion relating to strategic or other factors broader than the individual submission.** Panel discussions made occasional references to the strategic circumstances of the case or compliance history of the PCBU. This broadly suggests that the right inputs are being used in the directorate SIRP to assess and determine matters appropriately in alignment with the framework that governs the decisions of the IDMP.

The IDMP process broadly aligns to good practice. Regulatory decisions are made consistently through the regular use of the IDMP submission template. It is intelligence-led as factual matters are clearly informing deliberations. Consideration of guiding principles and factors means decisions are made by reference to a set framework which fosters consistency in practice. It is risk-based as harm and emerging issues are considered to a limited extent.

However, the IDMP process needs further consideration of strategic priorities and legal factors. In practice, the IDMP does not expressly refer back to strategic priorities or legal factors when making decisions. This was deduced from their absence in the meeting agenda and minutes sample. This means that the process has room to closer align with best practice by encouraging individual decisions to be guided by reference to strategic goals and system level impacts considered. The inconsistent reference to strategic matters aligns with reflections from consultations with IDMP members, as explored in Section 8.2.2.

8.1.4 A formal quality assurance process for IDMP is required.

Quality assurance at SafeWork NSW is not formally embedded within decision-making practice. Best practice says that clear procedures allow organisations to improve processes by ensuring they can track what is happening, and that staff have something that can be easily cross-referenced. Oversight for decisions and the collection of data can inform this process. SafeWork NSW do not currently meet best practice, as it's been shown that they have limited oversight for IDMP decisions. To align more closely with

best practice, and improve the IDMP process, SafeWork NSW need to improve their oversight through the collection of data.

SafeWork NSW has limited oversight for IDMP decisions.

A review of the SafeWork NSW decision-making process has revealed that there is limited oversight for IDMP decisions. Reviews of supporting documentation and engagement with SafeWork NSW staff have indicated that IDMP decisions don't appear to be revisited after the panel have made their decision. A formal feedback loop to communicate with those who provided input to a matter's submission is lacking. Data isn't collected on current practice to review and ensure the quality of IDMP decisions.

IDMP decisions are not revisited. IDMP members have indicated that it is unclear to the IDMP about what happens once a case has been passed on to the investigation team. The IDMP doesn't always have a clear understanding of outcomes, which limits their ability to review and improve their process for deliberation, and further assess the quality of their decisions for future decision-making. Best practice principles highlight the importance of continuous improvement to promote efficient and effective decision-making. This is enabled by reflection upon previous decision-making processes and outcomes. Without a clear understanding of this, SafeWork NSW may find it difficult to improve and inform future decisions.

SafeWork NSW has not established a formal feedback loop to inform those who provided input to the decision-making process. There is an absence of a formal feedback loop in documentation such as the IDMF, the IDMP ToR and no mention of follow-up in the Submission Template. Inspectors reflected that there is some acknowledgement of decisions made, via email or by a brief conversation with a manager. However, this is highly discretionary on the available time and willingness of a manager. Inspectors have raised the lack of feedback as key area for improvement for the decision-making process, as it enables them to make more appropriate decisions that are in alignment with the requirements of the panel and the legislation in the future.

There is no data on current practice to review and ensure the quality of IDMP decisions. At present, quality assurance in practice requires cross-referencing and cross-checking multiple documents, with a director observing that "the water can get a little bit muddied." The dispersed nature of the documentation makes it difficult to measure and reflect on decision-making processes consistently. The use of data may aid SafeWork NSW in reviewing the quality of IDMP decisions by creating a central record against which decisions can be measured.

Oversight is required to improve the IDMP process.

Good practice requires clear measures against which organisations can evaluate their processes to drive continuous improvements. SafeWork NSW should address this by collecting data on decisions and their outcomes, to communicate back to staff along the decision-making process. This would support the continuous improvement of the IDMP process in response to the limited actionable insights produced by the current quality assurance process in place.

SafeWork NSW should collect data on decisions and their outcomes. This will allow inspectors and panel members to reflect on the deliberation process and the outcomes achieved, which may contribute to establishing a shared understanding of areas for improvement. Insights from stakeholder engagements have revealed that no further information is currently communicated on the direction of a matter once it has been determined that it will not progress with a view to prosecution. This may impede on the effectiveness of future decisions, and determining the appropriate response to matters after they have been dismissed by the panel.

The data must be analysed to develop insights that support continuous improvement. The purpose of collecting the data is to inform the effectiveness of future decision-making. Consultations with inspectors in CDR highlighted a gap in feedback on their submissions in the initial stages of the investigation. General sentiment suggested that there is an aversion to sharing feedback so as not to risk hurting anyone's feelings if their decision is overturned or for fear of opening a can of worms by discussing the matter further. However, inspectors have expressed a keenness to learn and receive feedback that may help inform their work to more appropriately respond to matters and prepare submissions that convey their case with adequate detail in the future.

Actionable insights are limited by the review process. Current practice at SafeWork NSW limits the detail captured by the review process, which means that it is difficult to convert them into actionable insights. Consultations with SafeWork NSW staff involved in the IDMP process highlighted the need to use technology and data capabilities to work smarter with the resources available, rather than utilising more to address the demand of matters to be addressed. Without these capabilities, insights with sufficient detail won't be generated to enable trend analysis that can be reported to staff. This impedes on the overall capacity for SafeWork NSW to improve the effectiveness of their decision-making processes in alignment with best practice.

Improvement opportunity 6: 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 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.

8.2 Delivery of the IDMP process could be more strategic in its focus.

The IDMP process could be improved through a greater focus on strategic factors in decision-making. Good practice suggests that in making any decision related to an investigation, regulators should have regard to both the individual circumstances of a matter, and the strategic factors that might be influenced by its work. However, the delivery of the IDMP process by SafeWork NSW does not have a sufficient focus on strategic issues. Concerns have also been raised in regard to deficiencies of legal expertise through the decision-making process. This has the potential to reduce the broader impact of decisions made by the IDMP.

8.2.1 The IDMP process has a role that extends beyond making determinations to investigate.

The IDMP process deals with individual matters, which have broader effects on workplace health and safety outcomes. Notifiable incidents are triaged before entering the IDMP process, and there are different outcomes depending on the circumstances. SafeWork NSW has limited resources to draw upon in addressing all matters that are in breach of WHS legislation.

The role of the IDMP and the supporting process is strategic in nature. The powers the IDMP exercises relate to decisions to investigate. However, the investigations it triggers are full investigations that consider all the drivers of a particular workplace risk or harm. Their effect is often wider than an individual decision to prosecute an employer, and the lessons learned as a result of these investigations can have a significant impact on state-wide workplace health and safety outcomes.

SafeWork NSW must strategically consider how best to use its regulatory toolkit to respond to all matters it receives. SafeWork NSW has a range of ways to investigate and respond to notifiable events that are brought to its attention. All notifiable incidents are considered by SafeWork NSW through its triage process. Many are subject to an initial investigation by an inspector. Following that initial investigation, many matters can be appropriately resolved through administrative action – including fines and notices. A full investigation may be required where other steps would be inadequate. This may be because the conduct giving rise to the notifiable event suggests a full investigation and potential prosecution is required. It may also be because the circumstances surrounding the notifiable event suggest broader trends or factors that should be the subject of SafeWork NSW's focus as a regulator.

To be effective, the IDMP process needs to balance the resources of SafeWork NSW against the requirement to support prosecution decision-making and broader regulatory action and deterrence.

8.2.2 Staff appear not to take a sufficiently strategic approach in practice.

The IDMP process does not sufficiently focus on strategic factors in making decisions. Materials and templates used to brief the IDMP do not include sufficient strategic materials. Guidance documents reference the need to consider strategic factors, without emphasising their importance. Senior level staff report that the strategic priorities of SafeWork NSW are not a core part of decision-making. Ensuring best practice regulatory decision-making will require these aspects of the IDMP process to evolve.

Good practice regulatory decision-making requires a focus on both the immediate circumstances and strategic considerations. A regulator should always work in a way that addresses both individual instances of harm and seeks to minimise harm across the whole space it regulates. This 'strategic' focus is also emphasised in the National Framework SafeWork NSW seeks to implement, as well as its own regulatory priorities.

Strategic factors are referenced inconsistently and only at a high level when preparing submissions.

As strategic priorities aren't embedded in the guiding documents, inspectors are not expressly encouraged to consider them when preparing submissions to the IDMP. Lack of express guidance and context within the process documents requires staff to rely on practice and experience to identify and consider strategic and regulatory priorities in decision-making.

There is limited consideration of strategic priorities when preparing submissions. A review of 18 submissions found that 'strategic priority areas' were generally left empty. While the priority areas and guiding factors are listed out per the IDMF, the "strategic priority areas" are empty cells to be filled out by staff drafting the submission.

This lack of consideration is reinforced by the IDMP submission template. The template has 'factors guiding decision-making' at the end, similar to an appendix, and does not provide context as to what are the latest strategic priorities. The template does not specifically include a list of the strategic priority areas, in contrast to the priority areas and guiding factors. There is no explanation in the template to refer specifically to the Regulatory Priorities 2023 to indicate to staff which is the most recent and relevant set of priorities for SafeWork NSW. The lack of express guidance and context within the process documents requires inspectors to rely on practice and experience in how to identify and detail strategic and regulatory priorities as a factor for decision-making.

CDR inspectors confirmed during consultation that there is an absence of considering strategic factors when preparing submissions. Insights from engagements of inspectors indicated inconsistent consideration of strategic priorities. Stakeholder insights identified a key challenge of IDMP decision-

making as being the balance of considerations between individual incidents and strategic priorities. Consideration of strategic priorities are a key area through which SafeWork NSW can be exercising their regulatory functions, and thus should have equal weight in their consideration. However, SafeWork NSW director engagement and a review of submissions to the Independent Review have indicated that this is not always the case.

Strategic priorities are not a driving factor behind decisions made by the IDMP.

Staff involved in the IDMP process note the lack of strategic focus in its work. This is because there is too much focus on the individual merits of a case. This was further evidenced in a review of IDMP meeting minutes, through senior SafeWork NSW staff reflections in consultations and also through anonymised submissions provided to the Review.

First, this is seen through a review of IDMP meeting minutes. Directors who sit on the Panel, as well as staff supporting the IDMP have highlighted concerns that their deliberations are too focused on the individual merits of cases, rather than on broader strategic decision-making. These reflections are supported in the review of the IDMP meeting minutes. They demonstrate an absence of strategic priorities in the notes or outcomes recorded in the minutes, which highlights that decisions are being made in relation to their individual circumstances rather than through considering the strategic benefit that may be realised through investigating it.

Secondly, this is seen through reflections of staff on the lack of support for psychosocial safety despite it being an ongoing priority for the regulator. Submissions to the Review have identified the de-prioritisation of psychosocial hazards when matters seen as life and death compete for an inspector's attention. Submissions have criticised handling of those matters, and failure to meet best practice in decision-making. They have further pointed out that the "two-tiered approach…has resulted in no prosecutions of issues relating to failure to manage psychosocial hazards". Other feedback from staff noted sentiment that psychosocial hazards are put forward without sufficient regard for proportionality or public interest, which again indicates failure to align with best practice principles of consistently applying a strategic lens to the decision-making process.

Thirdly, this is seen through dissatisfaction of IDMP submissions amongst staff. Submissions to the Review criticised the IDMP for making decisions in line with their own 'vested interests'. There were also concerns that media attention or pressure from high profile matters were averting the focus of decision-makers on the panel from their guiding principles and strategic objectives. Further engagement with inspectors expressed sentiment that the IDMP was only viewed as a tool to prosecute, without broader strategic considerations to more deeply understand potential lessons learned and opportunities for prevention programs. Criticisms viewed the overriding factor to be whether or not a matter will be successful in prosecution rather than other important factors. Despite this dissatisfaction, Nous has drawn the conclusion that these beliefs have been formed as a result of poor communication by the IDMP members to staff on how strategic factors play a role in decision-making.

Best practice suggests that involving more strategic considerations would allow SafeWork NSW to have the greatest regulatory effect. SafeWork NSW could use the scarce resources of the investigations team to effectively uncover insights into the drivers of emerging and potential risk to worker health and safety. Furthermore, strategic focus as a key driver in decision-making should be clearly articulated to all staff throughout the decision-making process.

Improvement opportunity 7: 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 SIRP when considering other compliance and 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 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.

8.2.3 Staff and the IDMP appear to lack legal expertise as part of the IDMP process.

Submissions to the IDMP require consideration of legal requirements to support effective decision-making. A review of SafeWork NSW documents have shown that legal requirements are considered to a small extent. However, consultations with inspectors and representatives on the IDMP have said that there is an absence in understanding the quality of evidence required to inform decision-making. Stakeholder engagements also allude to a lack of legal perspective within the IDMP.

The IDMP requires some acknowledgement of legal requirements to effectively support the outcome of investigations with a view to prosecute. SafeWork NSW's IDMP process is a precursor to potential legal enforcement via prosecution. Evidence gathered in file handovers from inspectors in response to notified events directly feed into investigations that form an evidence brief to submit to the IDMP. The content of these submissions forms the basis upon which the IDMP deliberate decisions which have the potential to lead to prosecution.

A review of sample SafeWork NSW IDMP submission documents show that there is some regard for legal requirements. Of the 18 sample Submissions considered, 15 referred to the availability of reliable evidence as a guiding factor, and two draw reference to culpability as a contributing factor. Stakeholder sentiment has noted that a legal perspective is required on the Panel to understand what can be prosecuted in court. This reflects an understanding of the role of evidence in supporting recommendations to continue investigations with a view to prosecute.

However, inspectors have said that the current process does not do enough to consider the quality of evidence. Inspectors have noted an absence of legal expertise in the preparation of submissions to the panel and that there is little understanding of what sufficiently constitutes 'good evidence'. It was suggested that this is due to a gap in the understanding of the requirements to prepare an evidence brief to take legal action. One explanation 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. As inspectors are no longer required to prepare the full brief of evidence up until the stage of prosecution themselves, their understanding of the inputs for decision-making has become limited to the guidance provided by the supporting documentation and feedback from colleagues. This creates challenges through an inconsistent understanding of the requirements for submissions to the IDMP that will allow matters to be appropriately and sufficiently deliberated.

SafeWork NSW directors say legal perspective within the IDMP is also required. Stakeholder engagements referred to the need to bring a clear legal perspective into the decision-making process, in balance with the other two lenses – strategic and operational. Each lens should be applied to all matters passing through the decision-making process. Current sentiment suggests that the supporting documentation and

feedback loops in place are not sufficiently equipping inspectors with the skills to adequately brief the panel in light of its legislative purpose. Without a full understanding of the legal context and weight, members of the panel may not always be able to adequately deliberate on a matter. Absence of legal expertise raises concerns for the inputs of the IDMP and its ability to deliberate on the outcomes for a matter with a view on whether legal action should be taken.

Note: SafeWork NSW has stated that they would welcome a representative, such as the Director of SafeWork NSW Legal as a member of the IDMP.

9 Improved training and internal communications could support better IDMP performance.

Good practice for decision-making requires that staff are appropriately equipped and supported, as well as processes to be fair, transparent and subject to oversight. Staff require training complemented by on-the-job learning to ensure they are undertaking appropriate ways of working at the right capabilities. Transparent, fair, and accountable processes are enabled by strengthening the quality of communication and feedback with internal stakeholders. In doing so, the IDMP process and SafeWork NSW staff within it are able to flexibly and continuously improve to deliver robust decisions.

9.1 Training could improve for staff supporting the IDMP process.

Decision-making practice and the IDMP process could be improved through a formalised training program. Good practice suggests staff should be supported to effectively apply decision-making approaches through training. However, senior leaders and staff involved in the IDMP process largely 'learn on the job'. A lack of formal training may result in nuanced elements of the IDMP process and the documents that support it not being applied as effectively as possible.

Good practice requires that staff involved in decision-making processes must be sufficiently equipped and enabled to work effectively. This generally requires staff to be trained and guided to work on new processes. It also requires refresher training to be offered to support ongoing learning and development.

On the job learning is generally sufficient but creates some challenges.

At present, staff involved with the IDMP process are not provided with formal training or development. Staff are generally developed through 'on the job' learning, with colleagues coaching them to understand key elements of practice. This is primarily through observation of IDMP by new managers and inspectors during their New Inspector Training Program. Staff are also referred to current versions of process documentation to support their personal learning and development.

Inspectors highlight the value of the support they receive from peers. However, they also report concerns about the consistency in the level of support that peers can provide. All staff engaged highlighted that they felt comfortable with the level of informal training and support that they had been provided with, noting that it has supported them to work effectively as part of the IDMP or to support the IDMP process. However, they also indicated that this support had been appropriate for them as they had a long lead time to be trained by peers, and that there was very low turnover in IDMP related roles. They did not see current arrangements as appropriate for all new starters, or for times of high turnover.

Consultations with representatives on the IDMP highlighted a specific challenge in terms of the development of managers. The IDMP process relies on input from investigations managers to support the preparation of briefing materials. No formal IDMP process training is currently available for staff as they are promoted to, or hired as, managers. This means that they rely on informal mechanisms to learn. Historically, this has included observing IDMP sessions, and being supported by existing managers and experienced inspectors.

Reliance on experience in practice rather than clearly articulated documentation means that each new staff member will be receiving varying levels of training. The lack of a clear structure or measure against which inspectors are trained means each new member has a different experience and hence gains a different level of skill. This doesn't align to best practice as it will lead to inconsistencies in approaching decision-making, based on the level of expertise that the new inspector has gained through their on-the-job experience.

SafeWork NSW staff have observed that it is issues with the capability and knowledge of managers that can delay IDMP decisions on particular matters. This was highlighted in stakeholder interviews with inspectors. One such example reflected on how it was difficult to get a submission right the first few times as there is little meaningful training or guidance. While some level of informal learning and training works, this is less relied up on with new flexible work arrangements. This puts new starters at a disadvantage and a greater burden on managers to review and provide guidance.

Informal training arrangements do not sufficiently embed a strategic decision-making focus.

Currently, only on-the-job and informal training arrangements are in place to guide staff in applying a strategic lens to the IDMP process. This, however, relies on experience and collaboration across staff during the SIRP process as well as within the IDMP itself. This perpetuates the existing lack of strategic focus amongst staff and does not align to good practice principles for regulatory decision-making.

Staff within the IDMP process do not receive formal training that is specific to strategic decision-making. Informal training measures within the IDMP means that staff rely on peers to explain the process and review of decisions in relation to strategic priorities through on-the-job learning. This is seen through the sample of IDMP Submissions in which 90 percent do not refer to specific strategic priorities in the provided section and the remaining 10 percent do so inconsistently. Consultations CDR Directors who participate on the IDMP have identified that there are inconsistencies during the SIRP when deciding when to implement the different types of notices. Centralised guidance for SIRP is primarily geared towards determining which matters are recommended for IDMP. There is little in the way of strategic guidance for when to issue notices including warnings, prohibitions and penalties in a consistent way across all directorates. As a result of relying on informal training and on-the-job experience, the absence of strategic considerations is perpetuated throughout the IDMP process.

Managers attending the Panel as a delegate of a director may not be appropriately equipped to participate on the Panel. While managers can currently act on the Panel as a delegate of a director per the Terms of Reference,[62] consultations with IDMP representatives have indicated that managers lack the right combination of strategic, operational, and legislative lenses. Directors reported that when managers were acting on the Panel, there was a risk that they are less inclined to question the view of other senior staff and therefore are limited in their contribution. Managers are also close to matters as they may guide inspectors through IDMP submissions. SafeWork NSW staff therefore perceive that managers may become invested in seeing their matter pass through to full investigation without a full appreciation of the strategic approach. This can work to undermine the confidence in acting managers across other Panel members.

In the absence of training and continuation of the existing practice, the IDMP will be limited in its ability to align to good practice. Good practice requires regulatory decisions to have a sufficiently strategic focus.

While a strategic lens may be acquired on-the-job, less experienced staff may struggle to consider this perspective. Training can encourage staff to incorporate these insights when matters are first handled. This would serve to introduce strategic objectives into earlier stages of the decision-making process and allow this approach to be applied more consistently. This would align SafeWork NSW more closely with best practice, as it would be more likely that matters are deliberated with sufficient weight on strategic insights.

Improvement opportunity 8: 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 process as well as managers acting on the Panel to contribute productively to IDMP discussions. Training will embed

[62] SafeWork NSW, IDMP Terms of Reference, 2022, pg. 3.

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:

- 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.

9.2 Internal communication with staff involved in the IDMP process is not well-established.

Improvements in internal communications related to the IDMP process will drive greater support for its decisions. Good regulatory practice suggests that stakeholders affected by a regulatory decision or process should receive clear, proactive, communications relating to that decision or process. SafeWork NSW effectively communicates with external stakeholders in relation to IDMP decisions. However, it does not effectively engage with internal stakeholders regarding these same decisions. This drives dissatisfaction among the inspectors and other staff that support this process. It may also limit strategic decision-making by SafeWork NSW.

9.2.1 Good regulatory practice suggests that people with a stake in a regulatory process should be kept informed about it.

Regulatory decisions can have a significant emotional, material and other impacts on people raising matters or their families. They can also have financial impacts on businesses and other groups. Finally, they can significantly affect the resources available within a regulator, and the morale of staff. As such, each of these stakeholder groups should be informed of the aspects of a decision that are relevant to them, alongside sufficient information to understand why and how the decision was made.

Staff within a regulator who are involved in the preparation of making regulatory decisions must receive feedback on that input. The decision-making team must work to ensure Contact Centre, intake staff and other data collection and collation functions have feedback on the regulatory decisions that are made. This should be done with a view to ensuring that information is better captured and summarised with each iteration of the process.

In addition, where staff have invested time and effort in the preparation for a decision, they should be engaged in a sensitive way about its outcome. This should be done with a view to ensuring that their contributions are recognised as well as to ensure they receive actionable feedback on the way they should work into the future.

9.2.2 External stakeholders personally affected by the decision must be sensitively and regularly engaged.

External stakeholders and organisations 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 communication, however there are still areas of miscommunication to be addressed.

Consultations with SafeWork NSW supporting the IDMP process have indicated that SafeWork NSW has established clear processes and procedures for external communication. The role of a family liaison officer and communication process in place reflect that these are broadly followed. This was also referenced in

consultations with senior leaders within CDR. This aligns with best practice as SafeWork NSW make a clear attempt to sensitively and regularly engage external stakeholders who are affected by the decision.

However, there is room for improvement as staff have indicated there are areas of miscommunication between SafeWork NSW and external stakeholders. Senior leaders have also indicated that the name of the panel is misleading, particularly for those outside of SafeWork NSW. Having "investigative" as part of the name poses a risk that families are put offside by misunderstanding that investigations have been fully investigated without consultation. Other regulators name similar committees as part of enforcement teams to reflect the full scope of the regulatory functions. It has been noted in Improvement opportunity 7: SafeWork NSW should incorporate a greater strategic focus into the IDMP process. that this could be addressed through reconsidering the name of the body.

9.2.3 Informal communication processes mean staff receive limited feedback on their inputs to the IDMP process.

The IDMP process has a formal process for recording decisions made by the IDMP. However internal communications are led by informal processes. This means that they do not effectively inform the staff who support preparations for an IDMP decision of its outcome, or of the rationale for that decision. This prevents inspectors from clearly understanding how their work influenced the outcome received. It may also contribute to some staff feeling dissatisfied with outcomes, on the basis that they do not fully understand the rationale for those decisions.

Decisions are communicated informally and verbally, with the level of detail subject to discretion.

Decisions are communicated back to staff verbally and via informal mechanisms. Generally, the manager responsible for a particular submission sent to the IDMP by an inspector will attend the IDMP meeting at which that submission is considered. They will then report back to their team on the rationale for that decision. The level of engagement with individual inspectors, and the messaging they receive about why a particular decision was made, is left to the discretion of their manager. The written records of IDMP decisions are not shared.

This does not align with best practice, and it has led to dissatisfaction amongst staff in the lack of information they receive on decisions relating to matters they were involved in. Inspectors who prepare submissions to the IDMP have reiterated that the level of communication they receive is entirely dependent on the capacity and discretion of the manager. This doesn't align with best practice as informal and verbal communication leads to inconsistencies in messaging from the decision-makers to other staff. This doesn't support inspectors to understand the rationale for decision-making and means 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.

Staff appear dissatisfied with the level of feedback they receive on decisions they support.

Staff appear frustrated at the fact that they do not fully understand the rationale of the IDMP for making a particular decision. Current processes in place to support communication can dilute the messages passed between teams. Good practice suggests that feedback for continuous improvement will enable staff to achieve more consistent decision-making.

Consultations with SafeWork NSW staff supporting the IDMP process highlighted that there is an internal communication process. Where matters are accepted for investigation, staff have indicated that the secretariat of the IDMP receives the case to allocate an investigating inspector, and the appropriate manager is informed. For cases that are not accepted for full investigation, there is a live feedback loop whereby the director relays information to the manager, who meets with the inspector to communicate why the case was not successful in being accepted for full investigation. The discretion of a manager determines how the outcome of a matter will be communicated. The current internal process poses a risk, as key details and context beyond the identification of facts and priority areas could be lost down the chain of communication.

Staff in the CDR directorates express discontent with IDMP decisions. Staff engagements referenced a gap in communicating the context for matters alongside recommendations. A general disconnect between staff involved in the decision-making process was also identified. Submissions to the Review reflect views that there is a lack of transparency and poor decision-making in the IDMP. However, discontent may be due to the absence of a consistently followed internal communication process in practice, and resulting sentiment that IDMP decisions are not driven by good governance.

Good practice emphasises the importance of feedback for continuous improvement in decision-making processes. This was also highlighted by inspector sentiment that feedback would enable better decision-making. Feedback may have broader implications on how fair and transparent decision-making processes are because the reasons for decision-making are clearly communicated against a consistently applied framework. Establishing greater transparency and clearer lines of internal communication may better align SafeWork NSW to good practice principles, and alleviate staff discontent as a result.

A lack of understanding of decision-making factors by staff may limit strategic inputs to decision-making.

Limited communication of decision-making insights between staff can contribute to a lack of understanding of decision-making factors. Best practice principles prescribe the consideration of system level impacts and reference to strategic goals in the decision-making approach. Lack of understanding and strategic focus may impede on the ability to appropriately brief the IDMP into the future.

Several directors highlighted that the limited exchange of insights on decision-making between the IDMP and staff limits strategic decision-making by SafeWork NSW. They highlighted that it is inspectors, and their managers, who have primary responsibility for ensuring that strategic considerations are included in the decision briefs sent to the IDMP. However, sentiment from engagement with inspectors suggested that strategic focus is not adequately considered by the panel.

The Directors indicated that where staff do not have a full appreciation of how the IDMP makes decisions they may be less equipped to brief the IDMP into the future. For example, if inspectors are not fully aware of how the IDMP considers strategic factors in making decisions on individual notifiable events, they may choose to exclude this content from future submissions. They may also downplay strategic factors due to a lack of awareness of how the IDMP seeks to make decisions.

Over time, behaviour such as this could cause the briefings provided to the IDMP to be less strategic than would otherwise be desirable. An absence of clear communication between the IDMP and other staff, means that this concern cannot be addressed to establish a positive feedback loop and encourage strategic considerations in the submissions to the panel. Clear communication would allow matters to be sufficiently deliberated by the panel themselves and enable more effective decision-making.

Improvement opportunity 9: 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 the matter 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 inspectors with more consistent tools to approach decision-making.

This feedback should be designed to:

- Ensure inspectors are well informed about how the IDMP made the decision,
- Communicate the factors the IDMP considered and did not consider, as well as the reasoning 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.

Appendix A Detailed Triage Process

SafeWork NSW's triaging process starts with the intake of incident reports to the Contact Centre in SWAS.

SafeWork NSW receives 'advice of events' which include:[63]

- Notifications of workplace incidents
- Requests for service, that is, requests for regulator response to a work health and safety issue
- Requests for advisory visits
- Requests to commence prosecution under s 231 of the WHS Act.
- Requests for an inspector to be appointed to resolve statutory disputes e.g. review of PIN issued by an HSR, Entry Permit Holder Dispute ('statutory request')
- Other matters not relevant to SafeWork NSW

The advice of events is received in writing or electronically through the Customer Service phone lines, the SafeWork NSW website or the Speak Up app. Contact Centre staff record information in the WSMS according to in-built prompts for the duty officer designed to capture the 'core information'. [64] During business hours this information is captured by the Contact Centre within SWAS and outside of business hours this done by an external service provider. Matters from emergency services are referred directly to RCEU.

The Contact Centre undertakes an assessment of whether the incident should be considered by SafeWork NSW and its criticality. This is through guidance that is built into the WSMS.

The Contact Centre first assesses whether the incident should be considered by SafeWork NSW. It assesses whether the matter is within SafeWork NSW's jurisdiction, relates to a duty under the WHS Act, and has sufficient information to be triaged. This includes notifiable incidents (s 35 WHS Act) and RFS'. Matters that are considered by SafeWork NSW must be assessed by the Contact Centre. Matters that should not be considered by SafeWork NSW have no action taken, referred to another agency where possible, or noted as insufficient information with the applicant notified if possible.

For matters within SafeWork NSW jurisdiction, the Contact Centre must assess criticality by reference to the definition in the National Triage Decision Making Model. Critical events are all notifiable incidents, high-profile request for service, and statutory requests. All critical events are allocated to RCEU for triage. Non-critical events are non-notifiable incidents, non-critical requests for service, and events received after hours. Non-critical events are allocated to Triage Advisors in SWAS for triage. [65] If the event is a request to bring prosecution under s 231 of the WHS Act 2011, it will be directly referred to the RCEU unit to determine the outcome as it relates to an existing event reported to SafeWork NSW.[66]

If the event is received via the Speak Up App or website, it bypasses the Contact Centre and is sent straight to Triage Advisors to be triaged.

Triage advisors and inspectors then apply a risk-based approach to triaging.

This triage approach is applied by both groups to determine whether the matter will receive an administrative or inspector response.

[63] SafeWork NSW, Framework for the Management of Notified Events Procedure, 2022, pg.9.
[64] SafeWork NSW, Framework for the Management of Notified Events Procedure, 2022, pg.10.
[65] SafeWork NSW, Framework for the Management of Notified Events Procedure, 2022, pg. 9.
[66] National Triage Decision Making Model as interpreted by the Framework for the Management of Notified Events Procedure, pg 15-16.

RCEU Inspectors must first assess whether the notified events trigger an automatic inspector response. This is by reference to the criteria within the National Triage Decision Making Model. Notifiable events that meet these criteria are referred directly to the inspectors within the operational units in CDR.

Those not eligible for an automatic response are assessed against the Response Categorisation matrix.[67] In doing so, RCEU Inspectors and Triage Advisors are able to assign a response category.

- Response Categories 1 to 3 in the Response Categorisation Matrix will receive an inspector response, with administrative support provided by the Contact Centre in SWAS. This may be a field or non-field response for an RFS,[68] or an inspector response for notifiable incidents.[69] The SWAS team is responsible for allocating the matter to the appropriate SafeWork NSW team for further action.
- If triaged as a Response Category 4, the Notified Incident or RFS will receive an administrative response in the form of a letter or phone call to the PCBU. This is performed by Triage Advisors or Contact Centre staff on behalf of RCEU Inspectors.

Notified Incidents and RFS must also be checked against the HPE by triage advisors.[70] High Profile Events may require a triage outcome that is different to what is in the Response Categorisation Matrix as it has been identified as a high priority to SafeWork NSW (e.g. of media interest, a strategic policy target). In these cases, responses in the HPE matrix takes precedence.

The triaging process enables SafeWork NSW to respond to the Advice of Events it receives in a manner that is proportionate to the risk they present and that uses resources in an efficient way. It is also in broader alignment with SafeWork NSW's function as a regulator as part of the Better Regulation Division of the Department of Customer Service to make NSW safer, fairer and more productive for consumers, workers and businesses.[71]

An after-hours process is in place to ensure critical incidents are dealt with in a timely manner.

The After Hours Emergency Response Service (AHERS) process governs the receipt and management of critical incidents and RFS referred between 4:30pm – 8:30am.

This process is staffed by a full team involving[72]:

- **External service provider**: receive and initially assess calls from PCBUs, workers, emergency services and the community in relation to events that occur outside of normal business hours. It is their responsibility to assess the event for whether it should be considered by SafeWork NSW and criticality of the matter. They notify SafeWork NSW of these events through appropriate channels of communication for further assessment and determination of a response.
- **AHERS and Asbestos and Demolition Duty Manager**: assess the notified event to determine SafeWork NSW's initial response and coordinates if a decision is made to send AHERS Inspectors to the scene. The Duty Manager uses the 'verbal notification of serious incident' form to record the event. On the next working day, a Triage Advisor enters this information into WSMS and completes the triage process.
- **Back up Duty Manager**: assume the role of the AHERS or Asbestos and Demolition Duty Manager if they are unable to be contacted by the external service provider.
- **After Hours Inspector**: receive instructions to attend the scene of a notifiable or other event as determined appropriate by the AHERS or Asbestos and Demolition Duty Manager. They are required to gather information and evidence and direct remedial action through the service of notices.
- **Triage Advisor**: support in the management of AHERS events referring to the Duty Manager's recommended outcomes.

[67] SafeWork NSW, Response Categorisation of Events, 2022.
[68] The field and non-field responses are outlined in SafeWork NSW, WHSDOM Procedure - Requests for Service - Field and Non-Field Response, 2023.
[69] The Inspector Response is outlined in SafeWork NSW, WHSDOM Procedure - Incidents triaged for Inspector Response, 2022.
[70] SafeWork NSW, High Profile Event Matrix, 2022.
[71] SafeWork NSW, SafeWork Regulatory Priorities 2023, https://www.safework.nsw.gov.au/about-us/safework-nsw-regulatory-priorities-2023.
[72] SafeWork NSW, Framework Management of Notified Events, 2022, pg. 11, 38.

Appendix B NCEP Principles

The NCEP has seven key principles as outlined in Table 11 below.

Table 11 I NCEP Key Principles

NCEP Key principles	
Consistency	Regulators endeavour to ensure that similar circumstances at workplaces lead to similar approaches being taken, providing greater protection and certainty in workplace and industry.
Constructiveness	Regulators provide support, advice and guidance to assist compliance with work health and safety laws and build capability.
Transparency	Regulators demonstrate impartiality, balance and integrity.
Accountability	Regulators are willing to explain their decisions and make available avenues of complaint or appeal.
Proportionality	Compliance and enforcement responses are proportionate to the seriousness of the conduct.
Responsiveness	Compliance and enforcement measures are responsive to the particular circumstances of the duty holder or workplace.
Targeted	Activities are focused on the areas of assessed highest risk or the work health and safety regulators' strategic enforcement priorities.

Appendix C Triage documentation alignment to the process

Strong alignment to triage process	Somewhat aligned to triage process	Not aligned to the triage process

Table 12 | Documents establishing and guiding the triaging process in SafeWork NSW

Document	Description	Alignment with the triage process
SafeWork Framework Management of Notified Events Procedure	This document is the primary triage document that outlines the teams involved, the legislation and policy that guide SafeWork NSW's processes and the procedures to follow when managing notified events. The document relates to all SafeWork NSW inspectors and SWAS staff that receive and mange incident notification and requests for service.	
Response Categorisation of Events	This purpose of this document is to guide the assignment of a response category for all events notified to SafeWork NSW. It's audience is SafeWork NSW inspectors and SWAS staff that receive and manage Notified Incidents and RFS'.	
Event Classification Schema Interpretative Guide	This document provides guidance material that has been developed to assist SWAS, inspectors and others to interpret the hazard/issue categories when triaging occurs within RFS or Notified Incidents.	
HPE matrix	The HPE matrix is a live document and enables regulatory priorities, trends in work health and safety incidents and concerns and matters of concern to the community to be put straight to Inspector Response. The document outlines the criteria of the event, what Directorate team it falls in, how it should be triaged, what allocation it should receive (as per the document above) and who to communicate it to about.	
Triage Principles	This document outlines what should be triaged to Category 4 – Administrative Response in relation to the SafeWork Response Categorisation – Operating Protocol. The document contains 7 Principles wherein if a RFS meets the criteria, it shall be triaged as an Administrative Response.	
Triage for Psychosocial Hazards	This document outlines in a flow chart the triage process when dealing with psychosocial hazards in the workplace. It also has considerations for applying discretion and codes of practice for when triaging this specific issue.	

Document	Description	Alignment with the triage process
BRD – Service Level Agreement 2022	This document outlines the Server Level Agreement between the IER unit and the Issues Resolution and Advisory Services Units. It outlines the terms and conditions under which SWAS will provide specified services to the IER including roles, responsibilities, and expectations for the service period from the date signed until the agreement is replaced.	
Requests for Service – Field and non-Field Response	This document outlines the procedure that applies to all RFS referred to Inspector Response following triage whether they be field or non-field responses. It applies to all SafeWork NSW inspectors and managers.	
Incidents Triaged for Inspector Response	This document outlines the procedure that applies to all Notified Incidents referred to Inspector Response following triage whether they be field or non-field responses. It applies to all SafeWork NSW inspectors and managers.	

Appendix D Triage process alignment to national policy

The following tables assesses how well the triaging process aligns to the national approach.

Strong alignment to the National Framework	Somewhat aligned to the National Framework	Not aligned to the national framework

Table 13 | Triage alignment to the National Framework

The National Framework		
What is required by the National Framework?	**What has SafeWork NSW done to meet this? Where?**	**How well does SafeWork NSW's triaging align with the National Framework?**
SafeWork NSW must adopt the Event Triage Decision Making Model	SafeWork NSW has put the Event Triage Decision Making Model into the SafeWork Framework Management of Notified Events Procedure which is the primary document that guides triaging at SafeWork NSW. It also includes a broken-down version of the Model with more detail to explain key decisions points along the process. SafeWork NSW has also adapted the WSMS to follow the flow of the Triage Decision-Making Model to make it easier for staff to follow and promote consistency.	
SafeWork NSW must adopt the range of terms and supporting definitions to be used administratively to support the decision-making model	SafeWork NSW has put the terms and supporting decisions in the SafeWork NSW Framework Management of Notified Events Procedure to guide SafeWork NSW staff when triaging.	
Supporting additional documents that are not required but available to regulators: • Service Charter • Core information to be collected during the data entry of Notified Incidents and RFS • Incident Information Release to advise the public of a serious incident • Guidance for the management of events which receive an administrative response action	SafeWork NSW has adapted the National Framework's charter to align with information with their Customer Service Standard: SafeWork NSW Incident Response and Investigations - What to Expect and Customer Service Standard - Raising a Work Health and Safety Concern which both outline what customers can expect from SafeWork NSW and what SafeWork NSW expects from customers. SafeWork NSW has also outlined their approach to site preservation in the SafeWork Framework Management of Notified Events Procedure'[73] in line with The	

[73] This can be found in Chapter 9 and Appendix 11.

The National Framework		
• Principles surrounding the management of site preservation requirements	National Framework's principles for site preservation.	

Table 14 | Triage alignment to the NCEP

The National Framework		
What is required by the NCEP?	**What has SafeWork NSW done to meet this? Where?**	**How well does SafeWork NSW's triaging align with the National Framework?**
SafeWork NSW must align their triage process to the NCEP principles	SafeWork NSW has adopted the NCEP Principles within Chapter 3.2 of the SafeWork Management of Notified Events – Framework. They are also reflected more broadly in SafeWork NSW's overall risk-based triaging approach, as discussed in Section 2.2.1.	
SafeWork NSW must use a range of compliance and enforcement tools to encourage adherence to work health and safety laws.	SafeWork NSW applies this throughout their triaging process, evident in the different outcomes that a PCBU may receive if it is found that they are in breach of the WHS Act 2011. Depending on the severity of the breach they may receive an administrative response, prohibition notice, penalty notice or an enforceable undertaking, among other outcomes.	

Appendix E SafeWork NSW Regulatory Priorities 2023

SafeWork NSW has annual regulatory priorities that are published on its website. The regulatory priorities for 2023 are outline in Table 15 below.

Table 15 I SafeWork NSW Regulatory Priorities 2023[74]

Priority	Description
Gig economy	Increase safety and WHS compliance in the gig economy sector, particularly food delivery riders and health care.
Safety around moving plant	Reduce workplace safety incident related to moving plant, particularly forklifts.
Seasonal workplaces	Increase WHS compliance to support itinerant workers, particularly in the agricultural sector and those working with amusement devices.
Psychological safety	Reduce the prevalence of psychological injury at workplaces, with a focus on mental health and wellbeing.
Respect at work	Reduce the incidence of bullying, sexual harassment, and customer aggression in the workplace, particularly in male dominated sectors and healthcare.
Exposure to harmful substances	Reduce the incidence of worker exposure to dangerous substances in the workplace, particularly silica and dangerous chemicals.
Falls	Reduce the incidence of falls from heights with a particular focus on construction.

[74] The regulatory priorities for 2023 are set out on the SafeWork NSW website: https://www.safework.nsw.gov.au/about-us/safework-nsw-regulatory-priorities-2023

Appendix F Detailed IDMP Process

The IDMP process begins with providing an Inspector Response.

Matters that are triaged by as Categories 1 to 3, that is requiring an inspector response, are referred to the relevant directorate within CDR. Inspectors respond to gather preliminary information and evidence of the incident and prepare corresponding reports. Matters that are assessed as falling within priority areas 1 or 2 from the IDMP factors for decision-making (per Appendix G) are escalated to a joint debrief to consider automatic acceptance. Information for the remaining matters is collated for the SIRP.

Automatic acceptance to full investigation bypasses the IDMP.

A joint response enables consideration of whether matters qualify for automatic acceptance to full investigation. This involves a debrief between the director, manager(s) and inspector(s) from IER and the relevant CDR Directorate, with the Panel Secretariat in attendance. They must decide whether the matter not only falls within priority areas 1 and 2, but also that "the risk/consequence is so serious, and the overwhelming public expectation is such, that the matter would be expected to proceed to investigation".[75] If accepted, files are handed over from the Inspectorate in CDR to Inspectors in IER and the matter is verbally noted at the next IDMP.

Matters that are not eligible or admitted to the automatic acceptance route go through the SIRP.

The SIRP is a panel, supported by a process, for the review and consideration of matters to determine which should be referred to the IDMP for 'full investigation' with a view to prosecute.

The SIRP may determine that a matter meets the threshold for consideration by the IDMP. In this case, they make a submission to the IDMP with their recommendation, evidence, and reasons in accordance with the template provided. Psychosocial matters must be reviewed by the ERG first. This is led by the Health and Safety Design Directorate with a representative from IER and at least one other Directorate without prior involvement in the matter. The ERG will make a written assessment on whether the matter should be referred to the Panel. All other matters for the IDMP go through a pre-panel review with the IDMP Secretariat to ensure all requirements and standards are met.

The SIRP may determine that matters do not meet the threshold for considerations. The SIRP may make other enforcement decisions including issuing different types of notices to the duty holder under the WHS Act or WHS Regulations. The SIRP may also recommend no further action. In this case, the Directorate is responsible for carrying out the processes to notify external stakeholders.

Decisions made by the SIRP are recorded in a Serious Incident Review Log and sent to the Safety Management Audit Team for review at the end of each calendar year.

The IDMP decides whether a matter should proceed to 'full investigation' with a view to prosecute.

The IDMP meet in accordance with the Terms of Reference. The Panel consists of six Directors within CDR (it does not include the Director for Building and Construction Compliance) and the Director of IER. A Panel chair is responsible for the convening and conducting of meetings.

Directors may delegate their duties on IDMP to Managers when they cannot attend. The IDMP is required to review the most important matters including notified fatalities and those in submissions to decide on whether they should proceed to full investigation with a view to prosecute.[76]

The IDMP deliberate on the submissions it receives in accordance with the IDMF. This involves consideration of matters against the IDMP factors for decision-making, that is, nine priority areas and 14

[75] SafeWork NSW, Investigation Decision Making Framework, 2022, pg. 8.
[76] SafeWork NSW, IDMP Terms of Reference, 2022.

guiding factors. As per the IDMF, "a quorum of the Panel consists of a designated or Acting Chair and at least four members (or their nominated delegates)[77]."

The IDMP may decide to accept or not accept recommendations or refer matters back to the CDR Directorate. The meeting minutes record the decisions, factors considered, and additional notes. The Panel Secretariat maintains a Panel Log of all information with regards to submissions.

[77] SafeWork NSW, Investigation Decision Making Framework, 2022, pg. 3.

Appendix G IDMP factors for decision-making

The IDMP process is guided by nine priority areas and 14 factors. These are outlined in the IDMF and extracted below in Table 16.

Table 16 | Priority areas and guiding factors for IDMP

Priority Areas	Guiding Factors
1. Notifiable incidents and occupational illnesses that result in a fatality. 2. Notifiable incidents or occupational illness that are likely to result in major and permanent disability (including; paraplegia, quadriplegia, acquired brain injury, blindness, amputation of a limb including a hand or foot, severe burns, asbestosis and silicosis) and/or work related incidents involving catastrophic disruption to a workplace, public infrastructure or the community. 3. Notifiable incidents that are a serious injury or illness not likely to result in major and permanent disability. 4. Risk of death or serious injury arising from a dangerous incident or identified during interventions such as complaints, verification programs and risk-based programs. 5. Repeated contraventions of work health and safety legislation. 6. Offences against inspectors, authorised officers and persons exercising health and safety functions. 7. Discrimination against workers on the basis of their health and safety activities. 8. Failure to notify incidents and or preserve the scene. 9. Strategic regulator and / or directorate – specific priority areas, such as new or emerging issues.	1. The severity and scale of potential or actual harm. 2. The seriousness of any potential breach of law. 3. The duty holder's compliance history, WHS Rating and such matters as notices and other actions taken by SafeWork NSW including prior convictions. 4. Whether the offending behaviour was excessive or repeated (recidivism). 5. The public interest (i.e. Whether an investigation would be the expectation of the public at large) – refer to NCEP for further details. 6. The existence and nature of any familial relationship between the injured or deceased person/s and relevant duty holder/s. 7. Emerging and escalating issues. 8. Availability of reliable evidence to proceed to investigation. 9. Whether the matter is within SafeWork NSW's jurisdiction 10. Whether another regulator is investigating the matter. 11. Foreseeability of the risk. 12. The potential to identify the root cause of an incident to inform industry of risk and to formulate prevention initiatives. 13. The likelihood that the investigation will be the catalyst for improved work health and safety outcomes. 14. The potential to promote better understanding, administration, or enforcement of WHS legislation, including building case law.