



Submission to: Independent Review of SafeWork NSW

MARCH 2023



NSW NURSES AND MIDWIVES' ASSOCIATION
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Background & Terms of Reference

Background

On 25 October 2022 the NSW Government announced the appointment of the Hon. Robert McDougall KC (the Independent Reviewer) to carry out an Independent Review of SafeWork NSW (the Review).

The Review will examine SafeWork NSW's performance of its regulatory functions (including educational functions) under the Work Health and Safety Act 2011 (NSW).

Terms of Reference

The scope of the Review is to inquire into, report on and where thought desirable make recommendations as to:

- 1. The performance and effectiveness of SafeWork NSW's compliance and enforcement functions. This part of the Review will consider complaints, inspections, investigations, and prosecutions, and will include consideration of SafeWork's Triaging and Investigation Decision Making Panel processes.*
- 2. The performance and effectiveness of SafeWork NSW's educational functions.*
- 3. The governance and culture of SafeWork NSW, including complaints as to alleged unlawful or undesirable conduct in the workplace.*
- 4. Appropriate measures to ensure that workers and their representatives (including Health & Safety Representatives), and the families of injured and deceased workers, have a genuine voice in the complaints, investigation, and enforcement processes.*

The Review will be an inquisitorial rather than adversarial process. While specific cases and detailed issues raised can be considered as part of the Review, the Review will not make determinations relating to specific work health and safety cases. The Review's focus will be on identifying deficiencies and recommendations at the organisational level.

The Review will be carried out on the assumption of complete cooperation and full disclosure from the parties involved. The Review activities will be determined by the Independent Reviewer and are expected to include the following:

- Interviews with current and former SafeWork NSW staff.*
- Interviews with representatives from other stakeholders (including, but not necessarily limited to, the Family and Injured Workers Support Group, industry and union representatives).*
- Review of documents from SafeWork NSW, relevant Parliamentary documents and reviews, media articles and other relevant sources.*
- Review of relevant enabling legislation including the WHS Act.*

- *Seeking and considering feedback obtained through a targeted stakeholder consultation and open public consultation (including a public call for submissions based on the Terms of Reference).*

An interim Report will be provided to the responsible Minister by 31 May 2023, with a final Report to be provided by 29 November 2023. Flexibility is needed in the timeline for the Review, to ensure proper consideration of all relevant matters and to allow for the possibility that new issues come to light that need to be examined.

The reports will be publicly released after they are provided to the Government. All material provided to the Review will also be made publicly available unless it was specifically provided in confidence.

NSW Nurses and Midwives Association – NSW’s largest union

Forward

The NSW Nurses and Midwives Association (the Association) is the registered union for nurses and midwives working in all areas including but not limited to public and private hospitals, residential aged care, disability, corrections, and in-home care.

The Association is NSW largest union representing approximately 75,000 nurses and midwives across the state. The Association is the NSW branch of the Australian Nursing and Midwifery Federation (ANMF). Nationally the ANMF has approximately 320,000 members.

Ensuring the health and safety of nurses and midwives at work is a major focus for the Association. Our vision is that nobody should go to work and be hurt or be killed, and that the safety of our members should not be compromised or placed second to the provision of first-class health care services for the community.

Association officers are engaged daily in the task of advancing safety for workers at their workplaces and supporting members who raise health and safety concerns in their workplace.

The Association promotes work, health and safety education and training. As an accredited training provider with SafeWork NSW, the Association is a provider of training to Health and Safety Representatives and runs regular member forums and webinars on a range of WHS topics of interest to members.

As the largest union in NSW representing workers with the largest number of serious injuries of any industry, the Association has greater engagement with SafeWork NSW than other unions, including quarterly stakeholder meetings.

Association position

What are the problems?

Workers in the healthcare and social assistance sector experience the highest numbers of serious injuries of any industry and have the second highest frequency rate of serious injuries (serious injuries per million hours worked).¹

¹ https://www.safeworkaustralia.gov.au/sites/default/files/2023-01/key_whs_stats_2022_17jan2023.pdf

Psychological injury rates across the sector are climbing at alarming rates, with healthcare workers almost twice as likely as other workers to sustain a serious psychological injury. Psychological injuries for nurses have increased by 150.6% between 2013-2015 and 2019-2021, with the most common causes of psychological injury being bullying and harassment (38.4%), work pressures (23.1%) and occupational violence (18%)².

Despite the serious risks being faced by Association members, SafeWork NSW is failing to take suitable regulatory action to ensure the health and safety of nurses and midwives in NSW.

Safework NSW publishes details of prosecutions from 2017-2022 on their website. There have been no prosecutions in relation to injuries to nurses or midwives or indeed of any health agency or residential aged care provider in this period.

There have been no prosecutions of health agencies in relation to occupational violence in NSW since 2007, despite at least 3 nurse fatalities arising from violence in this period and multiple serious injuries sustained by nurses every week.

SafeWork NSW has failed to take appropriate regulatory action of health agencies or residential aged care providers in relation to failure to manage risks arising from exposure to COVID-19 despite thousands of nurses contracting the disease in the last couple of years and at least one death of a nurse in NSW from COVID-19 contracted in her workplace. Despite ongoing representation from the Association, to our knowledge there have been no notices issued or prosecutions commenced.

The impacts of the COVID-19 pandemic on the healthcare workforce and the emerging workplace mental health epidemic highlights that progress on health and safety is not guaranteed and requires the concerted efforts of governments, employers and Unions.

It is critical that NSW workers and their Unions are empowered to take steps to ensure their health and safety in their workplaces.

All workers have an equal right to healthy safe and respectful work, without discrimination and free from violence and aggression. However, nurses and midwives are facing significant threats to their physical and psychological health from role overload, occupational violence and bullying and harassment.

Workers must be protected from all hazards and risks at work, including psychosocial as well as physical hazards and risks.

² Gelaw, A., Sheehan, L., Gray, S. and Collie, A. Psychological injury in the New South Wales Healthcare and Social Assistance industry: A retrospective cohort study. Healthy Working Lives Research Group, School of Public Health and Preventive Medicine, Monash University (2022).

Workers who are empowered to act collectively through their Unions are safer and healthier at work. Worker elected, Union trained and supported health and safety representatives (HSRs) are a critical determinant of healthy safe and respectful work.

Further information will be provided in relation to these concerns in the body of the submission below.

We welcome the opportunity to provide a submission to this Consultation.

This response is authorised by the elected officers of the New South Wales Nurses and Midwives' Association

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The performance and effectiveness of SafeWork NSW's compliance and enforcement functions. This part of the Review will consider complaints, inspections, investigations, and prosecutions, and will include consideration of SafeWork's Triaging and Investigation Decision Making Panel processes

1. Safework NSW is an ineffective work health and safety Inspectorate, and fails to meet many of the functions of the regulator set out in s152 of the Work Health and Safety Act (2011), in particular:
 - 1.1 *to monitor and enforce compliance with the WHS Act* – this submission will provide detailed evidence of SafeWork NSW's failures to monitor and enforce compliance with the WHS Act, particularly when it comes to a lack of compliance by government agencies or in relation to psychosocial hazards.
 - 1.2 *to provide advice and information on work health and safety to duty holders under this Act and to the community* – SafeWork NSW provides minimal advice and information targeting workers or HSRs, choosing to focus their advice and information on PCBUs and officers only.
 - 1.3 *to collect, analyse and publish statistics relating to work health and safety.* There is a significant lack of transparency and few statistics are made available by SafeWork NSW. For example, SafeWork NSW is currently working on a new healthcare and social assistance sector plan. No statistics were provided to stakeholders involved in the development of this plan. Relevant statistics to consider would include: performance towards the targets set out in the last healthcare and social assistance sector plan (to be able to consider the effectiveness of the activities in the last plan) as well as information about current trends in the industry to assist stakeholders to make informed contributions about actions that are most urgently needed. The GIPA process is a further obstruction to receiving information.
 - 1.4 *to foster a co-operative, consultative relationship between duty holders and the persons to whom they owe duties and their representatives in relation to work health and safety matters* – SafeWork NSW has no formal tripartite arrangements in place to foster cooperative, consultative relationships, despite tripartism being a fundamental principle enshrined in International Conventions to which Australia is a party. This lack of tripartite arrangements further inhibit the implementation of one of the key objects of the Act set out in 3(c) *encouraging unions and employer organisations to take a constructive role in promoting improvements in work health and safety practices, and assisting persons conducting businesses or undertakings and workers to achieve a healthier and safer working environment*

- 1.5 *to promote and support education and training on matters relating to work health and safety* - SafeWork NSW runs limited training with little to no focus on HSRs, workers or worker representatives. SafeWork fails to consult stakeholders about the suitability of training provided.
- 1.6 *to engage in, promote and co-ordinate the sharing of information to achieve the object of this Act, including the sharing of information with a corresponding regulator* – SafeWork NSW lacks transparency and fails to share information
- 1.7 *to conduct and defend proceedings under this Act before a court or tribunal.* SafeWork NSW limits its legal activities to the traditional blue-collar industries and hazards that it is most comfortable and familiar with. A review of the prosecutions taken by SafeWork NSW demonstrates that the construction sector, particularly falls from heights is the main area in which SafeWork conducts proceedings under the WHS Act. SafeWork is failing to conduct proceedings in other high risk industries such as the Healthcare & Social Assistance Sector, despite this being the industry with the highest number of serious injuries, and is failing to address emerging harms such as psychosocial harms and violence and aggression.

2. The decision to embed SafeWork NSW within the “Better Regulation Division” of the Department of Customer service has seen an increased focus on customer service (where employers are considered the “customer”) and a decreased focus on *the principle that workers and other persons should be given the highest level of protection against harm to their health, safety and welfare from hazards and risks arising from work or from specified types of substances or plant as is reasonably practicable.*

Regulating the safety of workers is different than regulating pubs, greyhounds, fair trading etc, and workers require specialty knowledge.

Recommendations:

1. SafeWork NSW should be removed from the Department of Customer Service and made a stand-alone work health and safety regulator independent from the influence of government.
2. SafeWork’s governance must include a board which includes representatives from the Union movement.
3. Safework should refocus activities on compliance and enforcement to ensure that workers are given the highest level of protection from harm to their health, safety and welfare.

The effectiveness of SafeWork NSW in complaints

Any assessment of SafeWork NSW's effectiveness in dealing with complaints should first contemplate how workers are encouraged to (or discouraged from) complaint making, including experiences with making a complaint by phone, the content of complaint forms, the availability of translators, the provision of information in other language, in addition to how complaints are triaged and allocated.

3. To contact SafeWork NSW by telephone people can call 131050, where a recorded voice message says "*welcome to customer experience*" providing no clarity that people have come to the right place to report a safety issue in their workplace. They are then presented with the following 2 options:

- *If you have an inquiry about workers compensation or home building compensation press 1*
- *If you are calling to report a notifiable incident or have an inquiry about work (pause) health and safety licenses or plant registration press 2*

On pressing 2, there is a message saying *welcome to SafeWork NSW* and the following options are presented:

- *If you are calling to notify a workplace fatality or you are a member of emergency services and calling to notify an incident press one*
- *To report an incident that is notifiable to Safework NSW press two*
- *Any inquiries about any licence card, notification or plant registration press 3*
- *For Covid 19 business assistance..... press 4*
- *All other inquiries please hold to speak to a consultant*

3.1 The menu options are confusing and do not clearly signpost options for workers.

3.2 There is nothing in the recorded message that clearly indicates to workers or their representatives that this is an organisation that exists to ensure workers are safe at work and that calls from workers or their representatives about workplace health and safety concerns are a priority to the organisation.

Recommendations:

4. That the phone menu options are reviewed and revised to facilitate access for workers and their representatives.

4. When people make it past the automated message service, there are further obstacles as many of the customer service centre workers taking calls about serious WHS issues are not adequately trained or experienced and appear poorly informed about the operations of SafeWork NSW and about the WHS Act. In the past callers would speak to a trained inspector when they rang the SafeWork NSW predecessor, WorkCover NSW.
- 4.1 It appears that the focus for the customer service centre workers has largely been on redirecting callers back to their own workplaces to resolve issues.
 - 4.2 Customer service centre workers have become the gatekeepers, stopping many matters proceeding for regulatory response.
 - 4.3 The lack of knowledge and experience in WHS of the customer service centre staff is resulting in incorrect advice being given to callers, and serious WHS issues not being investigated or resolved.
 - 4.4 Association members report difficulties having their issues accepted when they call through to the call centre, meaning that these issues never even get to the triage stage. This is highly concerning when the customer service centre staff are not supposed to be triaging issues, and do not have the knowledge or expertise to make such decisions.
 - 4.5 On the 3/11/2020 an Association officer contacted SafeWork NSW after an incident of occupational violence resulting in a nurse sustaining a [REDACTED]. This incident had not been reported to SafeWork NSW by the employer despite it being a “notifiable incident” under the WHS Act. The worker taking the call started by telling the officer that there wasn’t anything SafeWork could do about patient violence. He then argued about that a [REDACTED] was not a notifiable incident and suggested that SafeWork wasn’t going to look into the matter unless the Association had attempted to resolve the issues with the employer first. This interaction showed a clear lack of knowledge about the role of SafeWork NSW, the WHS Act and the role of unions. This request for service was eventually accepted as Association officers are well versed in these areas, however if this had been a worker calling to report an incident then it is unlikely that the matter would have made it past this first hurdle.
 - 4.6 On the 19/11/2020 an Association officer contacted SafeWork NSW after 2 nurses died [REDACTED] following an extremely poorly managed workplace investigation. The worker taking the call stated that this sounded like an industrial issue rather than a safety issue and that it wasn’t something SafeWork could get involved with. This demonstrated a poor understanding of the WHS Act which requires employers to eliminate risks to the health (including psychological health) and safety of workers by ensuring safe systems of work. After a lengthy discussion this request for service was eventually accepted, however this again demonstrates the lack of knowledge of customer service centre workers, and is another example of where it was fortunate that it was the Association rather than one of our members attempting to make the request.

- 4.7 On 28/7/22, An Association officer contacted Safework NSW in relation to problems with duress alarms at a major [REDACTED] hospital. The matter had been raised with the employer over many months by both members and Association officers and was unresolved. The worker taking the call stated that if the District had undertaken to fix the problem, then there is nothing that Safework could do. The Association officer emphasised that the promises to address the issue had come to nothing and the employer had had ample opportunity to address the issue and had not done so. Regardless, this matter was dealt with by way of an 'administrative response' which was a letter to the employer of unknown content. As predicted, the employer did not act upon the letter and issues with the duress alarms remain a concern at the hospital.

Recommendations:

5. That calls to SafeWork NSW about WHS issues are taken by trained inspectors with appropriate knowledge of the WHS Act and the operations of the regulator.

5. The SafeWork NSW website is difficult for workers to navigate to identify how to request assistance. Unlike other WHS Regulators, the SafeWork NSW website home page does not provide clear pathways for the reports of WHS incidents and issues.
- 5.1 At the top of the home page is a small heading titled 'Notify SafeWork'. This allows for reporting of only 'notifiable incidents' (as per the WHS Act & Regulation) and *Covid-19 related notifications*. There is no option for workers to request assistance from SafeWork NSW or for any other WHS complaint related to the workplace.
- 5.2 For all other matters SafeWork NSW has an online "Customer service centre - Enquiry form". This appears to be a generalist form for everything from general enquiries through to significant risks. It is difficult to locate and does not include a category of "union" for who is submitting the enquiry. Complainants are asked to provide their name, contact number, email and residential address. No specific information is provided to complainants about information to include or what will happen next.
- 5.3 A third process has been established for workers reporting psychosocial hazards/risks/incidents. This form is located in another part of the website entirely and is difficult to find unless you know that it exists and do a specific search for psychosocial or psychological hazards, risk and injuries. More information about the process for reporting psychological injuries is below.

Reporting psychosocial hazards/risks/incidents to SafeWork NSW

The Association is extremely concerned about the increase in psychological injuries sustained by our members. Workers in healthcare are twice as likely as other workers to develop a psychological injury and serious claims for nurses have increased by over 150%. These figures are an under representation as they are based solely on workers compensation data. Many healthcare workers are extremely reluctant to make a claim as they believe they will be reported as “impaired” to AHPRA and that this could impact their registration. These workers use their own leave, resign, or continue to work with significant injuries.

- 6 Despite psychological injuries being identified as a priority hazard in both the National WHS strategy and in the SafeWork NSW roadmap due to rising claims and increased burden of disease, the processes for workers to report psychosocial matters to the regulator are unnecessarily arduous and appear designed to discourage reporting of these matters.
 - 6.1 The form for reporting psychosocial hazards can be accessed as a PDF (to be completed, printed and posted back to SafeWork NSW by mail to Locked Bag 2906, Lisarow NSW 2252 – no information is provided about returning it by email) or alternatively as an online form. The online form must be completed by the user in one go as they are unable to save and return to it later.
 - 6.2 The form is inappropriately lengthy (the PDF is 8 pages long) and requires a level of detail that creates significant barriers to reporting.
 - 6.3 Workers are asked to confirm that they have checked *that what is occurring is a psychosocial hazard/harmful workplace behaviour in the NSW Code of Practice: Managing Psychosocial Hazards at Work (refer to Table 1 on page 7)*. That information referred to in Table 1 is not provided in this form and rather requires the user to search another Tab.
 - 6.3.1 The requirement to check a formal document such as a code of practice creates barriers to workers reporting, particularly workers with lower levels of literacy or who are culturally and linguistically diverse.
 - 6.3.2 The table referred to in the Code of Practice was always intended as a non-exhaustive list of psychosocial hazards. This is made clear on p6 of the Code which states “*Some of the most common psychosocial hazards are noted in Table 1. There may be hazards not relevant to your work or relevant to your work but not included*”. Restricting workers to only reporting hazards outlined in the non-exhaustive list in Table 1 is inappropriate.
 - 6.3.3 Asking workers to outline what outcome they want to see as a result of raising the issue is inappropriate as they may not know the specific answer other than “for my workplace to be safe”. This information is not requested for reporting of physical hazards.

- 6.3.4 Requires that workers outline what they have done to resolve the matter internally with their employer and states “*If your workplace has not been made aware of, or had an opportunity to respond to the hazards, this may limit the action SafeWork NSW can take*”. This statement has no basis in fact and is not always an appropriate course of action for the worker.
- 6.3.4 Requires that the worker provides *three examples (from the past 12 months) of psychosocial hazards, that can be supported by evidence.*
- 6.3.4.1 Reporting of physical hazards does not require workers to provide evidence and nor should reporting psychosocial hazards. Inspectors have broad powers to obtain evidence.
- 6.3.4.2 It is inappropriate for workers to have to demonstrate three examples of psychosocial hazards occurring, when one (serious) example may be enough to cause significant harm (e.g. sexual harassment/assault, occupational violence, exposure to severe trauma). This appears to be left over from when it was a form for reporting bullying which does require “repeated” unreasonable behaviour to meet the definition.
- 6.4 The “*Psychosocial hazards (e.g. bullying) – know who to contact*” landing page details that any matter relating to “*Discrimination*” should be referred to Anti-Discrimination NSW and to contact the Fair Work Ombudsman if the issue is about matters including “*being forced to do things against your will, being discriminated against, being threatened by your employer*”. All of these matters are WHS hazards, are listed in the Code of Practice for Managing Psychosocial Hazards and fall under the purview of SafeWork NSW as the WHS Regulator.
- 6.5 The complex approach to psychosocial matters on the SafeWork NSW website and through the Customer Service Centre, appears designed to limit reporting of these matters to the regulator. This is a significant concern for the Association given the large increases in psychological injuries as demonstrated by the SIRA data.
- 6.6 The Association continues to receive concerning feedback from members completing the “*Psychosocial hazards request for service form*” or the online “*Psychosocial hazards request for service form*” that the content of the form has the effect of dissuading them from seeking support from SafeWork NSW and that, if they do progress to notifying the request for service, the health and safety Regulator does not see its role to support them. Forms that appear designed by the Regulator to limit complaints is, surely, the antithesis of SafeWork NSW’s purpose. In contrast, WorkSafe Victoria has a single webform for complaints and which starts with the pleasantly reassuring preamble “At WorkSafe, we are committed to keeping all workplaces healthy and safe.”

We note the following:

- workers find the level of personal detail required to be unnecessary
- repeated statements by SafeWork NSW they will only be able to act on complaints if workers provide evidence to substantiate the allegations is considered problematic by workers as they feel that a reliance on substantiating evidence, rather than their direct evidence of their experiences, is undermining
- that often there is a limited understanding of what substantiating evidence means and how they can access and provide it
- there is an undue emphasis on the worker locating substantiating evidence themselves, notwithstanding the Regulator's extensive compulsive powers under s155 and s171
- when workers sign a release of the information they have provided to an employer where SafeWork NSW identifies their details and details of their complaint to the employer, there is no information about how or when their information would be provided and there is certainly no reassurance given about protection from adverse action etc. Workers already feel vulnerable in their workplaces, and SafeWork NSW foreshadowing a disclosure without consultation with the worker has dissuaded workers from seeking support.

Recommendations:

6. That the SafeWork NSW website is improved to facilitate reporting of WHS matters
7. That the website includes a readily identifiable tile on the home page for reporting any issue to SafeWork NSW
8. That there is one single online process for reporting and that SafeWork consults with Unions on usability
9. That information provided about reporting and the process of reporting takes into account potential language and literacy issues of those reporting
10. That Safework discontinues the use of the psychosocial hazards reporting forms (both PDF and online versions)

Triaging & Administrative responses

7. The triaging process is not clearly understood or explained to workers contacting SafeWork NSW and matters posing a serious risk are inappropriately triaged for an administrative response when they should have been allocated to an inspector.
 - 7.1 It is difficult to find information about the triaging system on the SafeWork website and requires searching through multiple lengthy documents. For example, the SafeWork NSW publication "*Our approach to work health and safety regulation*" details on page 5 that "*We use a triage model based on the level of risk to determine our type of response*". It does not explain what that triage model is.

Further searches of the SafeWork NSW website to find out what the triage process is are burdensome and unlikely to be undertaken by workers, particularly workers in distress or with language or literacy issues. This information can be found in the publication *Customer Service Standard* (May 2017) which states that the triage process includes:

- outside our jurisdiction
- insufficient information
- administrative response (letter) some of these may be followed up by an inspector within 3 months
- inspector allocated.

7.2 The Association believes the triaging and allocation of complaints by SafeWork NSW is inefficient and, in some cases, very concerning. Members have reported sending requests for service through to the regulator, including their contact details, and have heard nothing further. The triaging system is not fit for purpose, it is a barrier to ensuring that WHS matters are being appropriately addressed.

7.3 Members following up their issues with the regulator have been advised that their matter was triaged for an Administrative Response. When members ask what response has been provided to the letter sent by SafeWork, Customer Service Centre staff reported that they could not advise the outcome as only around 20% of the matters triaged for an Administrative Response were followed up by an inspector visit.

This outcome has left our members without any resolution to their WHS concerns.

7.4 The SafeWork Customer service standards indicate that high risk matters will generally receive an inspector response within one business day, and moderate risk issues within 3-5 business days. It is the experience of the Association that high-risk matters are frequently assessed as moderate risk and that the timeframes outlined in the Customer Service Standards are rarely met.

7.5 The Association asserts that many serious matters are not receiving the attention of an inspector and notes that at NSW Senate Budget Estimates in 2022 the following question and answers was provided:

*How many requests for service did SafeWork receive in 2022 so far? **2,231**.*

*How many of these requests for service received an inspection by a SafeWork inspector? **792**.*

8. The SafeWork NSW Customer Service Standard (May 2017), states that an administrative response will be provided *if the issues raised are assessed as low risk*.

It is the experience of the Association that many high-risk issues are being triaged for an administrative response. Some examples of poor triaging decisions

- 8.1 [REDACTED] – In late April 2020, Association officers contacted SafeWork NSW in relation to a major COVID-19 outbreak at [REDACTED]. At this time there had been 61 cases of COVID-19 in the facility, including 24 staff and 37 residents and multiple deaths of residents. On May 1st, the Association was advised that SafeWork had triaged the issue for an administrative response.
- 8.2 [REDACTED] – an Association member was injured following an electric shock from [REDACTED] in June 2022. Injuries sustained were extremely serious and at this time the member has been unable to return to work [REDACTED]. This was a notifiable incident under the WHS Act and was notified as required by the PCBU. The incident was triaged for an administrative response. The Association has followed this matter up with SafeWork as it was a serious incident and we are aware there have been other similar incidents both before and after this specific incident.

Recommendations:

11. That the SafeWork NSW website is improved so that the area for reporting issues also contains information about what they can expect from the regulator
12. The triaging process should be replaced with a system that allows for expert response in the first instance e.g. inspector receipt of incoming calls as per the system that used to exist under WorkCover NSW.
13. Adequate inspector numbers must be provided to allow the timeframes in the customer service standards to be met.

The effectiveness of SafeWork NSW in inspections

9. It is the experience of the Association that there are significant differences in inspection outcomes based on the inspector who is allocated the issue. These differences appear to relate to:
- General skills and knowledge of the individual inspector;
 - The inspector's knowledge and understanding of the sector;
 - The inspector's knowledge and understanding of the hazard/risk and controls;
 - Whether or not an inspector consults with workers and their representatives;
 - Personal preferences in approach of inspectors to education vs enforcement.

It is the position of the Association that when an inspector attends a workplace in response to a request for service and breaches of the WHS legislation are identified then notices must be issued addressing these breaches.

Inspectors report frustration at the limits to their powers when observing breaches of the WHS Act. In 2011 with the commencement of the WHS Act, inspectors lost penalty infringement notice capability to issue fines for a breach of s19.

- 9.1 The Association has raised the issue of PCBUs failing to notify notifiable incidents. One such example was in relation to a member working in a mental health unit in [REDACTED] from an assault by a patient. This was notified by Association officers on the 29/10/2020. No penalties were applied for the failure of the PCBU to notify a notifiable incident.
- 9.2 The Association has raised the issue of PCBUs failing to display improvement notices in accordance with the WHS Act. A failure to display notices means that the workers in the service are unaware that a notice has been issued or what measures their employer must undertake to address the identified issues. Often workers indicate that there appears to have been no change to safety in their workplace. One such example was in relation to a matter in [REDACTED] that had been notified to SafeWork NSW by the Association on 6/7/2022. No penalties have been applied for this failure to display improvement notices issued despite this being raised by the Association.
- 9.3 Where matters are allocated for an inspector response, the Association has serious concerns about the timeliness of the responses. We appreciate that this may relate to broader systems issues including a lack of trained inspectors, rather than to any individual inspector, but often when we call to follow up who a job has been allocated to, we are finding it is still sitting in a team queue well after the timelines for visits to be conducted as outlined in the Customer Service Standards.

Unfamiliarity with the Healthcare Sector/lack of specialty staff

10. Current structures within SafeWork NSW has seen a dilution of skills in specialist areas. Some years ago, a decision was made to move away from industry sector teams. Except for the construction industry, which has a specialist team, all other industries are covered by generalist inspectors who could be in a manufacturing site one day and a hospital the next.
 - 10.1 The healthcare sector employs the largest number of workers in NSW³ and has the largest total number of serious injuries of any industry and second highest frequency rate of serious injuries (serious injuries per million hours worked).⁴ Yet there is no healthcare sector team.
 - 10.2 Healthcare is a highly specialist and complex area, and it is essential that SafeWork NSW Inspectors have expertise and competence in the industries

³ <https://www.business.nsw.gov.au/industry-sectors/why-sydney-and-nsw/skilled-workforce/employed-persons-by-industry>

⁴ https://www.safeworkaustralia.gov.au/sites/default/files/2023-01/key_whs_stats_2022_17jan2023.pdf

that they receive notifications and complaints about, and in which they conduct inspections and investigations.

- 10.3 It is the experience of the Association that there are rarely adequate responses from inspectors when issues are notified unless we provide them with additional required information and guidance on what NSW Health or other PCBU's operating framework is.
- 10.4 It appears that inspectors are discouraged from seeking relevant information from people who may have appropriate expertise such as unions. The Association has a highly qualified and experienced team of WHS Professional officers who can provide relevant advice and assistance.
- 10.5 The Association is observing inspectors attend health premises where there are clear breaches of the WHS legislation without issuing an Improvement or Prohibition Notice. Some inspectors are instead opting to just talk to the PCBU and reach an informal agreement for the PCBU to 'fix' or resolve the WHS issue/s. This failure to issue Notices leave issues unresolved and without proper processes in place to ensure the work has been undertaken. It undermines the WHS framework in place in those organisations where similar workplace risks could be occurring across other premises of the PCBU. It also negatively impacts on ensuring appropriate due diligence information is available to the officers of the PCBU.
- 10.4 There appears to be a significant gap in understanding about the application of the Primary duty of care (s19) and its application to "other persons" not being put at risk from the work carried out as part of the conduct of the business or undertaking.

Almost weekly the Association learns from our members of patient on patient assaults (including sexual assaults) that occur in the health care sector as well as the unfortunate incident of patient suicides. The Association is unaware of any action of the Regulator to ensure PCBU's are meeting their duties to notify these incidents as per the WHS Act 2011. It should be noted that many of these matters also raise a significant risk of psychological injury from those nurses and midwives who are providing care for these individuals.

Recently Worksafe Victoria charged a health service [REDACTED] after a patient died [REDACTED] while undergoing treatment in the hospital's acute mental unit in 2015. The matter was listed for a filing hearing at the Melbourne Magistrates' Court on [REDACTED]

11. Examples of poor responses from SafeWork NSW inspectors

- 11.1 [REDACTED] was a [REDACTED] nurse who was killed by a patient on [REDACTED] 11/2019 when attending a home visit. Association officers notified SafeWork NSW within an hour of [REDACTED] death. No inspector attended the site of the fatality. The matter was not referred by the

inspector to the IDMP process and so there was never a full investigation conducted into this fatality.

Members report that there has been little change in work practices since this time and that they remain at significant risk. A further serious near miss involving a worker in the same [REDACTED] mental health team occurred on the [REDACTED] 2/23 where a nurse was [REDACTED]

11.2 [REDACTED] nurse working at [REDACTED] hospital where he died on [REDACTED] 4/2020 during an altercation with a patient. The matter was not referred by the inspector to the IDMP process and so there was never a full investigation conducted into this fatality.

11.3 [REDACTED] - The Association contacted SafeWork NSW on 5 February 2022 following a number of serious incidents at [REDACTED] including one where a [REDACTED] nurse was [REDACTED] and another where the emergency department was affected patient and the 2 nurses on shift were [REDACTED] waiting for police to respond.

An inspector from SafeWork NSW attended the site on a couple of occasions but issued no notices and took no enforcement action, leaving members at risk and feeling very unsupported. WHS officers from the Association attended the site and wrote a lengthy report in relation to identified WHS issues, and from here the PCBU created an 82-point WHS action plan to address the identified issues. The Association has been continuing to work with the PCBU on addressing these issues.

11.4 [REDACTED] - The Association contacted SafeWork NSW in October 2022 in relation to duress alarms that were not functioning properly in the emergency department. A central aspect of the notification was that management were advising nurses that the duress alarms were fixed, only for workers to discover that they were non-functional whilst trying to activate them during an emergency. Staff therefore had no faith in the process being undertaken to review duress alarm functionality, and no faith in management's assurances which had proven unreliable on multiple occasions. An inspector attended the site and spoke with the manager and on that basis assured himself that an issue with the duress alarms had been fixed. He did not speak to workers; and nor did he ask to test the alarms.

[REDACTED]

11.5 [REDACTED] contacted SafeWork NSW in approximately June 2022 in relation to psychological hazards, particularly work

overload and fatigue. Initially [REDACTED] sent concerns about the risks via the SafeWork SpeakUp App, however received no response or contact from SafeWork NSW. Then a group of staff each sent through a request and the matter was assigned to an inspector for response. The inspector visited the site on multiple occasions, conducted detailed interviews with workers and met with the PCBU. He indicated to Association officers that there were significant staffing issues at the site and that these posed a risk to staff psychological health but said there wasn't really anything he could do about it. Association staff pointed out the various actions that could be taken. No notices were issued. In December 2022 one of the members that had spoken with the inspector died [REDACTED]. The Association has now raised a Request for Service with SafeWork NSW to review this matter.

11.6 [REDACTED] – workers at the [REDACTED] contacted SafeWork NSW in December 2022 following a serious assault on 2 nurses by a known high-risk patient. Both nurses [REDACTED]. This is a site with an extensive history of assaults on nurses and is well known to SafeWork NSW. Inspectors attended the site and did not speak to the HSR despite obligations to notify HSRs of their attendance under the WHS Act. Further when an Association officer asked the inspector if he had spoken to HSRs he insisted that he had, even though he had not. No improvement notices or prohibition notices have been issued.

11.7 [REDACTED] – this is a site with a long history of serious injuries arising from violence and aggression. In early 2022 the unit was relocating to a new building. Prior to opening, the Association contacted SafeWork NSW as members had raised concerns about increased violence risk arising from the new site including poor line of sight and inadequate staffing. The inspector attending the site said he was new to the local office, and had just transferred from the construction team, but that he could identify the concerns that were being raised. The following day the inspector returned to the site with his manager, who stated that as there were no workers working in the new unit yet that the inspector could not take any action. He also asserted that occupational violence in a health context is a clinical issue and not a work health and safety issue. Accordingly, risks that had been identified by nurses were not addressed.

Following the unit opening a series of assaults on nurses occurred. Further WHS concerns were identified by nurses including staff being instructed to work in the high risk observation area alone, failures of the duress alarm systems, inadequate line of sight issues and sound proofing of the unit resulting in other staff being unable to hear screams for help from the high risk observation area. A HSR at the site issued a Provisional Improvement Notice (PIN) on 27 June 2022 to ensure staff were not working in isolation and for the duress alarms to be fixed.

The employer sought a review from SafeWork NSW with an inspector attending the site and cancelling the PIN. At no time following the cancellation of the PIN did the inspector take any enforcement action to address the identified WHS risks including the psychological health risks. The PIN is currently the subject of an external review process before the NSW Industrial Relations Commission,, and more than a year after the initial concerns were raised and almost 9 months after the HSR issued the PIN, the WHS issues at this workplace are unresolved. It is worth noting that the HSR who issued the PIN was [REDACTED] in this subsequent period – [REDACTED] was working in isolation in the high risk observation area, [REDACTED] duress alarm did not activate and no one could hear her cries for help.

- 11.8 [REDACTED] – in mid-2022, a member contacted SafeWork NSW after being assaulted by a resident at the residential aged care facility. The member raised concerns exposure to occupational violence and lack of appropriate personal protective equipment. The inspector attended the site [REDACTED] 7.22 and failed to speak to any of the workers involved. They took no action to address the issue of occupational violence or on the failure of the PCBU to comply with WHS Regulation 2017 Clause 44 Provision to workers and use of PPE to ensure the P2/N95 masks being worn had been fit tested in accordance with manufacturer specifications.
- 11.9 [REDACTED] – a patient with a known history of extremely challenging behaviours was admitted to the small medical facility. Nurses raised concerns about the appropriateness of the admission given the size and resources of the site, (no security and often only 3 nurses on duty), however those concerns were not addressed. Following admission, the patient has assaulted and abused staff many times. The Association contacted SafeWork NSW and the allocated inspector advised that “he works a bit differently to other inspectors” and may be able to address the issues with a few calls as he “has a contact in NNSWLHD”. The inspector attended the site [REDACTED] 2/23 and spoke to management and did not engage with workers. The Association is currently actioning this lack of consultation with workers at the site. The Association noted to the inspector that if he found a breach of the policies and procedures for the site then he is compelled to issue Notices, however he has not done so. The patient remains in the facility and continues to assault and abuse staff.
- 11.10 [REDACTED] – On 14 November 2022, the Association contacted SafeWork NSW in relation to a serious incident involving bullying, sexual harassment and racial discrimination of a member. On 18 November 2022 an inspector emailed to confirm receipt of the matter, before going on leave until 1 December 2022. In December, the inspector advised that he would be issuing a Section 155 Notice for documents and information from the PCBU, however that SafeWork could not action issues relating to discrimination. The Association noted that this is not correct as discrimination is a psychosocial risk and contained in the Code of Practice. No further contact was made from the inspector until 25 January 2023 advising the s155 Notice was due 27/1/23. On

13 February the inspector advised the he was still reviewing the documents and would then return to the workplace to discuss the information.

On 28 February 2023 the inspector advised that he had identified some compliance issues with the 'Code of practice – Managing psychosocial hazards at work' and had raised those issues with the PCBU. He said the PCBU said that they did in fact have systems in place to address those identified gaps of compliance. The inspector said that he relayed to the PCBU that his s155 Notice had sought the evidence required to assess compliance, however the PCBU said that they had not read the s155 Notice in that way. The Inspector advised the Association that he was about to go on a couple of week's leave and would review compliance of those matters on his return and issue a Notice if compliance was not in place.

The inspector's delays and poor decision-making has a serious impact on WHS at the site. In accordance with the Regulator's functions, the inspector should have actioned either a Penalty Infringement Notice for non-compliance with a s155 Notice or he should have issued an Improvement Notice for the gaps in WHS compliance he had identified. The inspector commented to the Association that it is very "difficult" for PCBU's to identify what compliance looks like with regard to psychological risks.

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12. The Association has been in regular contact with SafeWork NSW since the commencement of the COVID-19 pandemic in 2020 to discuss concerns about the lack of suitable controls for managing risks associated with COVID-19 outbreaks, particularly in residential aged care.

To date, the response from SafeWork NSW, (both from individual inspectors and from the organisation as a whole) has been entirely inadequate and continues to leave workers and others (particularly vulnerable residents) at significant risk.

- 12.1 ████████████████████ - The COVID-19 outbreak at ████████████████████ lasted from 11/4/2020 until 15/6/2020. By the end of the outbreak, 37 residents and 34 staff members had tested positive for COVID-19, and 19 residents had died, a mortality rate of 46% of the COVID-19 positive residents in the facility.

- 12.2 Association members contacted the union early on noting their fears of infection, and risks to residents. Members felt they were not adequately protected nor trained to deal with the unfolding incident. On 30 April 2020– the Association contacted SafeWork NSW in relation to risk to the safety of workers at ████████████████████ due to inadequate infection prevention and control measures and inadequate training.

- 12.3 On 1 May 2020 the Association was advised that SafeWork NSW had provided an "administrative response" regarding the WHS issues. Association officers

strongly objected to the suitability of an “administrative” response in light of the large number of infections and resident deaths at the facility. The Association asked for an escalation of the matter internally and for an inspector to be appointed.

- 12.4 A SafeWork NSW inspector was appointed – the Association reiterated concerns around the lack of suitable infection prevention and control measures in place at the facility.
- 12.5 On 4/6/2020 a SafeWork NSW Inspector confirmed that SafeWork had not attended the site as they had determined that the risk to their inspectors was too great. Rather they had made inquiries, which involved speaking to three managers (no workers) and reviewing documents. Following these inquiries, it was determined that SafeWork NSW did not propose to take any further action in relation to [REDACTED].
- 12.6 The Association believes that this lack of action represents a serious dereliction of the responsibilities of SafeWork NSW in their regulatory role, which continues to this day.

Recommendations:

14. That SafeWork NSW reinstitute specialist industry teams for industries with the highest harms (including healthcare and social assistance) to ensure that inspectors have the required industry knowledge to apply appropriate compliance and enforcement functions.
15. That a review is undertaken of inspector training.
16. That SafeWork inspectors be required to demonstrate that they have consulted with HSRs or with local union delegates when they attend worksites.
17. That SafeWork inspectors be required to consult with relevant unions with specialist knowledge of industries/sectors before attending worksites.
18. That inspectors be required to provide regular updates to the notifier of the issue about what regulatory and enforcement actions are occurring at the site.
19. That a review be undertaken of the capability of managers providing oversight to inspectors as it appears that many matters concluded have not appropriately addressed the WHS matters identified at the site.
20. That inspectors be required to issue notices where breaches of the legislation are identified.
21. That appropriate penalties are applied for failure to notify notifiable incidents and failure to display improvement or prohibition notices as required under the WHS Act.
22. Reinstigate penalty infringement notice powers for inspectors to issue fines.

SafeWork Organisational Response to COVID-19 in residential aged care

13. In addition to raising concerns about individual residential aged care providers, the Association has been engaging with SafeWork NSW since the commencement of the COVID-19 pandemic over concerns relating to the inadequate provision of personal protective equipment (PPE) for residential aged care workers in NSW, in particular the failure of employers to fit test workers requiring P2/N95 respirators.
 - 13.1 P2/N95 masks are disposable masks that work by providing an air-tight seal to protect the wearer against airborne particles, (such as COVID-19 or asbestos fibres). Manufacturers specify that the masks must be fit tested as required by Australian New Zealand Standard AS/NZS1715 before a user wears the respirator in the workplace. It is only through fit testing that the wearer can be assured that the make and model of the mask is able to form an airtight seal, and to do the job it is intended to do.
 - 13.2 Fit testing is conducted to verify the size/ make and model of respirator (P2/N95) provides the wearer with the expected protection. It must be undertaken for all workers required to wear a P2/N95. Fit testing ensures a seal occurs around the face resulting in air passing through the filter. Air will take the path of least resistance, so if the seal isn't there, the air will go around rather than through the respirator – and therefore lessen the protection.
 - 11.3 Fit testing of nurses occurs in hospital settings but has not been widely implemented in residential aged care, where the risk to workers and to vulnerable residents is extremely high, and where there has been significant numbers of COVID-19 outbreaks and subsequent worker and resident infections and resident deaths.
 - 11.4 Most employers in the sector are non-compliant with both the Australian Standard (mentioned above) and the WHS Regulation 2017 Clause 44 which requires that PPE is *selected to minimise risk to health and safety, including by ensuring that the equipment is—*
 - (i) *suitable having regard to the nature of the work and any hazard associated with the work, and*
 - (ii) *a suitable size and fit and reasonably comfortable for the worker who is to use or wear it,*
 - 11.5 The Association has made repeated representations to SafeWork NSW on these breaches occurring in the NSW residential aged care sector and to date SafeWork NSW has not taken any regulatory action to address this shortfall. We have requested that enforcement action be taken and that a “safety alert” be issued to the industry outlining PPE requirements (including fit testing of P2/N95 respirators). None of these actions have occurred.
 - 11.6 The Association notes that the SafeWork NSW website contains information about the requirements for fit testing across the construction sector including as

follows: <https://www.safework.nsw.gov.au/hazards-a-z/asbestos/asbestos-workers-and-removalists/fit-testing-and-personal-protective-equipment-ppe>

This construction advice is readily available (and so it should be), however it is difficult to understand how SafeWork NSW recognises the risks of airborne contaminants for construction workers yet appears to ignore airborne risks for workers in the aged care sector.

- 11.7 The WHS Act 2011 requires that employers must do what is reasonably practicable to eliminate or mitigate WHS risks to their workers. In recent advice the Australian Government Department of Health and Aged Care have provided guidance material to the aged care sector noting the requirements for fit testing where P2/N95 masks are being used and noted that it is the role of the state WHS regulator to enforce this safety requirement. The NSW WHS regulator has not taken any actions to enforce these reasonably practicable measures.
- 11.8 In latter months of 2022, the weekly statistics from the Australian Government Department of Health and Aged Care reflected over 2000 workers in the aged care sector were being infected weekly with COVID-19 in NSW.
- 11.9 It is incomprehensible that the state WHS regulator has taken no enforcement action to date in response to these numbers. New figures also show more than 1000 COVID-related deaths were recorded in Australia in the first month of 2023.
- 11.10 In 2022 the Association was liaising with various aged care providers and as a result of our intervention we note that a small number of providers have now put fit testing procedures in place, yet many larger providers have not. The failure of SafeWork NSW to regulate this safety hazard in aged care is creating an unfair, unsafe and unbalanced sector.
- 11.11 On 22/4/22 the Association wrote to SafeWork NSW in response to extremely high rates of worker infection with COVID-19 within the aged care sector to request that SafeWork undertake enforcement visits, to ensure that employers were taking reasonably practicable measures including providing appropriate and properly fitting personal protective equipment (PPE).

The Association's correspondence pointed out that RACFs had been provided documented advice by both the Department of Health and the Aged Care Quality and Safety Commission (ACQSC) detailing the requirements for infection control including requirements for fit-testing, and as such, by not implementing those actions the RACFs were in breach of the WHS Act 2011.

SafeWork NSW declined to take any action at that time instead advising the Association to highlight specific RACFs of concern in NSW.

Since that time the Association has regularly written to SafeWork NSW outlining specific sites of concern, however, SafeWork NSW has not taken any regulatory action in response to those notifications.

By comparison, the Association notes that in 2021 and in 2022 safety regulators in Victoria and in Queensland have taken action on COVID-19 in residential aged care, including the Victorian WHS regulator WorkSafe commencing prosecution action against both the Victorian Government and RACFs in relation to failures to manage the risks of COVID-19 in workplaces, including failures with fit-testing of PPE. To the point that we now have some large providers who fit test their staff in Victoria and Queensland but not in NSW.

It is astounding that SafeWork NSW have failed to take any regulatory compliance actions or industry education around this issue. This failure to regulate is directly contributing to the continuing infections of both residents and workers.

With the continued experience of the failures of SafeWork NSW to regulate the COVID-19 response in aged care sector, the Association wrote to the Minister of Customer Service Mr Victor Dominello on 16 January 2023 to raise our serious WHS concerns. At the time of placing this submission the Association has yet to receive a response from the Minister.

11.12 The WHS issues arising from COVID-19 are continuing and impact our members each and every day. In late 2022 the Association lost its first member, a registered nurse, to COVID-19, and that matter is currently before the regulator.

11.13 Following repeated requests for SafeWork to undertake an enforcement program relating to the requirement for aged care facilities to fit-test P2/N95 masks, the Regulator agreed to do so last year and has now commenced those visits.

In a meeting on 14/2/23, SafeWork reported that the aged care facilities fit testing project was about halfway through its aim of visiting 20 sites. SafeWork stated that none of the sites visited had fit testing procedures, however no Improvement Notices or other regulatory action had taken place. SafeWork stated that as a result of the inspector/s raising an awareness of fit testing, three of the ten sites visited had now *agreed* to implement fit testing procedures. The Association noted our disbelief that Regulator had still not issued any notices to require aged care providers to comply with the legislation as a Regulator should do when they observe a breach of the WHS legislation.

Recommendations:

23. Reviewer to assess the response of SafeWork NSW in relation to COVID-19 to identify why the regulator has failed to provide proper enforcement and compliance across the sector including the failure to ensure fit testing has occurred.
24. Reviewer to assess why SafeWork NSW has a different attitude to the PPE in health versus construction.
25. Establish tripartite arrangements including SafeWork NSW, worker representatives, employer representatives and academics across priority high risk industries (such as healthcare and social assistance).

The effectiveness of SafeWork NSW in investigations

12. The Association has numerous concerns about the effectiveness of SafeWork NSW in investigations, as well as in relation to the IDMP process.
 - 12.1 It is important to note that there are 2 different activities that may be considered as investigations processes, firstly the inquiries made by the initial inspector allocated to the matter, and secondly the “full” investigations that take place under certain circumstances to determine if a prosecution may occur. Both of these will be discussed.
 - 12.2 Full investigations occur if the initial inspector considers that there was adequate evidence to suggest a serious breach, in which case they refer the matter to the IDMP for review and if the matter is accepted by the IDMP then it is allocated for investigation.
 - 12.3 There are several issues with this process as follows:
 1. the lack of skills and knowledge of inspectors responding to issues means that many inspectors fail to accurately identify the issues and do not put forward issues to the IDMP for full investigation.
 2. The IDMP is made up of managers and directors of SafeWork NSW, some of whom have a limited understanding of the WHS legislation, (for examples of limited understanding of manager/directors please see notes under culture of Safework).
 3. Investigating inspectors have varying skills and attitudes.
 - 12.4 In the same way that there are significant differences to outcomes based on the initial inspector who is allocated the issue. It is the experience of the Association that there are significant differences to outcomes based on the investigating inspector, particularly when it comes to their knowledge of the industry and their attitudes towards workers and their representatives.

- 12.5 SafeWork NSW inspectors must respect that workers and their representatives hold specialty knowledge about their industries and the hazards and risks in those industries. Inspectors that do not consult with workers and their unions receive one-sided information and are unable to confirm or corroborate that they are in fact being told the truth by the PCBU.
- 12.6 There is a lack of transparency around investigations processes. SafeWork NSW must ensure that the notifier of the issue, injured workers and their representatives are kept advised of the progress of investigations as well as why decisions are made about whether or not matters will progress to prosecution.

Psychosocial hazards

- 12.7 In addition to the IDMP process, SafeWork NSW has a further process when it comes to determining whether they will investigate issues arising from psychosocial hazards. This two-tiered approach to determining if psychosocial hazards will be investigated as opposed to physical hazards has resulted in no prosecutions of issues relating to failure to manage psychosocial hazards, despite this being a “priority” area for SafeWork NSW.
- 12.8 On 6/22 the Association contacted SafeWork NSW in relation to a [REDACTED] employed in [REDACTED] who had been assaulted by [REDACTED]. The [REDACTED] had reported the matter internally and her employer had failed to respond. Following contact from the Association, the employer undertook an investigation however the member then experienced adverse treatment for raising her concerns (discriminatory conduct for a prohibited reason) – as per Part 6 Discriminatory, coercive or misleading conduct in the WHS Act 2011.

The inspector assigned this matter issued an Improvement Notice and submitted the issue to the IDMP for investigation, but had the matter returned to him with a request for further information. The inspector contacted the member to make an IMPACT STATEMENT for the IDMP. This is highly inappropriate, as this is only relevant for a judge to consider in determining the seriousness of an offence for the purpose of sentencing. It has nothing to do with whether or not a provision of the Act has been breached. This seems to suggest that an employer can breach their WHS duties so long as no one is too upset about it.

- 12.9 As mentioned earlier, SafeWork NSW applies an extra layer of review for psychosocial matters requiring the Psychological Health Team to do a review of the evidence in these types of matters before it can progress to the IDMP. That secondary level review has just occurred with this matter and the Association understands it is now progressing (in February 2023) to the IDMP process for their decision making.

Recommendations:

26. Ensure that those on the IDMP have the appropriate knowledge and understanding of the legislation to assess the suitability of matters for investigation.
27. Ensure there is a process of appeal for inspectors who are dissatisfied with the decisions of the IDMP.
28. SafeWork NSW must provide relevant information to the notifier of the issue in relation to the rationale for the decision reached by the IDMP.
29. Evaluation is needed of how matters are progressing under this new framework compared to the old system where the initial inspector allocated to the matter would see the entire process through from initial workplace response through investigation to prosecution.
30. Investigations must include discussion with relevant unions.
31. SafeWork must provide regular updates on the progress of the investigation to the notifier, relevant union and injured workers.

SafeWork NSW response to notifiable incidents

13. The Association believes the response from SafeWork NSW to notifiable incidents is concerning and warrants close scrutiny. In 2022 questions were asked during NSW Senate Budget Estimates about SafeWork's response to notifiable incidents with answers as follows:
 - In 2020/2021 SafeWork NSW inspectors visited sites in response to 1363 out of 7213 notifiable incidents.
 - In 2021/2022 SafeWork NSW Inspectors visited sites in response to 1,151 of 31,084 notifiable incidents.
 - In 2022 (up to the time of budget estimates) Safework NSW inspectors had visited sites in response to only 937 or 20,743 notifiable incidents.
- 13.1 These figures are alarming and represent a major risk to the workers of NSW. SafeWork NSW often states that their responses to matters includes a broad array of activities such as letters, telephone calls to PCBUs etc, however none of these actions provide the opportunity to identify core issues and barriers impacting safe work activities, or the opportunity to speak to workers and HSRs that a site visit can provide.
14. The Association holds significant concerns about SafeWork NSW's response to the horrific death of ██████████ in 2019. ██████████ was killed ██████████ when on duty working as a Community Mental Health

██████ for ██████████. ██████████ was visiting the patient in his home when he was killed. The Association is concerned that SafeWork NSW did not send an inspector to the site of the fatality. In order to understand whether systems of work are adequate to ensure the safety of workers it is vital that SafeWork NSW understand the context and location in which these systems are intended to function, which is not possible without attendance at the site.

Recommendations:

32. All notifiable incidents must receive an inspector response.
33. Inspectors responding to notifiable incidents must attend the site where the incident occurred.

The effectiveness of SafeWork NSW in prosecutions

15. The lack of enforcement action within our sector is of grave concern to the NSW Nurses and Midwives Association, and this is communicated regularly to SafeWork NSW. There have been no prosecutions of a health agency in relation to occupational violence since 2007, despite at least 3 nurses killed by patients in incidents of occupational violence in that time, and serious injuries being sustained by nurses every week.
 - 15.1 A review of the prosecution information on the SafeWork NSW website shows that the focus of SafeWork NSW is almost entirely on blue collar industries. There have been no prosecutions of a health agency in the 6 years of prosecutions reported on the SafeWork NSW website, despite health having the largest number of serious injuries of any sector, nor have there been any that relate to psychosocial hazards despite this being the area with the largest increase in claims.
 - 15.2 SafeWork must be capable of taking enforcement action across all high-risk sectors including healthcare, and in relation to all high-risk harms including psychosocial.
 - 15.3 SafeWork NSW Prosecution guidelines state that *When undertaking a full investigation in response to a work-related death, SafeWork NSW will engage an independent expert to provide a report on causation and/or what was “reasonably practicable”, prior to making its enforcement decision.* To the best knowledge of the Association none of the 3 fatalities of nurses killed by patients in recent years nor the death of a nurse from COVID-19 has gone through a full investigation process, nor has an independent expert been engaged.

Recommendations:

34. Prosecutions cannot be confined to construction and must be undertaken in other high-risk industries including healthcare
35. Prosecutions must address new and emerging hazards including psychosocial
36. Safework NSW prosecutions must give effect to the SafeWork NSW prosecution policy including giving priority to target industries and hazards and serious injury types and fatalities.

The performance and effectiveness of SafeWork NSW's educational functions

16. The educational focus within SafeWork appears to be almost entirely directed at PCBU's / employers, with much of the education for PCBU's/employers attached to financial rebates. It is unclear if SafeWork NSW has undertaken any sort of robust assessment to ensure that the money being spent on safety rebates is improving WHS outcomes for workers.

16.1 Safework is not providing targeted education for workers and their representatives.

Health and Safety Representative Training

17. Health and Safety representatives are entitled to attend 5 days of SafeWork NSW approved training under the WHS Act. SafeWork NSW does not run this training, but rather approves external organisations and trainers to run the 5-day HSR training.

17.1 Despite the Association being a SafeWork approved training provider of HSR training, and working closely to support HSRs in their workplaces, the Association has never been consulted about the contents or appropriateness of the training (though we recently received revised course materials).

Other education for HSRs

17.2 Health & Safety representatives have a critical role to play in improving workplace safety. As workers in the workplace they have an in-depth understanding of the nature of the hazards and risks that exist in their workplaces as well as the control measures required to eliminate or minimise the risks. Additionally, as they are a part of the workplace, they can see whether actions are being taken or not and whether these actions are addressing the risk.

17.3 SafeWork NSW is failing to appropriately recognise the role of HSR in NSW workplaces and to provide support to HSRs as an important stakeholder. Resources on the SafeWork NSW website are oriented to employers, and there is no specific information or support provided to HSRs.

17.4 If you look hard enough you can find a series of 5 videos that purport to be for HSRs, (*This series of five webinar modules is designed to provide Health and Safety Representatives (HSRs) with an understanding of their role in the workplace*), however upon viewing it is clear:

- That the intended audience is employers; and
- That they were created some time ago (the presenter has been working in Queensland for the last 3 years, so they are older than that).

17.5 There is no specific section on the SafeWork NSW website with information for HSRs, there are no webinars or newsletters targeting HSRs and there is no HSR conference run as exists in other states. On one occasion (in 2017) SafeWork NSW ran a “consultation conference”, this conference did not target HSRs and the vast majority in attendance were employer representatives

17.6 The NSWNMA has previously attempted to seek information from SafeWork NSW about the numbers of HSRs within the healthcare sector, but no information could be provided as it appears there is little effort made to maintain a central list of HSRs or to look at where they are from. The WHS legislation provides for employers to notify SW of HSRs elected at their sites, but no one from the Regulator is enforcing or ensuring this is occurring. SafeWork NSW appears to have largely abandoned HSRs.

Recommendations:

37. SafeWork NSW should consult with Unions about education, tools and resources for HSRs
38. SafeWork NSW should have a dedicated section of its website containing information and resources for HSRs
39. SafeWork NSW should fund an annual HSR conference to be run by (or in conjunction with) NSW Unions.
40. SafeWork NSW should review the effectiveness of safety rebates provided to employers for attending SafeWork NSW training to determine whether this program is improving safety outcomes for workers in NSW.

The governance and culture of SafeWork NSW, including complaints as to alleged unlawful or undesirable conduct in the workplace.

18. The Association believes the overall governance of SafeWork NSW is poor and much of the expertise in governance has been lost when the WHS Regulator moved into the Department of Customer Service (DCS).
- 18.1 Within DCS, SafeWork NSW regulatory functions now sit within the Better Regulation Division (BRD) operating alongside other agencies including Fair Trading, Consumer Protection, and Building and Construction. These agencies have very little in common with the functions and inherent requirements of SafeWork NSW.
- 18.2 An active Board once oversaw the operations of the previous version of SafeWork NSW, WorkCover NSW, however with the move initially into the Department of Finance & Innovation and then DCS, executive oversight of SafeWork NSW is now via the Deputy Secretary Natasha Mann, who regularly confuses SafeWork NSW with Fair Trading, as is evident in her evidence to NSW Senate Budget Estimates in the last 12 months.

Please see the following extract from Senate Budget Estimates records:

How many requests for service has SafeWork received in relation to unsafe COVID WHS practices in Aged Care facilities or retirement villages?

SafeWork NSW received 53 requests for service (RFS) related to COVID-19 in residential aged care between January 2020 and June 2022 and 4 relating to COVID-19 in retirement villages.

How many notifiable incidents has SafeWork received in relation to unsafe COVID WHS practices in Aged Care facilities or retirement villages?

Aged Care: 104 workplace incidents and Retirement Villages: 8 workplace incidents.

How many of the desktop inspections undertaken by SafeWork into Aged Care facilities or retirement villages referred to at Budget Estimates were undertaken by SafeWork personnel?

The desktop inspections initially referred to at the Budget Estimates Hearing on 7 September 2022 related to Retirement Village inspections undertaken by NSW Fair Trading only. These inspections related to compliance with the Retirement Villages Act 1999. Further information provided at the Hearing was in relation to Aged Care facilities only.

How many of the desktop inspections undertaken by the Department of Customer Services referred to at Budget Estimates were solely looking at Covid WHS requirements such as PPE requirements for Aged Care facilities or retirement villages?

4.

- 18.3 The location of SafeWork NSW within the BRD has also seen SafeWork NSW represented at important national forums such as SafeWork Australia and the SafeWork Australia WHS SIG by people who work for Fair Trading and have never worked in and have no knowledge or expertise in WHS.
- 18.4 SafeWork's location in BRD in DCS is directly contributing to the inadequate WHS outcomes in NSW. SafeWork NSW should be a standalone Regulator. The Regulator should not be operating across different Divisions within a monolith Department.
- 18.5 It is notable that SafeWork NSW also used to produce annual reports that outlined their performance and work over the financial year and included information about future direction. That annual reporting ceased in 2018 and nothing has replaced it. The lack of transparency requires immediate attention.
- 18.6 The position of SafeWork NSW within DCS leaves it highly vulnerable to interference by NSW Government agencies. The NSW Government is the largest employer in NSW and workers employed by government agencies are entitled to expect the same rights to a safe and healthy workplace as any other workers.
- 18.7 The Association notes that when the Better Regulation Division was created it initially included the Liquor and Gambling regulator. We note with interest that the Liquor and Gambling regulator is no longer part of the Better Regulation Division due to concerns about government interference.

We draw attention to the Casino Inquiry Report p622 #27:

'The structure and powers of a Regulator are pivotal to its effectiveness. Clearly if a Regulator may be seen to be amenable to manipulation by government or political intrusion, its reputation will be compromised. It is imperative to ensure not only that it is independent but also that it is perceived to be independent to enable the Regulator to garner the respect necessary for its effectiveness'.

In order to address similar concerns with SafeWork NSW, the Association strongly believes that SafeWork NSW must be moved out of DCS to become a stand-alone regulator.

Unwillingness to address issues within the public sector

19. Despite high rates of injuries among government sector workers, SafeWork NSW appears unwilling to address serious WHS issues faced by NSW public sector workers.

19.1 As part of the SafeWork NSW Roadmap, the NSW public service was identified as a high-risk area requiring a specific plan to address injury rates in the public service. The Government Sector Plan was developed without a tripartite process, with employers and unions “consulted” separately rather than there being any attempt to bring stakeholders together to reach consensus on the issues faced by public sector workers or the appropriate focus for the plan.

19.2 The plan was developed in 2017 and largely consisted of an audit process, where government agencies were first to conduct internal audits before moving to an external audit process where agencies would audit each other. There has been a total lack of transparency and reporting around this process, however it appears that the plan was quickly shut down by the government agency employers and that the external audits never occurred.

Unions have not been consulted or provided with any information about what is happening with the government sector plan since the end of 2018.

19.3 Public sector employers are not subject to the same regulatory activity as other sectors despite the large numbers of serious injuries sustained by public sector workers.

19.3.1 SafeWork NSW publishes information about factors taken into account in determining whether a prosecution should proceed, which theoretically apply to all employers. However, SafeWork approaches the prospect of prosecution of public sector agencies differently than other employers.

19.3.2 Before any prosecution of a government agency, additional discussions are held between departmental secretaries to attempt to resolve matters without prosecution. This course of action arises from the Premier’s Memorandum No. 97–26: “Litigation Involving Government Authorities” which is based on the general principle that *litigation between Government authorities is undesirable and should be avoided whenever possible*.

19.3.3 The result of this application of the memorandum is that public sector workers are afforded less protections than other workers, with public sector agencies aware that they are unlikely to face any significant consequences for their failures to meet WHS obligations.

19.4 Safework appear to be strongly influenced by other government departments including the Department of Health.

- 19.4.1 Early in 2020 at the onset of the pandemic, the Association raised the significant WHS issues facing our members who were on the frontline of response with SafeWork NSW. At this point we were seeing large numbers of healthcare workers die internationally. Our members were not vaccinated and had inadequate systems in place to ensure their safety at work, including entirely inadequate PPE. At this stage NSW Health was failing to acknowledge that COVID-19 was an airborne disease.
- 19.4.2 The response from SafeWork NSW was that “*NSW Health are the lead agency*” in the response to the pandemic. This response demonstrates a failure of the regulator to consider their important role in ensuring the safety of healthcare workers during the pandemic.
- 19.4.3 Inspectors in SafeWork NSW were given authority to enforce public health orders when they should have been focusing on work health and safety.
- 19.4.4 The Association was advised that SafeWork had in fact sent SafeWork inspectors to work directly with NSW Health at the Ministry of Health in response to the pandemic. The Association believes that this was inappropriate and has resulted in NSW Health having undue influence over SafeWork NSW.

Expertise of Directors and senior managers

20. SafeWork NSW has appointed a number of Directors and senior managers who do not appear to have undertaken appropriate training to ensure that they have an adequate understanding of the WHS legislative framework and yet are making significant decisions about the operations of the organisation. Some examples of incorrect information provided by senior employees of SafeWork NSW are provided below:
- 20.1 When the Association raised concerns about no inspector attending the site of the fatality of [REDACTED], we were advised that this was because the incident occurred in the patient’s residence not a workplace. This is entirely incorrect as s8 (1) of the WHS Act 2011 defines a workplace as *a place where work is carried out for a business or undertaking and includes any place where a worker goes, or is likely to be, while at work.*
- 20.2 When the Association raised concerns about the handling of [REDACTED] death and were advised it was “really a police matter more than a Safework NSW matter”. This is incorrect. The police have a role in charging the person who committed the act, they do not look at whether the PCBU has adequate safe systems of work in place to ensure the safety of workers, this is the function of the regulator.
- 20.3 When the Association raised concerns about SafeWork entering into an Enforceable undertaking (EU) with a LHD rather than proceeding with a

prosecution, we were advised that an EU was an admission of guilt. This is incorrect, s216 (3) states *the giving of a WHS undertaking does not constitute an admission of guilt by the person giving it in relation to the contravention or alleged contravention to which the undertaking relates.*

20.4 In discussing the conduct of employers taking adverse action against a worker for raising a WHS issue, the comment was made that it was unfortunate that Improvement Notices for discriminatory conduct could not be issued. That statement is incorrect, and this was pointed out during the conversation. It is gravely concerning that a member of the SafeWork NSW Executive does not have an understanding on the capability of SafeWork's regulatory action for responding to discriminatory action

20.5 These examples are not mere differences of opinion but are factually incorrect. It is essential that Directors and Managers within SafeWork NSW have an appropriate level of knowledge and understanding as these are the individuals within the organisation leading the regulatory framework in NSW and sitting on the IDMP and so it essential that they have a robust understanding of the law and be aware of the scope of SafeWork's capability.

Recommendations:

41. SafeWork NSW must be removed from the department of customer service and be made a stand-alone regulatory agency with appropriate board oversight including worker representatives.
42. Those representing NSW at SafeWork Australia must be from SafeWork NSW, and be WHS experts.
43. Senior leaders within SafeWork including managers and directors must complete appropriate training to ensure a comprehensive understanding of the WHS Act and the functions of the regulator.

Appropriate measures to ensure that workers and their representatives (including Health & Safety Representatives), and the families of injured and deceased workers, have a genuine voice in the complaints, investigation, and enforcement processes

- 21 SafeWork NSW must recognise workers and their representatives as having legitimate interests in safety. SafeWork NSW must recognise workers and their representatives as having knowledge and expertise of their industries, of safety and of the worksites. Reform must give effect to this.

SafeWork NSW conducts its inspections and investigations in the dark. SafeWork NSW permits no external visibility about the process or progress of its investigations. The bulk of its decision-making is without timely external transparency or oversight. SafeWork NSW does not welcome or invite the expertise of Health and Safety Representatives or Unions during investigations, notwithstanding both have significant interest in making workplaces safer.

21.1 SafeWork NSW inspectors must comply with their obligations under s164(2)(c) to notify Health and Safety Representatives of entry and this obligation under s164(2)(c) must be made enforceable.

21.2 SafeWork NSW should be compelled to notify Unions of their entry to workplaces. SafeWork NSW should be compelled to consult with Unions about complaints that they have received, and which have influenced their decision to enter a site.

21.3 SafeWork NSW inspectors should be required to speak to notifiers prior to attending worksites and to provide regular updates on regulatory activities.

21.4. SafeWork NSW inspectors should be required to provide copies of any inspection reports and notices issued in response to a workplace issue to the notifier, the relevant union and workplace HSRs.

22. SafeWork NSW must be compelled to notify Unions, workers who suffer serious injury or illness in a notifiable incident, or their families (particularly in the case of death), of the outcome of their investigations. Further, those Unions, workers, or their families, must be provided with sufficient information to enable them to understand any decision/s reached.

22.1 SafeWork NSW is currently opaque and unaccountable. The Regulator is avoidant of scrutiny, and so disguises and hides its activities. Work health and safety is too important to allow the Regulator to operate in the dark.

22.2 It is critical, if confidence is to be restored in the Regulator, that persons who have reasonable expectations to know and understand actions that were or were not taken and the reasons why are provided with that information. It is critical, for improving the performance of the Regulator, that its complaints, investigation and enforcement processes are so far as possible conducted 'in the light'.

23. The regulator must consult the relevant Union and any injured workers prior to agreeing to a PCBU entering into an enforceable undertaking. The views of the Union and the injured workers must be properly taken into account in making that decision.

23.1 Recently the regulator commenced a prosecution of a NSW Health employer in relation to occupational violence for the first time since 2007. In the incident 3 [REDACTED] had been stabbed [REDACTED]. The Association was the notifier of the incident. The regulator obtained documents from the Association's own investigation of the incident under its s155 powers.

Despite the Association being the notifier and Association members being the workers injured, SafeWork did not consult with the Association before agreeing to the employer entering into an enforceable undertaking, nor did they consult about the contents of the enforceable undertaking. Furthermore, while part of the EU involved the establishment of a committee with an allocated union position, the union named in the EU to participate in the committee was the Health Services Union not the NSW Nurses and Midwives Association, despite the fact that it was Association members who had been injured in the incident, the Association had been the notifier of the issue and the Association had undertaken the initial investigation.

24. SafeWork NSW has no formalised tripartite structures. The Association notes that the Model law provides for jurisdictions to determine local arrangements under Schedule 2 of the Model Act "*The regulator and local tripartite consultation arrangements and other local arrangements*", however NSW has not seen fit to include such arrangements.

24.1 Tripartite arrangements are required at a whole of organisational level as well as at an industry sector level.

Recommendations:

- 44. SafeWork NSW inspectors must advise HSRs of their entry to a workplace
- 45. SafeWork must advise unions of their intention to enter a workplace and consult with said unions

46. That SafeWork NSW policies and practices be reviewed to ensure that it does not adopt overly restrictive practices restricting the provision of information to relevant persons.
47. That the *Work Health and Safety Act 2011* (NSW) be amended to create a statutory obligation that SafeWork NSW notify Unions, workers who suffer serious injury or illness in a notifiable incident, or their families (particularly in the case of death), of the outcome of any investigation and provide to those workers or their families sufficient information to be able to understand the decision reached;
48. That SafeWork NSW be required to consult with Unions and injured workers prior to accepting an enforceable undertaking.
49. That SafeWork NSW be required to implement tripartite consultative forums at both an organisational level as well as at an industry level for high risk industries.

Conclusion

The Association is extremely concerned about the health and safety of nurses and midwives in NSW. Rates of injury in the sector are extremely high and are increasing at alarming rates. SafeWork Australia data for the last few years shows a steady climb in national figures from 19,505 serious injuries in 2020 to 26,239 serious injuries in 2022.

Self-regulation by industry is not working. We need an effective and competent safety regulator who understands the issues in the sector and is prepared to take enforcement and compliance action to ensure that the health and safety of nurses and midwives is not being sacrificed to keep our hospitals running. The issues in the sector are complex and systemic. To make real inroads into reducing injury rates will require all stakeholders to play their part, this means we need proper tripartite arrangements, specialty inspectors with a robust understanding of the sector and a fearless safety regulator independent from the influence of government.

The Association appreciates the opportunity to make a submission to this inquiry and would be happy to meet with the reviewer to provide any additional information required.



Submission to Independent Review of SafeWork NSW

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