Ombudsman
New South Wales

Formal investigations — summary report 2021–22: A summary of completed investigations under section 13 of the *Ombudsman Act 1974* for the period from 1 October 2021 to 30 September 2022

A special report under section 31 of the *Ombudsman Act 1974*

25 October 2022

ISBN: 978-1-922862-03-7

NSW Ombudsman
Level 24, 580 George Street
Sydney NSW 2000

Phone: (02) 9286 1000
Toll free (outside Sydney Metro Area): 1800 451 524

Website: ombo.nsw.gov.au
Email: info@ombo.nsw.gov.au

© State of New South Wales, 25 October 2022.

ABN 76 325 886 267
Level 24, 580 George Street, Sydney NSW 2000
T 02 9286 1000 **Tollfree** 1800 451 524
www.ombo.nsw.gov.au

Ombudsman
New South Wales

25 October 2022

The Hon Matthew Mason-Cox MLC
President
Legislative Council
Parliament House
SYDNEY NSW 2000

The Hon Jonathan O'Dea MP
Speaker
Legislative Assembly
Parliament House
SYDNEY NSW 2000

Dear Mr President and Mr Speaker

Formal investigations — summary report 2021–22

Pursuant to section 31 of the Ombudsman Act 1974, I am providing you with a report titled *Formal investigations — summary report 2021–22: A summary of completed investigations under section 13 of the Ombudsman Act 1974 for the period from 1 October 2021 to 30 September 2022.*

In accordance with section 31AA of the *Ombudsman Act 1974*, I recommend that this report be made public immediately.

Yours sincerely

Paul Miller
NSW Ombudsman

Table of Contents

About this report **2**
Confidentiality of investigations 2
Investigation reports 2
Special (public) reports relating to investigations 3
Annual summary reports 3
A residential out-of-home care service provider: Placement risk mitigation and response to a critical incident **4**
Background 4
What did we find? 4
What did we recommend? 5
City of Ryde Council: A resident's complaint about stormwater management requirements **6**
Background 6
What did we find? 7
What did we recommend? 7
Department of Communities and Justice (Housing) and NSW Land and Housing Corporation: Modifying public housing properties to meet the needs of tenants with disability **8**
Background 8
Why did we investigate? 8
The stories of the 3 public housing tenants 9
Mary Cole 9
Anne Bailey 9
William Kelly 9
What did we find? 9
What did we recommend? 10
SafeWork NSW: Complaints by a local council about asbestos enforcement actions **11**
Complaint 1 11
What did we find? 12
Complaint 2 12
What did we find? 12
Uncertainty around permissible ministerial control and direction over SafeWork's decision-making **13**

About this report

This special report contains a summary of formal investigations completed by the NSW Ombudsman in the last 12 months.

The Ombudsman may conduct a formal investigation into the conduct of a public authority or a community service provider if it appears to the Ombudsman that the conduct, or any part of it, may be:

- contrary to law
- unreasonable, unjust, oppressive or improperly discriminatory
- in accordance with any law or established practice but the law or practice is, or may be, unreasonable, unjust, oppressive or improperly discriminatory
- based wholly or partly on improper motives, irrelevant grounds or irrelevant considerations
- based wholly or partly on a mistake of law or fact
- conduct for which reasons should be given but are not given, or
- otherwise wrong.

The Ombudsman may also investigate a community services complaint if it appears to the Ombudsman that it raises a significant issue of public safety or public interest, or a significant question as to the appropriate care or treatment of a person by a service provider.

Such an investigation can be commenced whether or not anyone has complained to the Ombudsman about the conduct.

The Ombudsman typically conducts very few formal investigations in any year, as most complaints we receive do not result in a formal investigation. This is because we generally aim to resolve complaints at the earliest stage possible, and if a satisfactory outcome can be achieved through inquiries or conciliatory engagement with the agency and the complainant, we will do that.

In the period from October 2021 to September 2022, the Ombudsman completed 4 formal investigations, the outcomes of which are summarised in this report.

Confidentiality of investigations

The *Ombudsman Act 1974* (NSW) requires that all investigations must take place in the absence of the public.

Investigation reports

If, following investigation, wrong conduct (of the kind referred to above) is found to have occurred, the Ombudsman must produce a full investigation report.

That report is provided only to the relevant public authority and to the relevant minister. The Ombudsman may also provide a copy of the investigation report to the complainant, if appropriate.

The full investigation report is not otherwise made public by the Ombudsman. The report is also 'excluded information' under the *Government Information (Public Access) Act 2009* (**GIPA Act**) and an application cannot be made to the Ombudsman for it under the GIPA Act.

Any request for a copy of a full investigation report would need to be made to the relevant public authority or the relevant minister, who would need to consider any public interest considerations for and against disclosure. Relevant public interest considerations against disclosure may include if the report contains personal or health information about a complainant or other person.

Special (public) reports relating to investigations

The Ombudsman may, at any time, make a special report to Parliament on any matter arising in connection with the discharge of the Ombudsman's functions.

Occasionally, following the completion of an investigation, the Ombudsman may also prepare and present to Parliament a separate, special report concerning the investigation. That is typically done where the investigation (or a series of investigations) raises particularly significant issues of broader public interest.

A special report to Parliament relating to an investigation may differ from the corresponding investigation report that has been provided to the relevant public authority and minister, including, for example, by excluding or anonymising personally identifying information or by focusing only on the particular issues of public or systemic interest that were raised by an investigation.

Annual summary reports

Whether or not a special report has been prepared in respect of a particular investigation, it is the Ombudsman's current practice to publish and present to Parliament a special report annually that identifies and briefly summarises the formal investigations that were completed in the previous 12 months. This report is the annual summary report to 30 September 2022.

A residential out-of-home care service provider: Placement risk mitigation and response to a critical incident

Public authority: A community service provider[1]

Responsible minister: Minister for Families and Communities

Investigation report issued: 26 August 2022

Finding: Unreasonable conduct

Recommendations: Apology; policy and practice improvements

We investigated a complaint from a young woman following the occurrence of a critical incident in an Intensive Residential Care service managed by a community service provider funded by the NSW Government. We found that the provider was aware of risks when making placement decisions relating to the young woman, but that it failed to implement mitigation strategies which had been recommended at the time of placement. We also found that its response after the critical incident did not adequately address the young woman's needs. We also found that an internal investigation into the matter was inadequate.

Background

The young woman had been accepted for a placement in an Intensive Residential Care service and resided there for over 2 years. Intensive Residential Care was a residential program for children and young people aged 12–18 years in out-of-home care. The program was targeted to children and young people with high support needs and who required more intensive therapeutic, programmed support than could be offered through other services.

A critical incident occurred in 2016, and the young woman complained to us in 2018 about the risk to which she had been exposed and the lack of support given to her after the incident. Initially, we referred the complaint to the provider for internal investigation. However, when the provider gave us the investigation report, our assessment was that it did not adequately address the substantive issues of the complaint, and we commenced our own investigation.

What did we find?

All residential care placements carry the potential for risk because of the very nature of the high needs of the young people who require the service. When the young woman was considered for placement at the Intensive Residential Care house, the staff tasked with assessing the suitability of the particular home for the young woman acknowledged there were risks in the proposed placement, but decided they could be mitigated with the implementation of some risk mitigation actions.

1. In accordance with the Ombudsman Act, our investigation was conducted in private. To better protect the privacy of the complainant, we have also chosen not to publicly name the community services provider. Our full investigation report has been provided to the complainant, to the relevant service provider and to the Minister for Communities and Justice, being the minister responsible for authorising, and providing funding to, the services of the relevant provider.

However, we found that the provider then failed to adequately develop and implement strategies to mitigate the known risks. We also found that certain transition and support plans had not included risk mitigation strategies, and behaviour support plans were incomplete. Vigilant supervision and monitoring were not in place.

We also found that the provider did not adequately support the young woman following the critical incident. Instead, she was required to move to another residential care house, even though her preference had been to stay at the residence that she considered to be her home. The provider acknowledged that moving her was not ideal, but noted it was a difficult situation and placement options were limited. We found that the response to the young woman did not meet her support needs, and that the provider could have given more guidance to its staff on how to provide appropriate and compassionate support to the young woman.

We found that the internal investigation had failed to gather and critically assess all relevant information. We also found that the investigation did not listen to the young woman's experience or seek to understand her perspective on the events that occurred. While the young woman was interviewed, the purpose of that interview was unclear and was not explained to her.

What did we recommend?

We recommended that the provider apologise to the young woman for failing to take sufficient action to prevent harm to her, and then failing to respond in a way that met her needs after the critical incident occurred.

Since our investigation, the provider revised a range of relevant policies and procedures. We recommended that it update its critical incident policy to clarify governance arrangements, staff training requirements, and the circumstances when an investigation will be conducted internally and when it will be outsourced. We also recommended that the provider update and refine guidance for both staff and managers on conducting investigations.

The provider has agreed to implement our recommendations.

City of Ryde Council:
A resident's complaint about stormwater management requirements

Public authority:	City of Ryde Council
Responsible minister:	Minister for Local Government
Investigation report issued:	1 April 2022
Finding:	Unreasonable conduct
Recommendations:	Apology; ex gratia compensation; policy and practice improvements

*We examined the decisions of Ryde Council (**Council**) to order Mr B to carry out various drainage and other works on his residential property, following complaints that Council had received from a neighbour that stormwater was running onto the neighbour's property and into their swimming pool.*

We found that Council's decisions to require Mr B to undertake significant and costly works were unreasonable and had been made without proper consideration of relevant matters. Council should have taken into account the steps Mr B had already taken voluntarily to address the neighbour's concerns and it should have considered whether there were other possible sources of stormwater issues on the neighbour's property.

Background

Mr B had lived at his home in Ryde for over 50 years. In late 2016, Council received reports from Mr B's neighbour, who had recently installed a pool, that stormwater runoff was affecting their pool area during heavy rain. The neighbour claimed that sheds on Mr B's property near the boundary were the cause of those issues. After a visual inspection of the properties, Council spoke to Mr B, who agreed to remove the sheds and install any missing downpipes and guttering on the remaining structures.

In April 2017, after Mr B had begun work to remove sheds and install gutters and downpipes, Council issued him with an order under s 24 of the *Local Government Act 1993* requiring him to engage an engineer or plumber to design a stormwater management system. After Mr B hired an engineer for that purpose, Council insisted that particular works be undertaken – being works that would be required of new developments under a recent Council Development Control Plan (**DCP**). The works that Council insisted upon, which included the installation of large absorption pits and a rainwater storage tank, exceeded what the engineer considered to be reasonable and necessary. The engineer was also of the view that there could be other sources of the stormwater affecting the neighbour's property.

In 2018, after Mr B had spent approximately $20,000 responding to Council's requirements, one of Mr B's family members complained on his behalf about Council's actions. Council maintained its actions were reasonable, stating it issued the order to Mr B because structures on his property did not comply with its DCP. After our preliminary inquiries did not resolve the issue, we decided to commence a formal investigation.

What did we find?

Council's conduct was unreasonable. It had ordered Mr B to undertake specific actions without:

- considering or exploring the possibility of alternative sources for the neighbour's stormwater run-off concerns
- conducting a required risk assessment of damage to the neighbour's property
- assessing whether the works it required were proportionate to the risks being mitigated
- taking into account the action Mr B was already voluntarily taking, and his continual communication and co-operation with Council's requests.

Council failed to consider adopting a staged approach — for example, inspecting the work Mr B had voluntarily done to see if it had addressed any problems before requiring more significant and costly work to be done.

Council's new DCP did not apply as a binding requirement for existing properties, and so at best it could be taken into account as a guide or non-binding standard. However, Council applied the DCP in an inflexible and rigid manner. It did not take into account the financial impact of the proposed works and Mr B's individual circumstances, including his financial means and vulnerable status. Further, Council did not keep adequate records of its decisions or communications.

What did we recommend?

We recommended that Council apologise to Mr B and make an *ex gratia* payment to cover some of his costs. We also recommended that Council improve relevant processes, including:

- creating or updating processes and guidance material about how stormwater issues and related compliance actions are dealt with, and make it publicly available
- developing a process for staff to follow when considering the DCP as a standard for existing properties
- confirming improvements in its recordkeeping practices.

In June 2022, Council advised us that it had commenced work on most of the recommendations. We will continue to monitor the progress of implementation through quarterly updates from Council.

Department of Communities and Justice (Housing) and NSW Land and Housing Corporation: Modifying public housing properties to meet the needs of tenants with disability

Public authority:	Department of Communities and Justice (Housing); NSW Land and Housing Corporation
Responsible minister:	Minister for Families and Communities; Minister for Homes
Investigation report issued:	9 May 2022
Finding:	Unreasonable conduct
Recommendations:	Apologies; root cause analysis; policy and practice improvements

In 2022 we finalised an investigation[2] into the delivery of disability modifications to public housing properties, taking an in-depth look at the experiences of 3 tenants. We found unreasonable delays in completing the modification works, poor communication and ineffective handling of the 3 tenants' complaints, among other issues. We made 27 recommendations, including that the relevant agency issue an apology to 2 of the tenants, an in-depth root cause analysis of service delays and the creation of a centralised repository for complaints.

Background

Public housing is the joint responsibility of the Land and Housing Corporation (**LAHC**), which acts as the 'landlord' of public housing properties, and the Housing division of the Department of Communities and Justice (**DCJ Housing**), which is the tenancy relationship manager.

Many of the complaints we receive from public housing tenants are about property maintenance, including issues with disability modification requests. The volume of such complaints had risen following the introduction of a new housing maintenance contract in 2016.

Why did we investigate?

Although LAHC and DCJ Housing had been cooperating with us to resolve tenants' complaints at the individual level, we had seen little overall change to the trend in complaints or in the issues they raised. We were concerned about protracted delays in completing maintenance work (including on disability modifications), poor communication with tenants, inadequate visibility over contractor's work and ineffective complaint-handling processes.

In 2019 we decided to start a formal investigation focused specifically on the delivery of disability modifications. Complaints about disability modifications were often particularly concerning because of the vulnerability of those tenants and the impacts of delays and any service failures on them. Issues arising in complaints about disability modifications also largely aligned with broader trends in maintenance-related complaints.

2 This investigation was the subject of a public report that was tabled in Parliament on 29 July 2022 (*Modifying Public Housing Properties to Meet the Needs of Tenants with Disability — Issues Identified through Complaints).*

We examined the experiences of 3 tenants as their requests for disability modification progressed through the system.

The stories of the 3 public housing tenants[3]

Mary Cole

Mary had a spinal condition that meant she was unsteady on her feet. She had already fallen several times on the slippery kitchen floor, resulting in a broken knee. LAHC took 9 months to apply a non-stick coating to the floor, during which time no one kept Mary informed of any progress or explained the increasing delays. When the non-slip coating proved ineffective, LAHC eventually replaced the floor as initially requested. The Deputy Secretary at DCJ Housing apologised personally to Mary in June 2021.

Anne Bailey

Anne had an intellectual disability and a condition that limited her mobility. She needed assistance with daily tasks, including showering. Her declining mobility meant she could no longer safely access her bathroom, so in 2017 Anne's occupational therapist applied for modifications to the bathroom and the floor. It took 7 months to modify the floor, and over a year for the bathroom work (which was initially overlooked) to be completed. While she was waiting, Anne suffered a serious reinfection of a wound due to the lack of access to a shower.

William Kelly

William Kelly's mobility was significantly restricted following a traffic accident, and he used a wheelchair to move around. He submitted a transfer request as his unit was not wheelchair accessible. The request took over a year to be approved. While William waited for the transfer, DCJ Housing denied his request to install a ramp, so William installed a makeshift ramp. When it rained and the ramp became slippery, William had to enter his unit via the stairs and leave his wheelchair outside.

This situation continued for 18 months, despite numerous inquiries and requests to DCJ Housing to progress William's transfer to a suitable, wheelchair accessible home. From February 2018 to June 2019, DCJ offered, then withdrew several properties as they were not wheelchair accessible. In April 2020, William received an offer to transfer to another property, which he accepted pending appropriate modifications. Following a dispute as to what modifications would be approved, William relinquished his unit and left the NSW public housing system.

What did we find?

- **Delays:** protracted, cumulative delays in the delivery of housing modifications had a significant impact on the lives of all 3 tenants, who lived in unsuitable properties throughout this time.
- **Poor communication and inadequate recordkeeping**: DCJ Housing failed to confirm receipt of documents and requests, provide accurate and timely updates on the progress of modification works, and tell the tenants about important decisions made about their modification works — thereby limiting their opportunity to appeal those decisions. Both agencies also failed to keep accurate records about the disability modification requests.
- **Poor oversight of contractors**: LAHC did not maintain adequate oversight of the contractors' progress on the tenants' modification requests — it lacked direct access to information on how works were progressing and was consequently unable to update the tenants when needed.

3. We have changed the names of all tenants to protect their privacy.

- **Inadequate complaint-handling processes**: the 3 tenants lodged various complaints with DCJ Housing and LAHC while they waited for works to be carried out. Responses to their complaints were unreasonably delayed, and in several cases DCJ Housing did not act on all the issues raised.

We drew on our analysis of other complaints to make the following broader observations on factors that may have contributed to the above issues:

- The system is insufficiently focused on the needs of the tenant. The agencies should place the tenant at the centre of service provision, in line with the NSW Government's *Towards a customer-centric government* strategy.
- The extent of LAHC's legal obligation to provide 'reasonable adjustments' to avoid discrimination on the basis of disability is unclear and should be clarified.
- Data collection around disability modifications is lacking — currently, neither agency collects standardised data on disability modification requests.

What did we recommend?

We made 27 recommendations in total, some for both agencies to implement, and some specific to either DCJ or LAHC. These included that both agencies:

- conduct an in-depth root cause analysis of delays in processing requests
- update their internal policies and procedures to clarify the guidance available to staff about recording information and communicating with tenants
- develop business rules to guide staff on how to deal with urgent disability modification requests.

We also recommended both agencies conduct staff training on the processing of disability modifications and on handling complaints, and that they consider enhancing or upgrading their IT systems to improve recordkeeping.

We are pleased that DCJ Housing apologised to one of the tenants, and that both DCJ Housing and LAHC have begun to implement some of the recommendations. The agencies will report on the progress of the implementation quarterly.

SafeWork NSW:
Complaints by a local council about asbestos enforcement actions

Public authority: SafeWork NSW

Responsible minister: Minister for Innovation and Better Regulation

Investigation report issue: 3 May 2022

Finding: No adverse finding

Suggestion: Consideration of legislative amendment

*In 2018, while we were already investigating regulatory actions taken by SafeWork NSW (**SafeWork**) against Blue Mountains City Council's (**Council**) asbestos management practices,[4] we received 2 additional complaints about SafeWork from Council. We decided to investigate those additional complaints, but deferred the investigation until we had completed the existing investigation. Our investigation of the 2 additional complaints has now also been completed. We made no adverse findings about SafeWork's conduct in respect of those complaints.*

Complaint 1

Council complained about SafeWork NSW's decision to impose conditions on Council's asbestos removal licence. It said that the decision had been triggered by critical media coverage rather than actual safety concerns, that SafeWork had not given Council notice before imposing the conditions, and that Council was being subjected to conditions that were not applied to other government authorities.

SafeWork initially granted Council a licence to remove asbestos on 5 August 2018, with no additional conditions (beyond the standard licence conditions that apply to all licences under the relevant legislation). On 10 August, a radio program contacted SafeWork about the granting of the licence. On 13 August, comments were made on the radio program by its host that were critical of the granting of the licence. Later that day, the Minister responsible for SafeWork stated that he had asked for a review of SafeWork's decision to grant the licence.[5] On 5 October, SafeWork wrote to Council to advise that, after reviewing the licence, it had decided to impose a number of additional conditions for a 12-month period. The conditions required additional and more frequent reporting to SafeWork on activities conducted under the licence.

SafeWork's stated reasons for imposing the conditions were that Council was a new licence holder, asbestos removal was not its core business, and SafeWork had ongoing investigations regarding Council's management of asbestos.

4. That previous investigation was the subject of a public report: *Investigation into Actions Taken by SafeWork NSW Inspectors in relation to Blue Mountains City Council Workplaces* (Report, 21 August 2020) <http://www.ombo.nsw.gov.au/__data/assets/pdf_file/0009/134397/Investigation-into-actions-taken-by-SafeWork-NSW-Inspectors.pdf>.

5. Under the *Work Health and Safety Act 2011* (Cth) the Minister may request a review of decisions made by SafeWork.

What did we find?

We found that the decision to impose the conditions on Council's asbestos removal licence was not unreasonable. Although the stated reasons given for the decision to impose the conditions were limited, they were not manifestly unreasonable, and were rationally connected to SafeWork's stated purpose, which was to assist it to monitor Council's compliance with the *Work Health and Safety Act 2011* (**WHS Act**) and the *Work Health and Safety Regulation 2017* (**WHS Regulation**). The conditions were largely procedural in nature and did not otherwise constrain the authority granted to Council under the licence.

Complaint 2

Council complained about SafeWork's decision to prosecute it for a number of alleged breaches of the WHS Regulation, claiming that the decision was unduly motivated by political concerns.

The alleged breaches had come to SafeWork's attention in May 2017 and related to Council's management of asbestos at 2 sites, including that Council failed to prepare and keep an asbestos register or a written asbestos management plan, and did not to provide training for workers. However, SafeWork only commenced the prosecution in May 2019, serving Council with court attendance notices a few hours before a statute of limitations[6] (a time limit) on prosecution expired. Council had been given less than 2 working days to provide written submissions before the prosecution was commenced.[7]

Council complained that SafeWork had not given due consideration to its submissions. Council further complained that SafeWork had not properly considered the alternative of entering into an 'enforceable undertaking'[8] with Council before commencing prosecution.

Upon commencing the prosecution, SafeWork indicated to Council that it would still be willing to consider any further 'representation in relation to the proceedings'. Council subsequently made a further submission in June 2019. After subsequent consultation, Council entered into an enforceable undertaking with SafeWork in December 2019 and the prosecution was then discontinued.

What did we find?

Delay in commencing an investigation of the 2017 allegations and receiving relevant legal advice, coupled with the length of time the investigation took, meant that SafeWork's consultation with Council before the prosecution was started was conducted in haste. This gave Council the impression that it had not been a fair process. This delay, and the imminent expiry of the statute of limitations period, meant that SafeWork had insufficient time to thoroughly explore and negotiate with Council the possibility of an enforceable undertaking as an alternative to commencing formal proceedings.

While the timeframes in which events occurred were less than ideal, SafeWork's decision to commence the prosecution was not wrong. Doing so before the statute of limitations expired was necessary for SafeWork to preserve its position. Since an enforceable undertaking was not yet in place, had SafeWork not filed the prosecution at that time, it would have been barred from prosecuting the alleged breaches if negotiations for an enforceable undertaking failed. In the circumstances (albeit to some extent of its own making, given the earlier delays), it was not unreasonable for SafeWork to preserve its legal position as regulator by commencing a prosecution while also entertaining discussions with a view to a possible enforceable undertaking.

6. WHS Act s 232(1)(a). Offences under the WHS Act are subject to statutory time limits – they must be commenced within '2 years after the offence first comes to the notice of' SafeWork..
7. Ministerial Memorandum 1997-26 *Litigation Involving Government Authorities* states that a government authority vested with the power to commence prosecutions should consult with a government authority against which proceedings are contemplated.
8. An enforceable undertaking is an alternative to prosecution, where SafeWork may accept a written undertaking given by a person in connection with a matter relating to an alleged contravention of the WHS Act.

Uncertainty around permissible ministerial control and direction over SafeWork's decision-making

The investigation highlighted a question of legislative clarity around the nature, extent and manner of a permissible ministerial 'override' of statutory decisions by SafeWork under the WHS Act.

Schedule 2 to the WHS Act[9] expressly provides that SafeWork is generally subject to the 'control and direction' of the Minister, except in relation to:

> (a) the contents of any advice, report or recommendation given to the Minister, or
>
> (b) any decision that relates to proceedings for offences under this Act, or
>
> (c) any decision that relates to a WHS undertaking.

Although Schedule 2 appears to require SafeWork to act on the command of the Minister in all other cases (except those specifically stated above), this is not the case. The Minister's power to control and direct is always subject to an inherent limitation, which is that the Minister cannot direct SafeWork to do something that it is not legally authorised to do or to do anything that would otherwise be unlawful.[10]

There may, however, be some ambiguity as to how Schedule 2 is to be read with those provisions of the Act that confer specific statutory decision-making functions on SafeWork itself – such as a decision to grant a licence and impose licence conditions.

If legislation has conferred a specific decision-making power on a specified person, then that person must make their own decision and cannot be directed by, or otherwise act under dictation from another.[11] This is particularly important where the legislation provides that a decision can be made only if the decision maker has a particular state of mind, such as being 'satisfied' that something is the case.

There may be a question as to how that principle applies here, where there is a general statutory power of the Minister to control and direct the decision maker.

In other places, any potential ambiguity has been avoided by clear provisions. For example, Queensland's *Work Health and Safety Act 2011* expressly states that 'the regulator must act independently when making a decision under this Act'. This makes clear, in a way that the NSW Act does not, that the Minister is not able to control and direct a specific statutory decision made by the regulator – such as a decision to grant a licence, or to impose conditions on a licence.

The *Protection of the Environment Administration Act 1991* (NSW) takes a different approach. It gives the Minister an explicit power to 'call in' the Environment Protection Authority's functions.[12] Importantly, this means that when the Minister does want to control the regulator's decision, this must be done formally and by a transparent process, with any Ministerial direction and determination required to be made public.[13]

By contrast, the lack of express clarity in the NSW WHS Act has the potential to undermine the perception that SafeWork's decisions in specific cases are consistently evidence-based on public interest grounds, and unaffected by irrelevant political considerations.

---

[9] The NSW WHS Act is based on national model work health and safety legislation. The provisions of each state's WHS Act is required to reflect that model law. However, the model law includes certain 'jurisdictional notes' in relation to provisions that will differ from jurisdiction to jurisdiction. One such provision is schedule 2 of the Act, which is to prescribe 'the regulator' for that state. Given that schedule 2 is a jurisdictional provision, it is open to NSW to amend it without affecting the nationally consistent WHS regime.

[10] *Waters v Public Transport Corporation* (1992) 173 CLR 349, 380.

[11] NSW Ombudsman, *Investigation into actions taken by SafeWork NSW Inspectors in relation to Blue Mountains City Council workplaces*, (Report, 21 August 2020). Online at: http://www.ombo.nsw.gov.au/Find-a-publication/publications/reports/state-and-local-government/investigation-into-actions-taken-by-safework-nsw-inspectors-in-relation-to-blue-mountains-city-council-workplaces.

[12] Section 13A.

[13] Section 13.

In light of this, we suggested that SafeWork consider seeking an amendment to the WHS Act to clarify that the Minister's control and direction of SafeWork does not extend to include directions about statutory decisions in particular cases. (Alternatively, if it is considered appropriate that the Minister should have such a power of direction, then consideration should be given to amending the legislation to clarify the mechanism by which that occurs and ensure that any direction or determination of the Minister is made transparently.)

SafeWork supported increasing the clarity and transparency of the roles of both the Minister and SafeWork in principle, but noted that any legislative amendment would be a matter for the government.

This page is intentionally blank.