

Commission of Inquiry into the CFMEU and Misconduct in the Construction Industry

WITNESS STATEMENT OF DEBORAH NGAIO DARGAN

1. I, Deborah Ngaio Dargan, of an address known to the Commission, affirm:

Background

2. I hold a Bachelor of Behavioural Science (Psychology and Disability) and a Master of Human Services (Rehabilitation Counselling) from Griffith University.
3. Between February 2000 and December 2006, I worked as a Review Officer at Q-COMP, the Workers' Compensation Regulatory Authority for Queensland, which was responsible for overseeing insurers, medical assessment tribunals, and scheme-wide guidance.
4. Between January 2007 and May 2010, I worked as a Rehabilitation Consultant / Staff Health and Safety Advisor within the Staff Health and Wellbeing Unit at Commonwealth Rehabilitation Services. My responsibilities included job capacity assessments to measure people's capacity for work and case managing people who had suffered a psychological or physical disability, with a view to rehabilitating them and having them return to work.
5. In 2010, I was appointed as a Principal Inspector (Psychosocial) at Workplace Health and Safety Queensland (**WHSQ**) within the Office of Industrial Relations (**OIR**). WHSQ is the body within the government responsible for improving workplace health and safety in Queensland. My role was centred on psychosocial risk management, which involves identifying and addressing hazards in the design or management of work, the work environment, and workplace interactions or behaviours, that may result in psychological harm and which may lead to physical harm.
6. In 2015, I transferred from the Investigations Unit to the Construction Team to assist with the management of injury-related incidents and risk-based prosecutions. I frequently conducted interviews with injured workers, drawing on my earlier psychosocial investigative experience.
7. In July 2024, I was promoted to my current role as Operations Manager in the Construction Team. In this role I am responsible for a team of inspectors. I report to Kym Tollenare who is the Regional Director of the Brisbane Region.

Overview of my time as a Principal Inspector

8. In 2010, when I first started as a Principal Inspector (Psychosocial) my role was predominantly focused on carrying out investigations into bullying complaints and suicides, where workplace factors were alleged to have contributed. The purpose of these investigations was to establish whether a compliance notice or prosecution was warranted.
9. Before I started in 2010, WHSQ recognised psychosocial risk as a workplace health and safety (**WHS**) risk initially under section 28 of the *Workplace Health and Safety Act 1995* (Qld) and later under section 19 of the *Workplace Health and Safety Act 2011* (Qld) (**WHS Act**). From the time I started there was an intent in WHSQ to take enforcement action for contraventions of the WHS Act arising from psychosocial risks.
10. From the commencement of that role, I recall reading WHSQ publications linking risk-management processes to psychosocial stressors. I recall WHSQ running training for industry groups on psychosocial hazards using the WHS framework. I ran training sessions for employer network groups. WHSQ had a dedicated psychosocial unit, headed by a noted expert from the University of Queensland, Associate Professor Kirsten Way.
11. In 2011, my role was expanded and I started investigating incidents, deaths and other breaches of the WHS Act. In 2014, I was tasked with investigating right of entry breaches by

the CFMEU. In my experience it was rare for a union other than the CFMEU to be investigated for a right of entry breach. I was one of a group of four inspectors in the northern region undertaking these investigations. A number of these investigations reached the point where they were ready to be referred for prosecution.

12. Shortly after the Palaszczuk Government was elected in 2015, the appetite for the right of entry prosecutions lessened, and I recall the WHS Act was amended to no longer require union officials to provide 24 hours' notice for entry, which was the basis for many of the proposed prosecutions.

Location and team

13. In 2015, I transferred to the North Brisbane Construction Team. We were initially located at an office in Bowen Hills but later relocated to Brendale. We were a tight knit group with some very experienced inspectors, such as John Barber and John Carmosino, providing great support and mentoring. I recall that my colleagues and I took a lot of pride in our work as inspectors, recognised that we had a serious job to do and believed in doing the right thing in accordance with the legislation.
14. As a Principal Inspector (Construction) between 2015 and 2024, I reported to an Operations Manager named Nicholas Drapes. Towards the end of my time as a Principal Inspector, there was significant turnover in management. After Mr Drapes went on sick leave, I continued to report the Operations Manager role, which was held at different times by Mark Murphy, Mark Houston, Jason Plath, Brian Cullerton, and Robert McDonald.
15. I recall that the South West Gold Coast District Construction Team, that included Mount Gravatt, had higher turnover than our office and a less experienced inspectorate. I perceived many of the experienced inspectors that remained working from Mount Gravatt, such as:
 - (a) Travis Dungey, John Azcune, Chris O'Donnell, and Anzac Te Oka; and
 - (b) the Operations Manager from the Gold Coast office Chris Mutton,would simply do as they were told by management, without questioning whether it was correct and in accordance with their duties and the legislation governing their role.
16. My perception was informed by my contemporaneous discussions with other inspectors about notices which had been issued and by my subsequent role processing the withdrawal of notices which had been reviewed. Given the statutory role of inspectors, it was important that they all asked themselves whether they were acting in accordance with legislative requirements.
17. When I commenced as a construction inspector, the North Brisbane Construction Team was responsible for Brisbane's central business district (**CBD**). In November 2023, responsibility for the CBD was reallocated to the South Brisbane Construction Team.
18. It is my belief that the willingness of many of the inspectors in the South Brisbane Construction Team to simply do as they were told, led WHSQ management to reallocate the CBD to them. My perception was that the North Brisbane Construction Team inspectors were more likely to stand their ground and not issue notices for alleged breaches of the WHS legislation identified by the CFMEU, when notices were not warranted. WHSQ senior management at the time included Marc Dennett (Executive Director) and Helen Burgess (Director of Construction Compliance and Field Services).

Case Intake and Allocation Procedure

19. Between 2020 and July 2022, I was periodically responsible for allocating matters located between the Gold Coast and Bundaberg. Due to workload, this geographical area was later divided and I handled matters south of the Brisbane River. I ceased in the allocator's role when I was promoted to Operations Manager in July 2024.

20. During my time as a Principal Inspector, the intake and allocation of notifications and complaints was governed by the Event Management Procedure (**Procedure**). The Procedure required all incident notifications, statutory requests, complaints, and concerns (**events**) to be received, triaged and input into the case management system by a team called Assessment Services.
21. There have been various versions of the Procedure, but the substance of it has remained consistent. Exhibited to this statement and marked "DD-1" is a copy of version 10 of the Procedure. Whilst there are different versions of the Procedure before and after this version, the triage process didn't substantially change. This is a version of the Procedure which I was required to follow while I was an allocator.
22. Under the Procedure, events were allocated a priority level. Response timeframes varied depending on risk severity. For example:
 - (a) complaints of a high-risk nature required commencement as soon as reasonably practicable;
 - (b) critical events and fatalities required commencement of response within 24 hours of notification;
 - (c) incidents involving serious injuries, dangerous events or serious electrical incidents within 48 hours; and
 - (d) complaints or injuries of a less significant nature within seven working days.
23. Once triaged, events were emailed to the relevant allocator, who would then allocate them to inspectors. In allocating tasks to inspectors, urgency, risk, inspector availability, and workload were considered.
24. The triage system described in the Procedure is designed to support a consistent, risk-based and legally compliant regulatory response. The key reasons Assessment Services triages matters in this structured way include to:
 - (a) ensure urgent and high-risk events receive the fastest possible regulatory response;
 - (b) apply a consistent, statewide method for initial assessment;
 - (c) confirm jurisdiction before sending inspectors;
 - (d) efficiently manage high volumes of notifications;
 - (e) ensure inspectors attend with appropriate planning and information;
 - (f) meet statutory obligations under legislation; and
 - (g) support transparent record-keeping and accountability.
25. Inspectors were required to drop other work, including proactive tasks, to attend urgent matters. Notifications from Queensland Ambulance Services always required immediate attendance.

How allocations operated in practice and CFMEU influence

26. After the Palaszczuk Government came to power in 2015, priorities shifted within the Construction Team. Over time CFMEU complaints began to be treated as the highest priority, regardless of risk.

27. From 2018, when Ms Burgess became the Director of Construction, she played a significant part in driving this change. I recall Inspector Carmosino, who was responsible for allocating jobs, telling me that Ms Burgess regularly called him and instructed him to dispatch inspectors immediately to CFMEU-related matters. This was a frequent occurrence. I estimate that it was occurring on a daily basis.
28. This resulted in inspectors being required to abandon legitimate safety work, including work addressing serious risks such as people working at heights, to attend CFMEU complaints that were of lower or negligible risk, including matters such as unclean site toilets. This further stretched resources when it became WHSQ policy that CFMEU right of entry requests had to be attended by two inspectors. The need to have two inspectors in attendance was a direct result of concerns raised by inspectors who were exposed to aggressive conduct from CFMEU officials.
29. To give an example of inspectors being pulled away from a serious safety risk, in 2019, Inspector Barber and I were at a job located at Lomandra Court, Indooroopilly. At the job we identified that there was a sub-contractor on a roof level without edge protection. We were in the middle of a conversation with the sub-contractor when a phone call came in. We were directed to leave site immediately and attend a CFMEU complaint. We told the sub-contractor that we would not be taking any enforcement action because we had another job to get to. We suggested he hop down and not get back up on the roof level until the edge protections were in place. Instances like that one used to happen quite a bit.

Right of entry

30. To enter a site, the CFMEU officials need to have a reasonable suspicion of a contravention of the WHS Act. The purpose of their entry is to investigate that reasonable suspicion. Often, CFMEU complaints would be very vague, lacking detail and not be tied to specific risks (serious or otherwise). Often, they would fail to list specific non-compliance with sections of the WHS Act. They would instead contain broad references to the general duties found in section 19(1) and 19(2) of the WHS Act, such as no fall from height protection, inadequate amenities and poor traffic management. Despite this vagueness, inspectors were directed to immediately attend sites where the CFMEU was seeking entry.
31. I know from personal experience and from conversations with other inspectors that quite often CFMEU complaints would not be substantiated. Despite this, CFMEU matters frequently consumed several hours, meaning inspectors could not return to their original jobs. The reason those matters took so long is largely because the attendances on site were not limited to the right of entry dispute, or even the identified contraventions in the initial complaint. It would instead turn into a general inspection, because the WHSQ Operations Managers would direct inspectors to stay on site with the officials. The result of this was that we were required to follow the CFMEU officials around while they identified matters which they asserted to be contraventions and pressured us to write prohibition, improvement or infringement notices. I deal with the different types of notices in paragraph 36 to 40 of this statement.
32. This process completely removed inspectors' agency. It damaged our reputation and standing in the eyes of the persons conducting a business or undertaking (**PCBUs**) as many viewed us as tools of the CFMEU. This raised with me by PCBUs so frequently that I cannot identify a specific example.
33. Over time, Ms Burgess began contacting inspectors directly while they were enroute to CFMEU initiated jobs and asking why they were not there yet. I can personally recall seeing this happen to other inspectors, who sometimes received multiple calls from her tracking their progress. She would ask where they were and why they were not on-site yet. As a work allocator, Ms Burgess would often call me to ask for updates about when inspectors would arrive at site on CFMEU jobs. She did not make calls of this nature in relation to any other type of job.
34. On 6 November 2019, I attended a Tomkins construction site at 19 Railway Terrace in Milton. The purpose of my visit was a CFMEU right of entry request for assistance. Rather than

simply follow the official around site while they conducted an audit, I attempted to limit the attendance to those matters raised in the right of entry notice. I don't recall whether I was still on site, or whether I had left, but I was spoken with by my Operations Manager, Nicholas Drapes who instructed me that this was not how site visits were to be conducted, and that I was to walk the site with the CFMEU official.

35. I can recall on many occasions attending sites in response to CFMEU complaints and the CFMEU officials were not yet present at the site, despite having demanded an inspector's attendance. I would later find out that the CFMEU officials just intended to be there later in the day. This resulted in a waste of the time of two inspectors who either had to wait for the CFMEU officials or leave and return later. In my view, attending before the CFMEU officials had raised or attempted to resolve an issue with the PCBU was inappropriate and further reinforced the view held by many PCBUs that inspectors were there to do the CFMEU officials' bidding.

Statutory notices and expected practice

36. WHSQ inspectors exercise statutory powers under the **WHS Act**. They may issue:
- (a) improvement notices;
 - (b) prohibition notices;
 - (c) infringement notices; and
 - (d) non-disturbance notices.
37. Improvement notices address non immediate risks and may be issued on site or afterwards (depending on whether the breach still exists).
38. Prohibition notices must be issued immediately on site where an inspector reasonably believes an activity involves a serious risk due to immediate or imminent exposure to a hazard.
39. Non-disturbance notices must be issued prior to leaving a site where a notifiable incident has occurred. A non-disturbance notice is a written directive requiring the recipient to preserve a site and prevent any disturbance for a specified period, usually to support investigations.
40. Infringement notices carry a fine but do not specify corrective action, and often accompany other notices.
41. During my time as an inspector, WHSQ has utilised two different case management softwares (being CISr and subsequently Rapid). A case management software is a digital system designed to help organisations track, store, and manage information related to various cases in a centralised location. Under CISr, notices could be generated in hard copy or electronically. Under Rapid notices are typically issued electronically.
42. It is standard practice for inspectors attending serious or high-risk incidents to telephone their Operations Manager before leaving site, to discuss proposed notices and any further steps required.

CFMEU influence on notices, pressure and the loss of inspector discretion

43. CFMEU officials frequently met inspectors at site entrances and insisted on walking the site with them. There were a number of issues with this:
- (a) officials only had a limited legal right to access site, and the inspections conducted often went well beyond that;

- (b) it gave the officials further opportunity to pressure inspectors to issue notices;
 - (c) officials would often stand in operational areas and argue with PCBUs and inspectors about legal matters; and
 - (d) inspections with officials often took far longer than they ought to, as the officials would often wander around the whole site.
44. All the issues described above took valuable inspector time away from other priorities.
45. I know through personal experience and through my many discussions with my colleagues, including Mr Barber, Mr Carmosino and Frank D'Allura that CFMEU interactions often began cordially, but quickly deteriorated if an inspector declined to issue a notice at the demand of the Union. Because this was so common it is difficult to remember a specific example.
46. Some inspectors, seeking to avoid conflict, issued notices in circumstances where I did not believe the statutory threshold was met. I did not engage in this practice.
47. Where an inspector refused to issue a notice, CFMEU officials would often walk away, make a phone call, and shortly thereafter the inspector would receive a call from their Operations Manager, often criticising them for not issuing the desired notice.
48. It was highly unusual for Operations Managers to call during an inspection, apart from when the CFMEU official on site had requested a notice that I had declined to issue. This happened often and showed a consistent pattern.
49. On several occasions, inspectors were removed from site and replaced with others who would issue the notices sought by the CFMEU. This undermined inspectors' professional standing in front of PCBUs.

University of Queensland - Health and Safety Representative election incident

50. On 20 November 2019, I attended a site at University of Queensland's St Lucia campus with Inspector Barber. The principal contractor was Hansen Yuncken who were engaged to build the Andrew N. Liveris Building.
51. Inspector Barber and I were allocated to determine whether a person had been validly elected or nominated as a Health and Safety Representative (**HSR**) for a work group. CFMEU official Andrew Blakely had made the complaint and asserted that the election was valid, and he pressured us to issue a notice against Hansen Yuncken.
52. The WHS Act prescribes clear requirements for HSR elections, including that all workers in the work group be given an opportunity to nominate or be nominated. In our view, there was inadequate evidence that these steps had been followed. We concluded that the election of the HSR was invalid and declined to issue a notice. We were directed, I don't recall by whom, to complete a precis of the interview we conducted and that we were not to act further until instructed.
53. Subsequently, Inspector Chris O'Donnell told me that he was dispatched to the site and that he had issued a notice requiring Hansen Yuncken to accept the HSR preferred by the CFMEU. In my experience, Inspector O'Donnell typically followed directions from Ms Burgess in contentious matters.
54. When Inspector O'Donnell informed me that he had issued the notice, I challenged him and asked whether he really thought that there was a breach of any legislative requirements that meant a notice should be issued. I do not recall him providing a response.
55. This incident reinforced my view that union-driven pressure was overriding inspector discretion and legislative requirements.

Withdrawal of Notices

56. In 2022, I was assisting to address a substantial number of overdue unpaid infringement notices and reviewing notices where the recipient had elected to go to court. As part of that role, I would conduct an assessment of the validity of those notices and make a recommendation to the relevant director about whether or not they should be withdrawn.
57. In addition to that ordinary process, there were additional occasions where Ms Burgess would ask for notices to be withdrawn. My recollection from my reviews is that those notices largely related to CFMEU initiated jobs. Once I received a request from Ms Burgess, I would enter the online system and send her the paperwork to sign, which would then allow me to withdraw the notice. Over time I came to the view that there seemed to be a practice of inspectors issuing infringement notices at the request of the CFMEU, only to have many of them withdrawn.

Impact on my Mental Health

58. By 2019, the cumulative pressure from CFMEU interactions and lack of support from management caused me significant psychological harm. I felt I was being dismissed or “gaslit” when raising concerns.
59. Around this time, these factors had such an impact on me that I would return home from work and then immediately go to bed, leaving the house only to care for my children by undertaking tasks such as taking them to school sport (where I would often sleep in my car). I experienced significant loss of joy and sustained exhaustion.
60. On 21 June 2021, I attended a CFMEU request for assistance at the Tomkins Commercial site at Woolloongabba with Inspector William Harris. During the site inspection, CFMEU officials Luke Gibson and Dennis Mitchell repeatedly argued with me and challenged my opinions about hazards they perceived on site in an aggressive way. This occurred in front of Tomkins staff. I later heard from Inspector Mark Norris that someone from Tomkins had spoken to the union about the bullying being unacceptable behaviour on site.
61. After being on site for over 4 hours it was agreed between all parties that a break was needed. Inspector Harris and I went to a café over the road and started writing some notices. At this time, I received a phone call from Mr Houston who had been advised we had left the site with imminent risk present. This occurred despite Mr Gibson agreeing to the break. I advised Mr Houston we were waiting on the site engineer to discuss the chains on the glide form. The form deck was not in use that day and therefore no imminent risk was present.
62. On 22 June 2021, while attending another CFMEU request for assistance at the Minicon Construction site on Hope Street in South Brisbane with Inspector D’Allura, I received a call from Operations Manager Mr Houston. Mr Houston said words to the effect that he had received a complaint regarding our behaviour on site yesterday and that there will be an investigation.
63. Already feeling distressed and unsupported, I reached breaking point and decided to leave site. Inspector D’Allura, having observed my distress, made sure I was okay to drive before I left. I immediately commenced a period of sick leave which lasted for approximately three months.
64. I sought psychological support and was diagnosed with anxiety and depression due to workplace stress. My psychologist described my condition as ‘moral injury’, meaning prolonged exposure to situations requiring me to act contrary to my ethical and professional obligations.

A lack of accommodation and threats to employment

65. I understood that the *Workers’ Compensation and Rehabilitation Act 2003* (Qld) stated that if someone’s psychological injury was a result of reasonable management action taken in a

reasonable way by the employer in connection with the worker's employment then the worker would not be covered. I recall looking at my line of managers: Mr Houston, Ms Burgess and Mr Dennett and not having any faith that they would support my claim. Which is why I decided to use my accrued sick leave.

66. After three months of sick leave, my doctor cleared me to return to work but recommended I avoid CFMEU-related jobs.
67. A health and wellbeing officer informed me that if I could not perform union-related work, I would not have a job. There was no offer of redeployment or alternative duties.
68. Communications occurred through Staff Health, and I believed Mr Houston and Ms Burgess were directing the process because I am aware that Staff Health consult with the Operations Manager and Director as part of their standard process.

Internal report to Mr Houston

69. In 2021 I reported concerns to my line manager Mr Houston, during a monthly one-on-one meeting, including that:
 - (a) the CFMEU officials were dictating inspectors' priorities and demanding immediate attendance regardless of risk;
 - (b) inspectors were being required to abandon proper safety work (including high-risk jobs) to attend CFMEU-driven complaints;
 - (c) inspectors who refused to issue improper notices were being removed from sites and replaced by inspectors who would issue them; and
 - (d) that this conduct was undermining inspector discretion and was contrary to the legislation.
70. Mr Houston said words to the effect that the Labor Government would remain in office for four years, that the situation would not change, and that I could either accept it or leave. I was frustrated by his response, but I was not particularly surprised given how long this had been going on.
71. I perceived that WHSQ senior leadership, including Mr Dennett and Ms Burgess, supported, or at least tolerated, the approach being driven by the CFMEU. I believed improper conduct was occurring and no one intended to intervene.
72. By that time, I was mentally exhausted and did not escalate those matters further. I relied heavily on colleagues including Mr Barber and Mr D'Allura for support. I am aware that Mr Barber made complaints to Together Union and separately issued a provisional improvement notice on OIR.
73. My resilience was worn down. I attempted to apply for other roles but was unable to perform well in interviews due to stress.

Milton crane incident and internal investigation

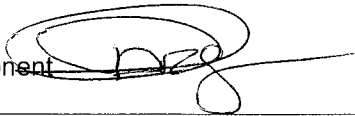
74. On 12 April 2022 I was called to a Hutchinson Builders' site at Milton, where a crane had malfunctioned with a load suspended above a roadway.
75. I commenced my inspection by assessing the immediate controls that were in place to manage any risk from the crane. In my view, adequate traffic controls were in place and the immediate risk was controlled, because no one was permitted to access the area where a suspended load might fall. I was informed that a crane technician was enroute.

76. Two CFMEU officials arrived and spoke over me while I was talking with Hutchinson staff, demanding documents and obstructing my work. When I asked if we could move somewhere else so I could be heard, one of the CFMEU official asked for my name then walked away to phone Ms Burgess.
77. Distressed, I stepped away and attempted to contact Mr Barber who was unavailable. I returned, requested key documents relating to the commissioning and maintenance of the crane be emailed to me, and left the site.
78. Later another inspector, Peter Stevens, attended and confirmed the situation remained controlled.
79. I was subsequently the subject of an internal investigation conducted by Mr Houston.
80. Two allegations were examined:
 - (a) that I left the site leaving an uncontrolled hazard; and
 - (b) that I left the site abruptly.
81. The first allegation was not substantiated. The second, leaving site abruptly, was substantiated and I received a letter advising the matter was referred to Executive Director Andrew Harris for 'internal management'. The substantiated finding was made even though:
 - (a) I was distressed by CFMEU behaviour and the call to Ms Burgess;
 - (b) I attempted to obtain assistance;
 - (c) the hazard was controlled when I departed; and
 - (d) a subsequent inspector confirmed the controls were adequate.
82. Exhibited to this statement and marked "DD-2" is the letter that I received from Mr Houston.


Closing Observation

83. In late 2023, Ms Burgess was removed from her role as Director of Construction Compliance and Field Services. Since Ms Burgess' removal conditions have improved significantly. Some things changed quickly, for example union officials became less aggressive and more receptive to the decisions made by inspectors. Other habits and patterns of deference to the CFMEU have been harder to shake off and elements remained, although not to the same degree as before. In my view, we are regaining our independence as an inspectorate and as a regulator.
84. My hope in providing this statement is that safeguards will be established to ensure no inspector or public servant is subjected to the pressures and experiences I have described.

I affirm the contents of this statement are true.

Signature of Deponent 

Place Brisbane Date 2 / 3 / 2026

Before me (signature of witness) 

JACK DOMINIC KERIN
Full name of witness (please print)

- Justice of the Peace (JP #)
- Notary public
- Lawyer
- Other authorised person (specify)

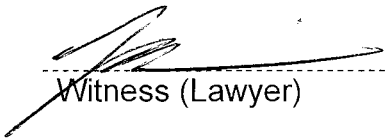
Commission of Inquiry into the CFMEU and Misconduct in the Construction Industry

ANNEXURE SHEET

This is the document referred to as DD-1 in the statement of Deborah Ngaio Dargan affirmed at Brisbane on 2 March 2026



Deborah Ngaio Dargan



Witness (Lawyer)

Event Management

Purpose

To provide a framework for all regions on the management of events referred by Assessment Services and/or notified directly to regions by other sources.

To provide guidance for officers when responding to complaints of potential community concern to manage the expectations of the complainant through clear communication and reduce the risk of complaint escalation.

This procedure is required to be read in conjunction with the *Work Health and Safety Act 2011* (WHS Act), *Safety in Recreational Water Activities Act 2011* (SRWA Act) and the *Electrical Safety Act 2002* (ES Act).

Where a matter to be responded to involves the SWRA Act, the functions of the Regulator, the compliance and enforcement measures and inspector powers are as provided by the WHS Act and applied through Part 4 of the SWRA Act. Seek advice from the line manager if you need further information.

Policy Statement

COVID-19: to ensure the health and safety of the inspectorate when visiting a place when responding to an event or request for assistance, it is the Office of Industrial Relations' (OIR) policy that Inspectors must comply with any OIR operational policies and [directions of the Chief Health Officer](#).

It is the Office of Industrial Relations' (OIR) policy that:

- all incidents notified to Workplace Health and Safety Queensland (WHSQ) and the Electrical Safety Office (ESO), and all complaints and concerns regarding health and safety matters, and all statutory requests or referrals to the Regulator or Chief Executive are receipted as 'events' in the Compliance and Investigation System – refresh (CISr) system.
- events are managed electronically in accordance with the standards established within this procedure and the CISr data recording standards and business rules.
- a response assessment review must be undertaken for each response assessment by the allocated Inspector's line manager (or delegate) in order to consider the appropriateness of actions taken.
- WHSQ and ESO inspectorate staff must contact all complainants (if known) prior to taking action regarding their complaint to discuss the confidentiality of their complaint, OIR's privacy policy and potential issues such as the PCBU suspecting the complainant's involvement in OIR's attendance on site if the complainant has raised the same issue within the workplace previously.



- WHSQ and ESO inspectorate staff must make reasonable attempts to contact all complainants (if known) to provide feedback on the actions and outcomes regarding their complaint.
- events involving complaints where the potential for escalation is evident, a line manager is required to contact the complainant by phone within two (2) business hours of the region being notified of the complaint.

Refer to the [definition for procedures](#) table for any commonly used terms located within this procedure.

Context and Legislative Application

The WHS Act and ES Regulation requires PCBU's to notify the Regulator of various incidents (i.e. notifiable incident, SEI, DEE) and also allows persons to make statutory requests or referrals to the Regulator or Chief Executive. In addition, WHSQ and the ESO have provisions in place to allow anyone to make a complaint or raise a safety concern about workplace practices or unsafe electrical events.

These incidents, complaints and requests are created as events in CISr, each with a unique identifying number ('event number') and triaged to determine an appropriate response (e.g. phone call, letter, workplace visit).

The response activities completed for each event are undertaken in accordance with the OIR [Compliance Monitoring and Enforcement Policy](#) (CMEP). The CMEP was introduced following the Best Practice Review, as a supplement to the [National Compliance and Enforcement Policy \(NCEP\)](#), and continues to adhere to the compliance and enforcement principles of consistency, constructiveness, transparency, accountability, proportionality, responsiveness and targeted. The response activities also reflect national WHS harmonisation arrangements.

The purpose of monitoring compliance and, when required, enforcing compliance, is to ensure duty holders comply with their obligations. This may require directing remedial or compliance action. The threat of being caught and the deterrent effect of a strong regulator will provide a better environment where the risk of exposure to injury and illness is minimised. Enforcement measures available to the inspectorate include prohibition notices, improvement notices, electrical safety protection notices, unsafe equipment notices and infringement notices (on the spot fines).

WHSQ and ESO Inspectors attend workplaces, domestic premises and public spaces for a variety of reasons. Inspector visits can be planned in advance or undertaken at short notice in response to a number of circumstances, including incident notifications, complaints and duty holder requests for an Inspector to assist in issue resolution and/or dispute resolution relating to the cessation of work and/or WHS entry permit holder right of entry. The initial activities undertaken by an Inspector in relation to these matters are referred to as first response activities.

First response activities

As the first response activities may be the first and only opportunity to obtain information at the workplace or incident site, it is essential that a thorough and detailed first response (preliminary investigation) is conducted to ensure that all relevant information available at the time is obtained.

First response activities can be critical to ensuring appropriate evidence is gathered and determining whether a duty holder is non-compliant with legislation. First response activities lay a foundation for any ensuing investigation or other Regulator/Chief Executive actions.

The timing and degree of the first response activities undertaken for each matter may vary according to the severity of the event, the degree of risk involved and the public sensitivity around the notification or request. On this basis, first response activities can be undertaken for both a critical event and low-level complaint.

This procedure establishes processes to ensure the timely and consistent processing of first response activities. First response activities may be carried out prior to the matter being created as an event in CISr.

Event management

The RMT through its delegate is responsible for the triaging, management and review of all events (incident notifications, statutory requests and/or complaints) referred to the region by the AS, emergency services or by other persons.

Events are usually triggered from receipt of notification of an incident, statutory request and/or complaint and are triaged by AS to determine a relevant response for each matter (e.g. no further action required, regional response required, AS to discuss and address the matter directly with the duty holder, or close out). In some circumstances, AS may liaise with the technical units and the RMT in determining a relevant response.

CISr is used to record actions in relation to the management of the notifications, including ongoing review as events are escalated and referred to and managed by regions. CISr's data recording standards and business rules provide organisational direction and consistency around data entry definitions and standards. Where OIR operational procedures contain additional CISr data recording instruction, the requirements of the operational procedures must also be followed.

Events referred by AS to the regions (regional response required) are triaged by the region to determine the required regional response. This response can include a determination to close out the event, create and allocate a response assessment, allocate as an investigation, or an escalation through these responses as required.

Response assessments

Response assessments are undertaken where Regulator activity is required to confirm compliance with the legislation. Follow up activity can be undertaken in many ways. For example, an Inspector being allocated to visit the workplace to verify compliance, or an officer requesting documentation or other information from a duty holder/obligation holder by telephone, letter or email and using this information to verify compliance.

Response assessment review

All response assessment work undertaken by an Inspector is assessed by a line manager who must complete a review (response assessment review) of work undertaken. This review assessment can be undertaken by a delegate where the matter is a priority level 3 or 4.

Response assessment reviews promote consistency, transparency and accountability by operating on the premise that all response assessments completed by an Inspector are reviewed by an RMT delegate to consider the appropriateness of actions taken. The review may result in the response assessment being closed (completed), returned to an Inspector for further work, escalated in level to an investigation, or directed to another workgroup.

Investigations

Investigations are carried out by Statewide Investigations in relation to incidents or events that involve fatalities, matters where the culpability of a duty holder is considered to be significant, and can relate to circumstances where persons are exposed to risk or there is an injury outcome.

Feedback

The OIR is committed to a high level of service provision when responding to client needs. Managing a client's expectations during OIR interactions is an essential element of public service.

WHSQ and ESO inspectorate staff **MUST** make reasonable attempts to contact all complainants (if known) to provide feedback of the outcomes from their complaint issues. This feedback can be over the phone, in person, or in writing.

The extent of the feedback will depend on the relationship of the person with the event. Ideally, feedback should be provided at the closure/finalisation of the OIR interaction, as it allows actions taken and outcomes to be communicated rather than the limited information available whilst interactions are ongoing.

This timeframe for providing feedback also coincides with RTI processes, where information can only be released once a matter is finalised. Note: Any fees paid by an RTI applicant for information requests are forfeited if a matter is ongoing.

Operational Procedure

This operational procedure is prescribed in 4 sections outlining the progressive event management process and the corresponding responsibilities:

Operational Procedure Contents	Responsibilities
1. Event notification and triaging	Advisory Services Assessment Services RMT or Delegate Duty Manager Administration Officer

2. Event/work allocation	Administration Officer RMT or Delegate
3. Event/work response	Inspector Duty Manager RMT, Delegate or Inspector
4. Event review and closure	RMT or Delegate Inspector Administration Officer

1. Operational Procedure – Event Notification and Triaging

Advisory services

Receipt incident notifications

Receipt any incident notification received and forward to the relevant unit for response. If the event is identified as outside of WHSQ and ESO jurisdiction at the outset, receipt it as usual through the Advisory/Assessment Services standard process.

If it is unclear whether an event is within WHSQ or ESO jurisdiction, process the event as a priority level 3 in CISr. Where an event is later identified to be within WHSQ or ESO jurisdiction, upgrade it to a higher priority as required.

Note: In CISr, complaints are usually processed as priority level 4 and incidents as priority level 3.

Note: For receipt of events that are complaints involving a situation of potential community concern, refer to [Appendix J – Complaint escalation management \(for potential community concerns\) for appropriate action](#).

Assessment Services

Triage and refer events for regional response

Triage in CISr any incident notifications, electricity entity notifications, statutory requests, complaints and/or any matters referred to AS by a region in accordance with AS operational procedures.

Determine action to:

1. Close out event;
2. Undertake AS administrative response; or
3. Refer event for regional response via CISr.

Note: The AS Manager, will provide each RMT with details of the event matters dealt with as administrative response, to enable a follow-up audit (10%) of these workplaces by the regions.

Note: In some circumstances, (e.g. matters involving chemicals or psychological risk), the awareness of, and complexity of, event issues may need to be identified through liaison with the technical units.

Note: For significant events, first phone regional RMT delegate with details.

Note: For potential community concern events, refer to [Appendix J – Complaint escalation management \(for potential community concerns\)](#) for appropriate action.

Refer events for regional response in CISr as appropriate. Ensure any events referred for regional response are categorised as either:

- Priority Level 3 - all notified incidents, or
- Priority Level 4 - all complaints (including statutory request).

Note: Consumers with reasonable concerns about the electrical safety of electrical equipment should be referred to the electricity distribution entity to take the action necessary in the interests of the electrical safety of persons (i.e. makesafe).

Liaise with the RMT for guidance on how to progress events where the duty holder or ABN is unknown.

Assessment Services / Regional Management Team

Determining event issues

Determine whether the event is a notifiable incident.

Determine whether the event requires the preservation of the incident site.

Where preservation of the incident site is required, inform the person with management or control of the workplace at which the notifiable incident occurred, of the duty to ensure so far as is reasonably practicable, the incident site is not disturbed until an Inspector arrives at the site or any earlier time that an Inspector directs. While this is a duty of the person with management control of the workplace under the relevant legislation, a reminder can be given by a phone call to the person.

Refer to [Appendix A – Preserving and releasing incident sites](#).

Where an Inspector becomes aware, or reasonably suspects, that a SEI or DEE has occurred at a workplace or domestic premises, and if an inspector is not on site, further assistance may be gained from a person under section 143 of the ES Act where the Inspector may require a person whom they reasonably suspect has knowledge of the circumstances, to give the Inspector reasonable help to preserve the incident site. This requirement may be given either orally or in writing.

Refer to [Appendix E - Event triaging definitions](#) for an SEI or DEE definition.

Determine whether the event is a complaint involving potential community concern or a situation where the potential for escalation is evident at the time of initial complaint. See [Appendix J – Complaint escalation management \(for potential community concerns\)](#) for appropriate response.

Regional Management Team Member or Delegate

COVID-19: to ensure the health and safety of the inspectorate when visiting a place when responding to an event or request for assistance, it is the Office of Industrial Relations' (OIR) policy that Inspectors must comply with any OIR operational policies and [directions of the Chief Health Officer](#).

Manage receipt of events made direct to the region

Where incident notifications, electricity entity notifications, complaints and/or other statutory requests for Inspector assistance are made directly to a region, determine whether the matter requires an urgent regional response.

1. Where an urgent regional response is required, complete first response activities as a priority. Seek for the PCBU to notify advisory services on an approved form, otherwise refer the matter to advisory services via the online form to create an event in CISr for regional response.
2. If the matter does not require an urgent regional response, seek for the PCBU to notify AS on approved form, otherwise forward the matter to the advisory services via the online form for processing.

Refer to [Appendix B – Referring regionally notified events to Assessment Services](#).

Managing ‘Out of jurisdiction’ and ‘No further action’ matters and fatalities

At the first opportunity, meet with the RMT to discuss the incident and decide which RMT delegate triages the event.

When responding to an incident, and a potential breach of other legislation not administered by WHSQ is identified, WHSQ should consult with the agency responsible for administering the other legislation. If necessary, relevant information can then be shared in accordance with section 271 of the Work Health and Safety Act 2011.

When an event involving a fatality is determined to be out of WHSQ/ESO jurisdiction, or there is no further action identified – the IM must notify the decision and/ or any action taken to Coronial and Investigations Liaison Unit by email at ohs.coronialliaison@oir.qld.gov.au.

Duty Manager

Manage receipt of events for after-hours/emergency situations

Where an immediate Inspector presence is required for an incident notification received outside of standard business operating hours or in an emergency situation, send an Inspector to complete first response activities without the event first being created. The Inspector is to collect all necessary information to enable an event to be created and also to advise the PCBU of their obligation to notify the Regulator about the incident.

Note: It is not the responsibility of advisory services to receipt and authorise the attendance of an Inspector to an incident site for incident notifications received outside of standard operating hours or in an emergency situation.

Where the matter is within jurisdiction notify other relevant agencies of this decision (i.e. QAS, QPS).

Further information can be obtained from the [After-hours on call arrangements](#) procedure.

Refer events to other responsible agencies

Refer any matters relating to other jurisdictions to the responsible agency.

WHSQ and ESO have in place a number of [Memoranda of Understandings](#) (MOUs) featured on the WorkSafe Queensland website with other agencies. Processes for referral to these

agencies must follow the protocol set out within the relevant MOU.

Regional Management Team Member or Delegate or Duty Manager

Electrical Safety issues

The Manager or inspector is to ensure appropriate and reasonable steps are taken to ensure the location has been made electrically safe, which include directing the PCBU to arrange isolation, or notifying the relevant electricity distribution entity.

If the matter is related to a current or former electrical licence holder, refer to the relevant OIR operational procedure, [Disciplinary action referrals for current and former electrical contractor licence holders](#) and/or [Disciplinary action referrals for current electrical work licence holder](#).

Determining if WHSQ or ESO will lead the OIR response

Events will be allocated by the OM/ESM, delegate, or duty manager.

1. ESO will be lead agency for response assessments relating to incidents occurring in domestic premises involving:
 - a home owner;
 - tenants;
 - non-electrical persons not involved in a workplace activity; or
 - incidents that involved electrical licence holders.
2. WHSQ will be the lead agency for electrical incidents which occur at a workplace. For example, electrical events involving plant or vehicles contacting overhead and underground electric lines; or plant or vehicles entering or approaching an exclusion zone for overhead electric lines.

In each event above, the other agency may be called upon for expert or technical advice.

Refer to the [Electrical matters: Determining if Workplace Health and Safety Queensland or Electrical Safety Office is lead agency](#) document to further identify lead agency situations and considerations.

Preparation of a Significant Incident Notification (SIN)

Prepare a SIN report for matters that involve:

1. fatalities; or
2. significant incidents that have or may attract media attention, and/or raise significant community concerns.

See [Appendix C – Significant incident notification email templates](#) for further guidance.

Email the SIN to the distribution list (type '[DL-Significant Incident](#)' in the email recipient field).

Note:

- For matters reported to WHSQ/ESO as fatalities, confirm (with ambulance, hospital, police) the person is deceased before sending out a SIN;

- Be succinct and use general information that does not identify individuals;
- Only report facts and do not pre-empt outcomes of investigations; and
- Use appropriate language that is sensitive to context.

Regional Management Team

Monitor receipt of events

Allocate RMT delegate the responsibility for management of referred events within CISr.

Ensure that the CISr event screen is reviewed at a minimum of once every work day.

Record all activities in CISr.

Regional event triage

Review and action each regionally allocated event (regional response) in CISr by completing the compulsory triaging matrix for each event.

Refer to [Appendix D – Event triaging matrix](#) and [Appendix E – Event triaging definitions](#).

There are three triaging outcomes:

1. **No further action – requires RMT decision** to determine that no further activity is required (further information can be obtained via a phone conversation prior to triaging, with an activity required to be completed in the event screen of CISr).
2. **Response assessment** – further information or other follow up activity is required in the form of an Inspector visit to the workplace, request for documentation or other evidence from a duty holder to verify compliance or other written request (e.g. letter, fax or email).

Note: The RMT has discretion to allocate a regional response as:

- an administrative response (i.e. phone call, letter or email);
 - a response assessment; or
 - an investigation.
3. **Investigation** – the matter satisfies criteria for escalation to an investigation.
 - The matter is within jurisdiction and involves a fatality; or
 - The matter is agreed by the IM to be escalated to an investigation.

Note: All activities conducted in the event triage process must be recorded in CISr.

Regional response

If adequate information is available, allocate as a response assessment or investigation to an Inspector (investigating officer) through CISr.

Note: Use discretion regarding the number of Inspectors to be dispatched to the site. Contact other regions in circumstances where additional resources are required.

When allocating inspectors to attend workplaces in response to an entry permit holder request for assistance and the entry permit holder or worker representative will be on site at the same time, the RMT will allocate more than one inspector to attend unless there are exceptional circumstances.

Exceptional circumstances may include entry permit holder requests for assistance, when

there is evidence of a serious and imminent risk and a second inspector is not available, for example in remote locations or after hours. The RMT should consult with the attending inspector if another inspector is not allocated and ensure all parties agree with the arrangements. The priority for the RMT is to fulfill OIR's regulatory function while ensuring the health and safety, including psychological health, of its workers so far as is reasonably practicable.

Sensitive issues

Consideration must be given to prior experience of the allocated Inspector.

Ensure that traumatic or distressing incidents (including fatalities) are not allocated for completion to a sole Inspector within their first 12 months of service.

Consider possible impacts on Inspector/s when allocating first response activities (e.g. allocating matters involving young children to Inspectors with young families).

Inspector psychological health

Consider the psychological health and safety of Inspectors as a result of the first response activities undertaken and refer the Inspector to the Employee Assistance Service as appropriate. Guidance can be sought from OIR operational document [Managing traumatic and distressing incidents](#), and OIR [Work-related violence and aggression policy](#) and the [prevention and management guidelines](#).

Administration Officer

Update response assessment master spreadsheet

A region or office may create a master spreadsheet for tracking all response assessments.

Note: This can be a standalone spreadsheet, or a CISr generated report.

2. Operational Procedure – Event/work allocation

Regional Management Team Member or Delegate

Creating and allocating a response assessment

Where the event is a fatality, the IM takes responsibility of further actioning.

Where the event is an injury or illness requiring immediate treatment as an in-patient, the RMT is to discuss who takes responsibility for further actioning. Allocating a response assessment will be undertaken by the OM or delegate and allocating an investigation by the IM.

A request or referral to the Regulator under the Act; an enforcement priority; a serious electrical incident; or any other injury or illness requiring a person to have immediate treatment as an inpatient, will require a mandatory allocation of an inspector to undertake a response assessment.

A serious injury or illness; potential significant event; or critical event that could have resulted in an injury or illness requiring a person to have immediate treatment as an inpatient in a hospital; a complaint of non-compliance; serious contravention of the WHS Act; or a dangerous electrical event, will require the RMT, or delegate, to apply discretion to determine

required action when assessing the event (e.g. administrative response, response assessment, or referral to IM for consideration of an investigation).

All decisions/actions must be recorded in CISr as an activity within the corresponding event or response assessment, and/or investigation.

Note: Individual event details will determine the level of response and appropriate allocation should be discussed with the RMT. These event types are typically allocated as response assessment due to the serious nature of the event and/or in accordance with the CMEP.

Refer to [Appendix D – Event triaging matrix](#) and [Appendix E – Event triaging definitions](#).

Create the response assessment from the event in CISr and allocate it to an Inspector.

Email the Inspector allocated the response assessment to advise them of the work allocation.

Ensure you advise the Inspector:

- whether confidentiality has been requested,
- whether the matter involves potential community escalation concern, and
- of any information or directions required that may assist the Inspector with his/her enquiries.

The Inspector is to complete the CISr entries and save all files into the electronic folder for the event.

Create additional response assessments from the event in CISr (as required)

Where an event has more than one duty holder, the RMT will create an additional response assessment for each duty holder identified.

Where the assessment services Manager, has provided details of the workplaces that had their event matters dealt with as administrative response, the RMT will ensure that a follow-up audit of ten percent (10%) of these workplaces is conducted by the inspectorate to check compliance against the matters raised.

Planning Inspector activities

Inspectors will receive a CISr automated email notification of an allocated response assessment.

Conduct an initial planning meeting with the Inspector/s allocated the response assessment in the following circumstances:

1. where the incident, complaint or the request/referral to the Regulator is significant in nature (i.e. serious injury, high risk, potential community escalation concern); or
2. where the Inspector's competency in the area of the event requires guidance (i.e. new Inspector to WHSQ, matter outside field of expertise).

In some circumstances the planning meeting may be undertaken by phone and/or email. If the Inspector is known to be out of email contact (i.e. rotational trips to outer regional areas), make sure contact is made by phone to conduct the initial planning meeting.

Response assessment timeframes

Response assessments are to be commenced within the following timeframes:

Nature of event	Timeframes for commencement
Statutory request for Inspector assistance	These have stipulated response times that must be followed. Refer to the relevant operational procedures for more information.
Critical event or incident involving death	As soon as reasonably practicable and within 24 hours of a being notified to WHSQ/ESO.
Incidents involving serious injuries/illness, dangerous events, serious electrical incidents	Within 48 hours of regional notification, or as directed by the RMT (e.g. matters where excess travel or work out of hours is required may extend this response time).
Matters of possible significant community escalation concerns	As required by relevant operational procedures relating to matters of possible significant community escalation concerns. See Appendix J.
Complaints of a high-risk nature	As soon as reasonably practicable.
Complaints, injuries of less significant nature	Within 7 working days , or as directed by the RMT (e.g. matters where excess travel or work out of hours is required may extend this response time).

Communicate any issues related to the ability to meet set timeframes to the RMT.

Note: The geographical location of the workplace/domestic residence may impact on the above timeframes (e.g. timeframes may need to be extended for places in isolated locations).

Administration Officer

Electronic event folder creation

Create an electronic folder for the event in the region's business data drive. Ensure you save the event folder as an event number (e.g. E229480) and the PCBU name.

Create subfolders within the electronic file for the event as below:

1. Event details
2. Notebook notes
3. Photos
4. Notices
5. Documents
6. Correspondence.

Save the CISr Email notification, Event Details Report, any documents in CISr and the Event Cover Sheet into the '1. Event Details' folder.

If details of the legal entity or ABN are not supplied or unavailable at the time the event is allocated, contact the Inspector who has been allocated the work to request these details be collected.

3. Operational Procedure – Event/work response

Inspector

Work allocated via email

Regularly check your email for any response assessments allocated to you.

Review the email from the RMT with the response assessment details. Ensure you note whether confidentiality has been requested.

Preparation to undertake the response assessment

Access the electronic folder for the event and review the contents of the folder titled, '1. Event details. This is to include the current history report of the PCBU involved in the matter being attended (circumstances requiring urgent attendance may prevent this being undertaken prior to first response).

Contact the complainant to ensure complaint details are correct and manage the complainant's expectations regarding the role of the OIR in actioning their complaint. Inspectors should:

- Discuss elements of the complaint.
- Discuss confidentiality and the potential for the PCBU or others to draw conclusions despite OIR maintaining the confidentiality of the complainant.
- Discuss the scope of OIR's jurisdiction and that Inspectors can only act upon what they see on the day.
- Clarify anything with the complainant which is unclear and paraphrase the information provided back to the complainant for their confirmation of its accuracy.
- Discuss the provision of feedback and the estimated timeframes surrounding this.
- Discuss RTI processes. This conversation is to be recorded in your official Inspector notebook and CISr.
- If the complainant does not request feedback, note this in your official Inspector notebook and CISr.

Where incident/complaint or statutory response is of a critical nature, it may be required to determine whether there are circumstances that require the issuing of a non-disturbance notice prior to you attending the workplace or incident site. Circumstances may include:

- a matter reported or referred, i.e. a complaint, that does not fit the criteria of a notifiable incident under the relevant Act;
- or a notifiable incident in circumstances whereby the RMT is not confident of the site being preserved until your arrival.

Where a non-disturbance notice is to be issued prior to attendance at the site, the notice must be issued in writing by the Inspector who will attend the site.

Review the information provided for the matter and obtain any additional resources that may be necessary to undertake the first response activities.

Resources include investigative tools (e.g. personal protective equipment, tape measure, sample bags, legislation, codes of practice, standards, etc.) and any assistance/expert knowledge required (e.g. OIR technical expertise, other agencies on site, jurisdiction, etc.).

Confirm with RMT any specific directions and whether you will be required to contact them before departing the incident site.

Conduct first response activities/response assessment

Upon arrival and entry to the workplace or domestic residence ensure you comply with OIRs' relevant operational procedures regarding powers of entry.

Ensure you comply with all relevant operational procedures when actioning the response.

Complete first response activities for incidents and complaints.

Follow the activities as prescribed in any relevant operational procedure relevant to the statutory request.

Record all activities undertaken in CISr. The information included in the activities should summarise the activities undertaken by the Inspector throughout the duration of the first response and/or response assessment.

ES Inspectors must ensure the appropriate report is completed for the corresponding notifiable incident:

Incident type	Reporting	Reviewing officer
Serious Electrical Incident	Serious Electrical Incident Examination (EIE) report must be completed within 10 working days of receipt of the notification.	Reviewed and signed by the ESM and forwarded to the IM and Director – Electrical Safety Compliance.
Dangerous Electrical Event and the original response assessment indicates that the matter is targeted for prosecution or will progress to the IM.	Dangerous Electrical Event (DEE) report must be completed within 20 working days of receipt of notification.	Reviewed and signed by the ESM and forwarded to the IM.

Preserving incident sites

Upon arrival at a workplace or domestic residence following a notifiable incident, determine whether the site requires continued preservation.

Refer to [Appendix A – Preserving and releasing incident sites](#).

If required, issue a non-disturbance notice to maintain site integrity.

RMT briefing

Contact RMT for mandatory briefing **before** departing the workplace or domestic residence and to seek further direction, if:

- RMT has requested a briefing;
- required to confirm departure time for safety and security reasons;
- seeking to release the incident site, plant or equipment; or
- uncertain about whether the first response activities undertaken are appropriate for the matter.

Regional Management Team / Duty Manager

Consider first response findings and provide direction (if relevant)

If the first response Inspector provides a briefing before departing the workplace, consider the information provided and make an assessment as to whether the:

- incident site can be released; or
- task should be reallocated to another workgroup based on initial inquiries (e.g. referral of task from ESO to WHSQ if it is determined that ESO is not the appropriate jurisdiction); or
- matter is likely to be escalated to an investigation or prosecution. Seek assistance and advice from OIR technical units as necessary.

Provide direction to the Inspector accordingly (e.g. conduct the necessary preliminary investigation activities, issue a non-disturbance notice, etc).

As appropriate, discuss the matter with the IM before providing advice to the Inspector or refer the Inspector to discuss the matter directly with the IM.

Determine requirement for gathering of evidence and communicate to Inspector.

Regional Management Team, Delegate or Inspector

Event management review

As soon as practicable after undertaking the first response activities, participate in an event management meeting and review findings. **Note:** Not all regional response activities require event management review. This will be conducted at the discretion of the RMT.

Complete the event management team meeting within the following timeframes:

Nature of event	Timeframes for completion
Statutory request for Inspector assistance or	As soon as practicable following first response
Critical event, other than a fatality	Within 7 working days following first response
All other notifiable incidents	Within 14 working days of receipt of notification

Record all first response activities in the relevant response assessment in CISr.

Inspector

Timeframes for completion of response assessment

Complete the response assessment within the following timeframes:

Nature of event	Timeframes for completion
Statutory request for Inspector assistance	These have stipulated completion times that must be followed. Refer to the relevant operational procedures for more information.
Incidents involving serious injuries/illness, dangerous events, serious electrical incidents	Must be completed or referred for investigation within 22 workings days of allocation, or as directed by the RMT (e.g. matters where excess travel or work out of hours is required or psychosocial matters may extend this response time).
Matters of possible significant community escalation concerns	As required by relevant operational procedures relating to matters of possible significant community escalation concerns. See Appendix J.
Complaints, injuries of less significant nature	Must be completed or referred for investigation within 22 working days of allocation, or as directed by the RMT (e.g. matters where excess travel or work out of hours is required or psychosocial matters may extend this response time).

Recording information

Record all details relating to all assessments in CISr within **five (5) working days** of completing the activity.

Compile all information and documents relevant to the response assessment and request closure via referral to the RMT for review, including (but may not be limited to):

- Inspection report (where the event involved a site visit and related to a duty holder in the Major Construction Projects Program or was undertaken in response to union activity)
- Statutory notices issued
- Inspector notebook entries
- Photographs
- Other documents as gathered.

Upon completion of the response assessment, choose activity type 'Referral to Manager' or 'Request Closure' in order to prompt the RMT delegate/line manager to review the response assessment. A decision on whether to close the response assessment or request further actioning will be made by the RMT delegate/line manager.

Ensure all information collected or created as part of the response assessment is saved in the electronic folder for the event. This will help reduce the amount of information CISr is required to store and help prevent CISr from operating at slower speeds.

When requesting documents from the PCBU, ensure you ask for documents to be emailed. Where documents are unavailable in electronic form, ask the PCBU to scan and email the relevant documents. Ensure the request is completed by the PCBU before leaving the site. If

the Inspector leaves the site without the documents having been emailed by the PCBU or the PCBU no longer agrees to the request, the Inspector will need to issue a formal written notice requiring the information under s 171 of the WHS Act. Where the PCBU does not have access to scanning and email facilities, take photos of the documents onsite, or take a copy of the documents with you to scan upon your return to the office. Ensure you store the scanned versions of any documents into the subfolder for the event titled '5. Documents'. There is no need to upload any documents into CISr.

Note: Any original hard copy documents an Inspector obtains as evidence (e.g. copies of safe work method statements, policies or procedures, etc.), or any handwritten notes the Inspector makes in the course of the response assessment must be scanned into the electronic folder for the event. Forward the hardcopy documents requiring archiving to the administration officer.

Save all emails into the subfolder '6. Correspondence' (drag and drop the email from Outlook into the subfolder or follow the menu prompts – file – save as).

At the completion of the response assessment, the 'Event Details' summary report is required to be generated prior to referral of the response assessment to the line manager or delegate. When all activities have been entered onto CISr, tick the 'Request closure of assessment' field in the CISr response assessment screen, and select a line manager or delegate to whom to assign the response assessment for review.

4. Operational Procedure – Event review and closure

Regional Management Team or Delegate

Review and closure of response assessments

Regularly check your email for any assessments that have been recently referred to you for review and closure.

Review the response findings and determine appropriate course of action. The response assessment review is a question matrix located within the CISr activities of the response assessment. See [Appendix H – Closure triaging matrix](#), for the specific questions.

There are three outcomes of the review:

Outcome	Action
1. Further activities are required to be undertaken before the assessment satisfactorily addresses the issue/s at hand.	Refer the matter back to the Inspector with information on the further activities to be undertaken and documented within CISr.
2. The response assessment satisfactorily addresses the issue/s at hand and no further action is required.	Close out the response assessment with closure statement in CISr.
3. The response assessment identifies the matter to be appropriate for escalation to an investigation, or referral to another workgroup.	Refer the matter to the IM for escalation, or to another workgroup for further action, and record action as an activity in CISr.

If the matter is related to a current or former electrical licence holder, consider referral to the Electrical Licencing Committee (for **Guidance** refer to *Disciplinary action referrals for current and former electrical contractor licence holders* and/or *Disciplinary action referrals for current electrical work licence holder*).

Review response assessment

The CISr exit triage must be completed for each response assessment. Upon receipt of the CISr notification requesting closure or referral to manager for a response assessment, complete the following activities:

- review all information in the electronic folder for the event;
- (in determining appropriateness of response, seek advice from OIR technical units as necessary);
- add review activities to the response assessment in CISr;
- complete the exit triage within the response assessment in CISr;
- create an activity within the response assessment in CISr for 'No further action' and record a 'Reasons for closure statement' in the 'Description' and 'Outcomes' fields; and
- change the allocation of the response assessment back to the actioning Inspector for their future reference.

Refer to [Appendix G – Reasons for closure statements](#) for examples of wording used to close out response assessments.

Manage events that require further work

Where the exit triage or RMT determines that the event requires further work, reallocate the event to the Inspector completing the work or to a different Inspector, or alternative workgroup (if appropriate). Save any electronic communication (e.g. emails, notes, etc.) into the electronic file for the event and create an activity in CISr for this action.

Manage events for closure

Where the CISr triage allows the event to be closed out, close the event and move the electronic folder for the event into an area designated for completed events. Ensure access to the folder for completed events is limited to the RMT and Administration Officers for information security, privacy and accessibility purposes (i.e. prevent information inadvertently being lost or deleted).

Forward to the Administration Officer, via email, any details to be updated in the master tracking spreadsheet. Forward any hard copy documents requiring archiving to the Administration Officer.

Manage response assessments that require referral to IM or other workgroup

Where the exit triage in CISr requires the response assessment to be referred to an IM or other workgroup, complete the following activities:

- allocate the file to the IM/ workgroup;
- provide the IM/ workgroup with the file location for the electronic folder for the event; and
- save any electronic communication into the electronic folder for the event (e.g. emails, notes).

Regional Management Team, Delegate or Inspector

Feedback on response actions regarding complaints

Where a response assessment relates to a complaint, the complainant must be provided with feedback on the actions taken in response to the complaint (unless feedback has specifically not been requested).

Feedback on actions taken in response to complaints involving potential for escalation are to be managed in accordance with the procedures in [Appendix J – Complaint Escalation Management \(potential community concerns\)](#).

Information able to be released when providing feedback includes:

- scope of inquiries made (i.e. site visit, phone call, document review, etc.);
- findings/outcome of the inquiries made; and
- actions taken (i.e. provision of advice, enforcement action taken to address the issues identified).

Ensure you do not disclose any personal information (e.g. names of persons). Instead, refer to company names and position titles held. You may provide the complainant with summary information about the type of notice issued and the contents of the notice but **do not** provide him/her with any copies of documents from the inquiries, including any notices issued.

Ensure you advise the complainant of his/her options should he/she be dissatisfied with the outcome/s of the inquiries and/or process followed. The options include:

- contact the nominated RMT member to discuss concerns;
- submit a customer complaint via the OIR website(worksafe.qld.gov.au).

Where a response assessment has been finalised and the matter is not being escalated for investigation, advise the complainant or incident notifier of his/her option to make an application under the RTI process to access the documents for the matter. Provide the complainant or incident notifier with the event number and direct him/her to contact the OIR RTI Unit on 3406 9982 or via www.rti.qld.gov.au.

Note: Under the RTI process, documents are only released where a matter has been finalised and application fees are not refunded for matters that are not yet finalised.

Feedback:

- does not have to be provided in writing. Feedback may be provided verbally through phone calls, Inspector interactions or email/letter communication. Refer to [Appendix I](#);
- must be recorded in the Inspector's official notebook and on CISr. This record must detail:
 - how and when the feedback was provided
 - the content of the feedback
 - the client's options under the departmental customer complaint management policy should he/she be dissatisfied with the service delivery outcome/s; and
 - the provision of right to information (RTI) processes.

When recording the provision of feedback as an activity in the response assessment in CISr,

use the activity type that best represents the mode of delivery of the feedback (e.g. 'phone call activity type' for phone call, 'site visit activity type' for a site visit specifically to deliver feedback, 'correspondence activity type' for an email, letter or fax).

Inspector

Collate hard copy documents

Collate any original hard copy documents obtained into a hard copy folder for the event and forward to the Administration Officer for archiving. Refer to [Appendix F – Event cover sheet](#). Ensure you clearly mark the front cover of the folder with the following information:

- event number
- entity legal name
- injured person (if applicable)
- electronic file location.

Note: The hard copy folder should only contain original hard copy documents obtained relating to the event. It does not need to duplicate the contents of the electronic folder for the event.

Manage additional information received after the event has been closed

Save any additional information received for the event after close-out has been completed into the electronic file for the event and create a corresponding activity in CISr. Forward any additional hard copy information relating to follow up visits to the Administration Officer for archiving.

Where a complainant contacts OIR with additional information after the event has been closed, and the additional information means the event is deemed as warranting further investigation, a new event must be opened. The relevant Manager or RMT will make the decision whether to continue the new event, or link to and re-open the previous event.

Administration Officer

Update master tracking spreadsheet and archive hard copy documents

Update the master tracking spreadsheet with any additional information supplied by the RMT.

Archive any hard copy documents received, including after the event has been closed, in accordance with records management protocol.

Where original, physical documents form part of the record set, the original must be retained, even if it is scanned and saved electronically.

Files should be identified so that they can be cross-referenced with the electronic file (i.e. the event number).

Appendices

Appendix A - Preserving and releasing incident sites
Appendix B - Referring regionally notified events to Assessment Services
Appendix C - Significant incident notification email templates
Appendix D - Event triaging matrix
Appendix E – Event triaging definitions
Appendix F – Event cover sheet
Appendix G – Reasons for closure statements
Appendix H – Exit triaging matrix
Appendix I – Complainant feedback letter template
Appendix J - Complaint Escalation Management (for potential community concern)

Document Approval

Stacey Ozolins

A/Executive Director,
Compliance and Field Services

Date: 21 August 2023

Donna Heelan

Executive Director,
Electrical Safety Office

Date: 13/12/2022

Yasmin Cox

Executive Director,
Specialised Health and Safety Services

Date: 24/03/2020

Andrea Fox

A/Executive Director,
WHS and Engagement Policy Services

Date: 23/08/2023

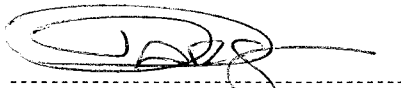
Version control

Version	Date	Amendments	Content contributor	Checked by	Amendment approved
-	17/01/2019	Merged off green sheet and tables removed, updated content, documentation merge to incorporate WRAP procedures and managing signification communication escalation concerns procedures	CFS/ IPS	Ben Bailey	All ED
9.4	23/03/2020	Procedure updated to include link to special COVID-19 reactive response additional triaging matrix	Nicky Sherwood	Ben Bailey	Andrea Fox Rob Wicks
9.5	19/8/2020	Minor clarification for exit triage and event closure	IPS on behalf of LAS and CFS	Ben Bailey	Yasmin Cox
9.5	4/12/2022	Update corporate branding, update hyperlinks to other procedures, insert text regarding the referral of events to other workgroups, update COVID-19 statement, require confidentiality issues to be discussed with anonymous complainants, updating minor information management practices identified as inconsistent with current practice.	IPS team update Lisa Lewis /Nicky Sherwood	Nicky Sherwood	Donna Heelan
9.6	22/02/2023	Update reference to remove One-Stop-Shop back to Advisory Services Updated abbreviations.	IPS team review	Ben Bailey	Andrew Harris
10	23/08/2023	Update to inspector allocation for EPH	Nicky Sherwood on behalf of Chris Coxon	Luke Massey	Stacey Ozolins

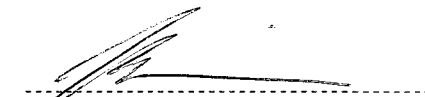
Commission of Inquiry into the CFMEU and Misconduct in the Construction Industry

ANNEXURE SHEET

This is the document referred to as DD-2 in the statement of Deborah Ngaio Dargan affirmed at Brisbane on 2 March 2026



Deborah Ngaio Dargan



Witness (Lawyer)

27 May 2022

Ms Deborah Dargan

By email: [REDACTED]

PRIVATE AND CONFIDENTIAL

Dear Ms Dargan

Internal assessment of customer complaint

I refer to a complaint to the Office of Industrial Relations (OIR) received on 12 April 2022 by email expressing dissatisfaction with your actions when you abruptly left a construction workplace whilst carrying out first response activities after a tower crane malfunction. This occurred at a construction workplace at Milton on 12 April 2022.

An internal assessment involves consideration of the issues raised in your complaint, any decisions and or actions arising from this consideration, and reasons for these decisions.

This letter is a record of the outcome of the internal assessment.

Background

On 12 April 2022 OIR received an email expressing dissatisfaction with the actions of Inspector Deborah Dargan who abruptly left a construction workplace whilst carrying out first response activities as a result of a tower crane malfunction. This occurred at Milton on 12 April 2022.

In short, the issues raised in the customer complaint were:

1. Inspector Dargan left site abruptly, for no apparent reason.
2. Inspector Dargan failed to take enforcement action to address non-compliance hazards posing a risk to the public posed by a suspended crane load over McDougall Street Milton.

Evidence considered

In reviewing the complaint, the following evidence was collected and considered:

- Typed notes of telephone interview: Mark Houston and Mr Dennis Mitchell (CFMEU Representative)
- Typed notes of telephone interview: Mark Houston and Mr Dylan Howard (CFMEU Representative)
- Typed notes of telephone interview: Mark Houston and Mr David Peel (Hutchinson Builders Representative)
- Typed notes of telephone interview: Mark Houston and Mr Matthew Cuthbert (Hutchinson Builders Representative)
- Typed notes of Microsoft Teams interview: Mark Houston and Inspector Deborah Dargan
- Typed notes of Microsoft Teams interview: Mark Houston and Inspector Peter Stevens
- Email from the complainant
- Photograph from the complainant

- Information contained on WHSQ internal databases
- Site diary notes from Hutchinson Builders

Relevant legislation

WHSQ administers the *Work Health and Safety Act 2011* (The WHS Act), and the *Work Health and Safety Regulation 2011* (the WHS Regulation). The object of the WHS Act in section 3 Securing compliance with this act through effective and appropriate compliance and enforcement measures and providing a framework for continuous improvement and progressively higher standards of work health and safety.

Referenced legislation can be viewed at: <https://www.legislation.qld.gov.au/>

OIR operational environment

Before reviewing the actions taken by OIR in response to your complaint, I will outline some relevant aspects of OIR's operational procedures that were in place at the time. These procedures have direct relevance to the organisational response to customer delivery complaints received.

- Customer Complaints Management Guidelines
- OIR Customer Complaints Management Policy
- OIR Compliance Monitoring and Enforcement Policy

Internal assessment findings

I will address my internal assessment findings in the order they have been elementised.

Element 1

The evidence supplied in interviews with CFMEU Representatives and Hutchinson Builders Representatives indicate that Inspector Dargan did leave the site abruptly, for no apparent reason.

The evidence obtained from the interview with Inspector Dargan contradict this.

On a balance of probabilities, I can substantiate this element of the complaint.

Element 2

The evidence supplied in interviews with CFMEU Representatives, Hutchinson Builders Representatives and Inspectors Dargan and Stevens provide a mixture of opinion. Generally, it was agreed that there was traffic control in place although some evidence supplied indicated that the traffic control was not entirely effective earlier on. All people interviewed indicated that the process for controlling both pedestrian and vehicular traffic improved swiftly when the street was closed, more spotters and more traffic cones and directional aides were implemented.

All people interviewed agreed that there were no uncontrolled hazards at the workplace. The CFMEU Representatives interviewed both stated that early on in the day they had made enquiries regarding the proposed methodology to lower the load given the tower crane was not operable. Technical people employed by the crane owner came to site and worked with the CFMEU Representatives and others to formulate a methodology.

I am unable to substantiate this element of the complaint.

Outcome

This now finalises the internal assessment of the complaint. Thank you for the assistance you have given for the investigation of this customer service complaint.

I have referred the findings of this service delivery complaint to Executive Director Andrew Harris, Workplace Health and Safety Compliance and Field Services for internal management.

I remind you if you have any concerns, the Employee Assistance Program provided through SMG Health is available to employees. This service is a confidential counselling and support service and is available on 1800 273 865.

Should you have any questions about the contents of this letter please contact me or Ms Helen Burgess: [REDACTED]

Sincerely,

[REDACTED]

Mark Houston
Operations Manager
Construction Compliance and Field Services
Office of Industrial Relations