REPORT ON PROCEEDINGS BEFORE

SELECT COMMITTEE ON THE CORONIAL JURISDICTION IN NEW SOUTH WALES

CORONIAL JURISDICTION IN NEW SOUTH WALES

UNCORRECTED

At Jubilee Room, Parliament House, Sydney on Monday 31 January 2022

The Committee met at 10:15.

PRESENT

The Hon. Adam Searle (Chair)

PRESENT VIA VIDEOCONFERENCE

The Hon. Catherine Cusack
The Hon. Rod Roberts
The Hon. Penny Sharpe
Mr David Shoebridge (Deputy Chair)

* Please note:
[inaudible] is used when audio words cannot be deciphered.
[audio malfunction] is used when words are lost due to a technical malfunction.
[disorder] is used when members or witnesses speak over one another.

The CHAIR: Welcome to the inquiry into the coronial jurisdiction in New South Wales. Before we commence I would like to acknowledge the Gadigal people, who are the traditional custodians of the land on which Parliament sits and where I am today. I would also like to pay my respects to Elders past, present and emerging of the Eora nation and extend that respect to any other First Nations persons present. Today's hearing is being conducted virtually. This enables the work of the Committee to continue during the COVID-19 pandemic without compromising the health and safety of members, witnesses or staff. I would ask for everyone's patience through any technical difficulties that we may encounter during the hearing today. If participants or witnesses lose their internet connection and are disconnected from the virtual hearing, they are asked to rejoin the hearing by using the same link provided by the Committee secretariat. Today we will be hearing from a family who has lost a loved one in a workplace accident. We will also be hearing from a number of industrial organisations—unions—and we are very thankful to hear evidence from the mother of Christopher Cassaniti, who, as I indicated earlier, tragically lost his life in a work fatality in April 2019.

I thank everyone for making the time to give evidence to this important inquiry. Before we commence, I would like to make some brief comments about the procedures for today's hearing. While parliamentary privilege applies to witnesses giving evidence today, it does not apply to what witnesses say outside of their evidence at the hearing. I therefore urge witnesses to be careful about comments they may make to the media or others after completing their evidence here. Committee hearings are not intended to provide a forum for people to make adverse reflections about others under the protection of parliamentary privilege. In that regard, it is important that witnesses focus on the issues raised by the inquiry terms of reference and avoid naming individuals unnecessarily. All witnesses have a right to procedural fairness according to the procedural fairness resolution adopted by the House in 2018. If witnesses are unable to answer a question today and want more time to respond, they can take a question on notice. Written answers to questions taken on notice are to be provided within 21 days.

Today's proceedings are being recorded and a transcript will be placed on the Committee's website once it becomes available. I will make a few notes on virtual hearing etiquette to minimise disruptions and assist our Hansard reporters. I ask Committee members to clearly identify to whom questions are directed. I ask everyone to please state their name when they begin speaking. Could everyone mute their microphones when not speaking and please remember to turn your microphones back on when you are getting ready to speak. If you start speaking while muted, please start again so that it can be recorded in the transcript. Members and witnesses should avoid speaking over each other, so we can all hear each other clearly. To assist Hansard, I remind members and witnesses to speak directly into the microphone and avoid making comments when your head is turned.

Before moving to our first witness I will make a couple of observations. One, I believe Marija Marsic, the assistant secretary of the Transport Workers' Union, will no longer be giving evidence this morning. It will be Mitch Wright, the media and political adviser to the union, who will be speaking on behalf of the union. Secondly, there is a small change in the composition of this Committee. Mr Khan is no longer a member of this inquiry. He has been appointed as a magistrate and we will miss his contribution, but we have Mr Peter Poulos, who replaces him but who is an apology for today's meeting.

PATRIZIA CASSANITI, Mother of Christopher Cassaniti, before the Committee via videoconference, sworn and examined

The CHAIR: I now welcome our first witness, Ms Patrizia Cassaniti. Can you please state your name and swear either an oath or affirmation from the material that has been emailed to you by the secretariat? Ms Cassaniti, we cannot hear you. If you can, unmute yourself and start again. No, we cannot hear you yet. I think we can hear you now, Ms Cassaniti. Just speak again.

Ms CASSANITI: Can you hear me now?

The CHAIR: Yes, perfect. Okay, we seem to have lost you again. The image is frozen and we cannot hear you.

Ms CASSANITI: Can you hear me now?

The CHAIR: I can hear you. Ms Cassaniti, maybe turn off the video and see whether that improves the audio.

Mr DAVID SHOEBRIDGE: I got Ms Cassaniti through pretty much all of that, with only a very tiny break.

The CHAIR: Okay. I do not think we got any of her here at the Parliament.

Ms CASSANITI: Alright, can you hear me now? I can hear everybody.

The CHAIR: Good. We can hear you now.

Ms CASSANITI: Did you lose me again?

The CHAIR: I am told that the transcript is recording you, and I think the Committee members can hear you. It is just me who intermittently loses you.

Ms CASSANITI: Right, okay. So I will continue?

The CHAIR: Yes.

Ms CASSANITI: No problem. I will start my statement.

The CHAIR: Yes. If you would like to give an opening statement, please proceed.

Ms CASSANITI: Sure. Good morning. Firstly I would like to take this opportunity to thank the Committee for allowing me to be witness to the coronial jurisdiction hearing. My name is Patrizia Cassaniti. I am Christopher's mum. He unfortunately passed away on 1 April 2019 in a tragic and totally unnecessary scaffold collapse. Christopher was crushed and suffocated to death. It would have taken a five-minute, complacent decision that was made to speed up the process to get the job done that took my son for life. That decision was to remove all the ties that secured the scaffold to the building and overload it by 19 tonnes of material that caused the scaffold to collapse. These actions are common and usually a major factor of incidents happening on job sites due to time constraints and cost-cutting processes that get the job done. As with Christopher's law, I hope that unrealistic time constraints and quoting costs of jobs are better regulated. I am grateful to the Coroner, who called me just before Christopher's funeral to explain how Christopher died and told me that the reason why she called was because [audio malfunction].

I want to know why [audio malfunction] and why it is so hard to get information. I would like to express that, from personal experience, it would be greatly appreciated if we were contacted more often during the process, as we feel left in the dark and that the death of our loved one is just a statistic. Today will be two years and 10 months after Christopher's death and I still do not know exactly what happened. Only God knows when I will. I have put in several requests for a coronial inquiry to take place but keep getting told that because there has been a prosecution there will be no need. I totally disagree with this decision, knowing that Christopher's case is one of the biggest investigations taken on by SafeWork NSW, with an outcome that did not match the severity of the crime, therefore not setting a precedent to other persons conducting a business or undertaking [PCBUs] for consequences dealt due to unsafe work practices.

I also speak on behalf of all other families who have lost [audio malfunction]. We all would like to see that when a death occurs at a workplace a coronial inquest must [audio malfunction], and a jury should be appointed to the case. The penalties we have in New South Wales are a slap in the face and no way enough for the sentence we endure, made even worse when an enforceable undertaking is given to the accused, only then to be given a discount when penalised after pleading guilty. Where is our discount? My husband, Robert, and

I received a life sentence for something we did not do. When the employer admits guilt and there is no trial, there are so many unanswered questions that [audio malfunction] guilty plea. Imagine the question [audio malfunction] if there were a coronial inquest prior to a prosecution. Thank you.

The CHAIR: Thank you, Ms Cassaniti, for that opening statement. With the indulgence of the Committee, I might ask some initial questions and then throw it open to the Committee members more generally. Ms Cassaniti, in relation to the incident in which your son lost his life, there was a SafeWork prosecution in the District Court. Is that correct?

Ms CASSANITI: Yes.

The CHAIR: And that was against the company that controlled the worksite?

Ms CASSANITI: Yes.

The CHAIR: And, as you understand it, SafeWork is currently undertaking a prosecution against the scaffolding company. Is that correct?

Ms CASSANITI: That is correct.

The CHAIR: But, in relation to the prosecution that has been finalised, that proceeded essentially by way of a plea—that is, the company pleaded guilty to a category two or lesser charge and, essentially, the evidence was somewhat contained in the District Court. Is that your understanding?

Ms CASSANITI: I believe that once the prosecution was made with the building company it was then found that more evidence was brought in, which then put the scaffolding company in the light to be prosecuted. This happened just before the two years had gone by—literally probably a couple of weeks beforehand—and I am not sure why that kind of stuff happens, because all the information is there. It has been going on for a very long time. And then, all of a sudden, new evidence is brought forward, putting the scaffolding company under category one offences and category two offences, as well, which kind of baffled me totally, knowing that the builder is 100 per cent responsible for anything that happens on site, yet they ended up with a category two.

The CHAIR: But, in any case, from your understanding, although there has been a prosecution under the Work Health and Safety Act, what you have learned about what happened to your son and what is going on more generally in the construction industry—how there are so many common issues. It is your evidence, is it not, that a coronial inquiry into the manner and cause of your son's death would reveal the systemic issues more clearly and better than the criminal prosecutions?

Ms CASSANITI: One hundred per cent. Even though I have been told and I have made several requests, every meeting with SafeWork, every meeting I have had with the police investigators—there have been several times where I have actually said, "I would like a coronial inquest, regardless of the outcome. This needs to be done whenever it needs to be done." The last time I put a formal statement in was 13 July, with the police investigator, to make sure that this coronial inquest goes ahead even though a prosecution has been formally given. I just believe that it needs to be done, otherwise it does not set a precedent for—as I said in my statement, it does not set a precedent for any other PCBUs for consequences regarding unsafe work practices.

The CHAIR: What would you hope would come out of a coronial inquiry that has not come out of the SafeWork prosecution?

Ms CASSANITI: I still do not know what happened to my son. I still do not know exactly what happened, what caused—I just know that the scaffold was collapsed because of the ties being removed and being overloaded, but there is more to it and I want to know. A lot of other people want to know. It is important for others to know what happened, what caused not just the ties and the overweight, because apparently it is something that the scaffolders have done that has put the blame totally to them regarding the actual scaffold collapsing. So, it needs to come out. It needs to be put in that coronial inquest so that everyone knows what happens, so that we can work on those recommendations that a coronial inquest can give on how to avoid this. When someone dies, it is too late. It is too late. We need to prevent. This is what my whole work is all about, to prevent more deaths from happening and more injuries from happening. This can only be done through coronial inquests and following through with recommendations that are given to government that need to be also followed through with government, not just be given and left on the table. They need to be actioned.

The CHAIR: Is it your understanding that the kinds of things that occurred in relation to what happened to Christopher are reasonably common in the construction industry, so there would be a lot of additional benefit from having a proper analysis?

Ms CASSANITI: Yes, very much so. I hear it all the time. I have done many talks on job sites where I have actually been told that some of the scaffolders have rushed off straight after my talk to go and check their

scaffolds, because it is a common practice. A lot of unlicensed workers take it upon themselves to remove components from scaffolds when they clearly know they cannot do this. As much as I keep pushing for things like anti-tampering devices to be put on scaffolds so nobody can touch these—it has to be done so that people do not touch it, but complacency will always override what we know is safe to do, always. As a worker, they are there to get the work done as quickly as possible because they are under time constraints and pressures, so they do remove things that they shouldn't to get the job done, putting others in danger.

The CHAIR: Thank you, Ms Cassaniti. Are there other Committee members who would like to take the next line of questioning?

The Hon. CATHERINE CUSACK: I have some questions if that is okay?

The CHAIR: Yes, Ms Cusack. If other Committee members wish to indicate, maybe send me a text so that I can give you the call. Catherine, the floor is yours.

The Hon. CATHERINE CUSACK: Thank you. Can I first thank the witness for appearing and just express my condolences? It is beyond our imaginations what you have endured.

Ms CASSANITI: Thank you.

The Hon. CATHERINE CUSACK: I suppose what I am hearing is that you quite rightly have questions that you want answers to, and the processes that you have been going through give you no hope that those processes will deliver those answers and outcomes. Is that a fair assessment?

Ms CASSANITI: Yes. I just find that all I hear is rumours from other people of what actually happened to my son, but I do want to know exactly what happened. The investigation made on my son's case is so large. It is one of the largest that SafeWork has taken on. They have 110 files of investigations regarding the case, yet I am only getting snippets of it. The whole thing needs to be aired out. People need to know what happened so that it does not happen again.

The Hon. CATHERINE CUSACK: And it is your perception that a coronial hearing will give you that public airing of the issues, which will alert people and ensure changes can be made?

Ms CASSANITI: Yes, because unless people know what exactly happened, how can changes be made?

The Hon. CATHERINE CUSACK: Can I ask you, because I am not familiar with the construction industry, why would somebody remove the ties from scaffolding? What is the purpose of that?

Ms CASSANITI: Workers such as finishing workers, like bricklayers, painters and renderers, use scaffold to be able to finish the product. Once the building has gone up, then you will have a bricklayer to finish off any balconies. You will have renderers that need to finish rendering on the surface of the building, or painters. They still need a scaffold to get up there on the outside of the building. Ties are put onto the building to secure the scaffold to it, but they are in the way. So, instead of calling the scaffolding company to bring in a professional to move the ties to a different place so that they are not in the way anymore but are still secured to the building, and then they continue work—this times time. This takes time and money to do, so a lot of people avoid that process and they do it themselves. They remove ties that are very essential—that must remain in place—so that they can continue to do the work. But then they cannot put them back again, because they have just finished the face of the building where that tie was tied onto.

The Hon. CATHERINE CUSACK: Thank you so much for explaining that.

Ms CASSANITI: No problem.

The Hon. CATHERINE CUSACK: Can I ask your experience of the investigation? I assume that there has been a police and SafeWork investigation. How have you found that? Has that been clear-cut and have they worked together well, or have you found it confusing and difficult to fathom where things are up to?

Ms CASSANITI: Extremely confusing. At first, the police was the one that stepped in, and then SafeWork—apparently once SafeWork takes over, they are the jurisdiction. They are the ones that finish everything and do all the investigations. What baffled me right from the beginning was that the police investigator that was trying to help with the investigation kept on being pushed aside to say, "SafeWork has now taken over, so we deal with it." Every time the police investigator went to do an interview with someone that was on the job site, she was told that they did not need to answer her because SafeWork has already been told. They had no obligations to give evidence to the police officer because SafeWork had already been told. I believe, being two government entities here, they should be working together and helping each other out to investigate the issue properly. [Disorder]

The Hon. CATHERINE CUSACK: Thank you. I have one last question, Mr Chair, and this is it from me. Is there a liaison person for you with SafeWork?

Ms CASSANITI: Yes, there is.

Mr DAVID SHOEBRIDGE: Thanks, Ms Cassaniti. Again, you have our collective gratitude for coming and for the work you have done since the tragic death, and I think it is collective gratitude that we have for the work you have continued to do. Has it been explained to you the difference between a criminal hearing and the way a defendant interacts with the criminal hearing and a coronial hearing—the difference between an inquisitorial proceeding, which is a coronial proceeding, and the traditional criminal law defensive proceeding?

Ms CASSANITI: Sort of, but it is still very confusing to me. I know that, obviously, when you do the criminal side of things, the investigations are based on the interviews and getting the information. Coronial is putting it all together and finding out what actually happened and putting in recommendations so it does not happen again. That is how I understand a coronial inquest to be.

Mr DAVID SHOEBRIDGE: I think you have a pretty good handle on it, Ms Cassaniti. I think you really have. That is what you want, in your case, is it not? You want the Coroner to be using those powers to get to the truth of what on earth happened.

Ms CASSANITI: One hundred per cent. I could never understand, right from the beginning, why a coronial inquest is done after a prosecution. When there is a death involved, it is not acceptable. The coronial inquest should be done before a prosecution, in front of a jury or in front of people that decide what actually happened, to be able to give the right penalty. Our penalties and the consequences in our New South Wales law really are very low. There are no consequences and the penalties are very low.

Mr DAVID SHOEBRIDGE: How long did all those criminal law proceedings take in the work health and safety?

Ms CASSANITI: It is still going.

Mr DAVID SHOEBRIDGE: Have you been given a deadline or a likely hearing date?

Ms CASSANITI: No. I still do not know what is happening. I know that the builder has been prosecuted and he is out of the picture now. Now it is the scaffolding company that is going, but they keep adjourning.

Mr DAVID SHOEBRIDGE: What do you mean "out of the picture" for the builder?

Ms CASSANITI: Well, the builder has already been prosecuted, so that is it for them.

Mr DAVID SHOEBRIDGE: Done?

Ms CASSANITI: They are done.

Mr DAVID SHOEBRIDGE: And now it is the scaffolder?

Ms CASSANITI: Yes.

Mr DAVID SHOEBRIDGE: Do you know if the scaffolder has entered a plea of guilty or not?

Ms CASSANITI: No. They keep adjourning. The next court hearing is on 14 February. My lawyers have sent a letter to them to say, "Will you be entering a plea?" But we have had no answer.

Mr DAVID SHOEBRIDGE: In terms of once those conclude—the scope for a coronial hearing after those have concluded. What has been, if any, the discussion about that?

Ms CASSANITI: I keep getting told that because there was a prosecution there will be no need, and I am totally against that. I do believe that we need one. Being such a big case and being one of the biggest cases SafeWork has taken on, a public coronial inquest must take place because a lot of people are still asking questions about what happened.

Mr DAVID SHOEBRIDGE: Particularly if there is a plea of guilty, only a tiny fraction of the evidence will actually find itself out in the court.

Ms CASSANITI: One hundred per cent. We need to know everything. I cannot bring my son back. There is nothing I can do to bring my son back. My work is all behind making sure that this does not happen again. Unfortunately I am on job sites all the time and I see things. People are still taking on unsafe work practices, even though there is a new law that was brought in by the Minister, Kevin Anderson, that even if you go ahead with unsafe work practices you can still get prosecuted, even if you do not die or get injured. But people do not

take that into account. They just do it, because this is the culture of the industry; they will still take on unsafe work practices and put themselves in danger.

Mr DAVID SHOEBRIDGE: In terms of your experience about the plea of guilty by the builder and how that court process played out, can you tell me what happened in that plea of guilty?

Ms CASSANITI: At first, when we were talking with SafeWork NSW, we were always under the impression that the whole case would be under a category one prosecution. We were not told until after they were actually prosecuted that they were downgraded to a category two, which floored my husband and I. I thought, "How on earth can such a big case now become a category two instead of a category one when everything was very clear-cut of why the scaffold came down?" The reason being is: Obviously with a category one, as it was when Christopher died, it had to be proven without reasonable doubt of who actually took the ties off for a prosecution to become category one. They only pleaded guilty to overloading the scaffold, and that is it.

Mr DAVID SHOEBRIDGE: On the day that the plea was accepted, was there a sentencing hearing? Do you remember the sentencing?

Ms CASSANITI: It was after a few days, yes.

Mr DAVID SHOEBRIDGE: How long was the sentencing hearing?

Ms CASSANITI: Not long at all.

Mr DAVID SHOEBRIDGE: Hours?

Ms CASSANITI: No. The sentencing, I think, was over within probably about an hour.

Mr DAVID SHOEBRIDGE: So all of that investigation—all of the statements, all of that hopefully complex understanding of what happened in the lead-up to your son's death—was all dealt with in a court process largely that was over and done with?

Ms CASSANITI: It was deflated, totally deflated. I always said to SafeWork NSW, "We need to work together to make sure that we set a precedent for unsafe work practices." At the moment—and I can tell you now, with people speaking to me—there is no precedent. No-one is scared of what is going to happen, because from such a big case the prosecution came to pretty much a slap on the wrist—a $900,000 fine, which was paid by the insurance company—and that is it. And then, a court order—and that is it that came out of it. To a massive builder that builds $220 million-dollar projects, $900,000 is peanuts, yet I am the one with the life sentence.

Mr DAVID SHOEBRIDGE: Ms Cassaniti, I fully understand why you think that that is nowhere near good enough and why you are pressing for a coronial case. Thank you for coming today.

Ms CASSANITI: No problem. As I said before, I cannot see justice going in any direction. This is why the coronial inquest, for me, is the most important thing, because I cannot change what happened. I can only change with the future is holding.

The CHAIR: Ms Sharpe?

The Hon. PENNY SHARPE: Thank you very much for coming along today. The loss of your son is horrendous for any person to contemplate and the work that you are doing is so important. Look, my colleagues have actually asked most of the questions that I was going to ask. They very ably covered them, so I will not ask you again. I did have one question, which was really just about your comment. Through the work that you are doing, you are going onto a lot of worksites. As you said, you are observing a lot of unsafe practices. In government generally I think there is a lack of enforcement in a lot of those areas. Is that something else that you think needs to be considered? If you are seeing all of these unsafe practices—we know that the union draws a lot of attention to these kinds of practices, but they are supposed to be enforced. What is your experience of seeing how that is working?

Ms CASSANITI: I believe it is the consequences that we do not have. We do not have enough consequences in place within New South Wales for these unsafe work practices to stop. And with Christopher's case, we did not put that precedent in place. We actually made it worse by making people think, "Well, this is the biggest case we've had, and look at where they're at. It's only a $900,000 fine. We can afford it. It's fine. Let's keep going." It needs to be tougher. We need to be matching and looking at other States and where they are at, where a lot of PCBUs are on notice. The prosecution is much, much heavier than it is in New South Wales, so they hold the reins. They hold the reins within their companies to say, "Hey, don't do that, because I'll end up in jail." We need that in New South Wales. We need tougher consequences and penalties for PCBUs to actually take note that unsafe work practices will not be tolerated. Unless those consequences come in place, I can speak until I am blue in the face. People won't take us seriously.

The Hon. PENNY SHARPE: You are really talking about a deterrent and industrial manslaughter. We do have a bill before the House—

Ms CASSANITI: Yes, we do. Thank you.

The Hon. PENNY SHARPE: —so hopefully that will get support later this year. Thank you very much for coming in today. I know that it must be quite painful to constantly be talking about this, but your work is so important and I really thank you for everything you are doing.

Ms CASSANITI: Thank you for having me. For me, it is important to work on this future that we hold. My youngest son has just entered the construction industry and my heart is in my throat. We need to take care of every Australian because no Australian should ever go to work and die.

The Hon. PENNY SHARPE: I could not agree more. Thank you.

The CHAIR: Do any other Committee members have further questions for this witness? No? Alright. Ms Cassaniti, on behalf of the Committee, we thank you for taking your valuable time to give us the benefit of your insights, given your tragic experiences. I know you are not a stranger to giving evidence to parliamentary inquiries like this, but we thank you for your time. Again, we stand in awe of your ongoing commitment to really raising the standards of safety and behaviour in the construction industry, against all of the odds. And, of course, you have our continuing condolences for your loss, for which there can be no reparation. Our next witness is not until 11 o'clock, so we might take a short adjournment until that time. The witness is excused. Thank you.

Ms CASSANITI: Thank you so much, and thank you for your time in putting this together.

The CHAIR: It's a pleasure.

(The witness withdrew.)

(Short adjournment)

LAURA TOOSE, Legal officer, NSW Nurses and Midwives' Association, before the Committee via videoconference, affirmed and examined

The CHAIR: We now welcome our next witness, Ms Laura Toose, the legal officer from the NSW Nurses and Midwives' Association to speak to the union's submission to this inquiry. I should just make a short declaration: My daughter is a nurse and is a member of this association and, until recently, was an employee of the union. The association has made a submission to the inquiry, submission No. 51. Do you wish to give a brief opening statement to speak to that?

Ms TOOSE: Yes, I do. Thank you, Chair. I thank the select Committee for the invitation to speak at this inquiry. Firstly I wish to acknowledge the traditional custodians of the land on which I am working, the Gadigal and Wangal people of the Eora nation, and pay my respects to Elders past, present and emerging. I am speaking to you on behalf of the NSW Nurses and Midwives' Association, the peak professional and industrial organisation for nurses and midwives. The primary connection between the work of the association and the Coroners Court is through legal representation provided directly to members. As noted in our submission, nurses and midwives may be asked to provide statements and/or be subpoenaed by the Coroner to give evidence in relation to reportable deaths that occur in connection with their work.

These deaths are often the unexpected deaths of patients in a clinical setting. These deaths also commonly occur in the context of someone being detained in declared mental health facilities and correctional facilities. Our submission selectively addressed parts of the terms of reference that are relevant to our connection with the court. In summary, the recommendations made in our submission focus on the adequacy of the resourcing of agencies who assist the Coroners Court; the adequacy of the training of New South Wales police in relation to coronial matters; the need for transcripts to be provided at no cost to parties; and the need for provision of access to specialised resources, including counselling, for witnesses, as well as the need for multi-agency approaches to investigations in industrial deaths. Thank you.

The CHAIR: Thank you. Committee members, who wishes to commence the questioning of the witness? Does anybody have any particular questions? If not, I might—

Mr DAVID SHOEBRIDGE: I have.

The CHAIR: You do? David, please start.

Mr DAVID SHOEBRIDGE: Thanks so much for the submission today. Could I ask you, in terms of the role of the union in representing your members during coronial investigations, what is the union's role and what is the experience of that process in the coronial system?

Ms TOOSE: Our role is to provide legal representation to members of the association. Where there is a request for them to either provide a statement or to give evidence in a coronial matter, they can contact us directly and seek representation by one of the employed legal officers, such as myself. The process that you asked about involves us generally, as a first step, seeking access to medical records for the deceased in response to that request and then taking instructions from our members and providing a statement, as requested. If the matter then proceeds to a hearing, then we would represent our members directly in those hearings.

Mr DAVID SHOEBRIDGE: In cases where there has been a death and there were concerns about the adequacy of medical care, the health system itself does a kind of "lessons learnt" investigation of that. Can you talk us through that?

Ms TOOSE: My experience is that usually a local health district [LHD] will conduct a root cause analysis investigation, the outcome of which is not admissible in coronial proceedings. But that is usually informative in terms of how an LHD might reflect on the care provided, be it in medical, nursing or midwifery—wherever the issues are identified. That may inform evidence that is given later on if a matter proceeds to hearing, or by way of the statement provided to the Coroner in circumstances where the Coroner may decide not to proceed to a hearing.

Mr DAVID SHOEBRIDGE: In other States and Territories that root cause analysis is routinely tendered in coronial proceedings and is a great starting point for the coroners in other jurisdictions to work out what actually happened and then to do a deeper dive. Does your union have any view about the admissibility of the root cause analysis in coronial proceedings in New South Wales?

Ms TOOSE: Our view, I imagine, would be that it is actually an important protection for our members that the root cause analysis is not admissible, and that is because of the way in which information that informs the root cause analysis is collected. People do not have access to legal representation prior. They usually do not have a support person. Lots of questions are asked. At the moment, they are free to give that information that might

help identify those really severe systemic issues without any concern that that information might be used against them later on, in either a coronial or a disciplinary process.

Mr DAVID SHOEBRIDGE: But, of course, this would come with unambiguous protections that it could not be used against anybody in any civil or criminal proceedings but simply be made available to the Coroner for the coronial proceedings. Given it is routinely provided in other jurisdictions, would that allay your concerns if there were those clear protections about it being inadmissible in any civil or criminal proceedings?

Ms TOOSE: No, it wouldn't. I think that protection is so important because coroners are in a position where they can make adverse comments in relation to nurses and midwives. Also, there are ongoing debates about whether or not "disciplinary" is included in the scope of what is civil. For our members, what we are generally trying to protect them against is any adverse finding or criticism from the Coroner and any potential referral to the Health Care Complaints Commission as a result of a coronial finding.

Mr DAVID SHOEBRIDGE: Alright. The protection could expressly include disciplinary and/or professional bodies—professional discipline—as well, but I do understand your position and I understand why you have it. Could I ask you about the delays? How are you finding the delays? What impact does that have on your members?

Ms TOOSE: Delays are a really tricky sort of issue because every case is different, and every case is going to have different reasons that there might be delays. Also, what is a delay is entirely dependent on context and how a matter might be reported to the Coroner. We have delays sometimes early on because of an inability to get those medical records and get statements provided in a timely manner. That might impact a time frame to some extent, but usually these matters are not going to be heard until three to five years after a death. There are delays that we see in terms of how matters are prepared by those assisting the Coroner. But again, that, from our point of view, is probably a resourcing issue in terms of how the solicitors employed by these agencies—the capacity that they have to collect and gather all of the information, particularly quite late on in the piece in the lead-up to a hearing, after it has been determined that a hearing will go ahead.

Mr DAVID SHOEBRIDGE: My final question is: What are you finding is the usual time frame for a defended matter? "A matter which goes to a public hearing" is probably the better way of describing it. From time of death to a matter that goes to a public hearing, what is the kind of time frame that you would say to your members to expect?

Ms TOOSE: I would say three to five years.

Mr DAVID SHOEBRIDGE: Do you think that is appropriate?

Ms TOOSE: It is very difficult to say. It is a little bit like an unfolding puzzle; you do not have all the pieces. Sometimes, very early on, those issues will not be identified until there is a request for one statement which leads to a request for another statement and then a third statement. It is really difficult to say that there is an amount of time that something should happen in. Recently I was involved in a matter that actually went to hearing really early, comparatively. Less than two years after the death, the inquest was due to start. On one hand you go, "Great. This is fantastic. It's happening. Things are happening quickly." However, the member that I represented was not asked to provide a statement until a month before the inquest, when they were also subpoenaed to give evidence and notified as a person of sufficient interest.

This is someone who provided a significant amount of care to the deceased prior to their death, over a period of two days. You can go, "Okay, this is good that the matter is being set down within a two-year period," but we have all of this evidence being collected really close to the hearing, which affects how long the hearing goes on for. It was set down for two weeks and I think we ended up having nearly four weeks of hearing all up. It is one thing to say, "Oh, it's delays," but on the other hand, it is also preparation. You want to make sure you have a good opportunity to prepare the matter so that you are not having part-heard matters that drag on and on and on.

Mr DAVID SHOEBRIDGE: But surely that is a case in point for better resourcing at the beginning to gather the evidence when it is fresh in someone's mind, not two years after the incident. It is a case in point for more resourcing, is it not?

Ms TOOSE: Yes.

Mr DAVID SHOEBRIDGE: Thanks, Ms Toose.

The CHAIR: Ms Sharpe, you had some questions?

The Hon. PENNY SHARPE: I do. Mr Shoebridge asked my questions about the root cause analysis; thank you for that. Thanks for coming in today. There are two things that I wanted to touch on—three, actually.

You have talked about the lack of cooperation from police in getting transcripts. Could you just take us through the process and what the difficulties are?

Ms TOOSE: I should just clarify: I have talked about the lack of cooperation from police in getting medical records, and then a separate issue being transcripts.

The Hon. PENNY SHARPE: Yes, sorry. That is actually what I meant—the medical records issue. I am going to ask you about the transcripts in a tick, too.

Ms TOOSE: Sure. The problem we have is that often when there is a request to provide a statement, that request will usually come through the local health district. A member of ours will get an email or something saying, "You've got to provide a statement to the police in this matter." There are times when police will come down to a hospital. They will take the nurses or midwives up to the police station and take a statement without actually informing them of their right not to provide a statement or their right to access the medical records in order to refresh their memory before making those statements. What is happening, what we are experiencing really frequently, is circumstances where we get in touch with the officer in charge and we say, "Look, we've received instructions from these nurses. We'd like to assist them to provide statements to the Coroner and we need to get a copy of the medical records." And they say, "No, you can't have those." And we say—

The Hon. PENNY SHARPE: Just to be clear, is there—you must get the medical records sometime, so that is not the rule. It is not part of the process. So, is it a discretionary issue with the police?

Ms TOOSE: That's right. It is that the police will say—they might say, "You'll need to write to the court." They might say, "You need to go to the LHD." They might say, "Ask the solicitors for the LHD." There is no clear process which really empowers them to share that information early on in order to facilitate the quick provision of statements, and that is really what we need.

The Hon. PENNY SHARPE: It sounds to me that that is really—and your submission touches on this. It really goes to a lack of understanding from police in relation to the process. Or is it a lack of awareness of the policy? I suppose what I am asking is: Are there reasons why the police would refuse that? Or is it more that they are just not across their ability to provide that to you?

Ms TOOSE: Absolutely, I think it is a lack of training. There is no bad blood between us and the police. It is just a lack of training and understanding, which often leads to these unnecessary conflicts when we are all on the same page, trying to get this matter moving along. Often our members are very willing to provide statements. They just want to get it done and dusted. We have to say to them, "Look, it is not in your best interests where you have made entries in this person's medical record to then give a statement just off the back of your memory, because it's not going to be accurate. You could give evidence in conflict with your own medical records." That is obviously not in their best interests.

The Hon. PENNY SHARPE: And, as we said, it could be quite a long time between when that happens and when you are asked to remember something, with the thousands of patients that you deal with on any given week.

Ms TOOSE: That's right. Sometimes people who have been involved in a traumatic death will say, "Yes, I've got a pretty good memory of that day," because everything sort of locked into place. But if it is an ordinary shift—I have one at the moment. The inquest is next month and the member provided care over a period of four hours, five years ago. There is no way people can recall when nothing on that shift happened. It was just a routine, ordinary shift. It is really difficult, and it is only with the provision of those medical records. Thankfully that matter is further down the track, so we just asked the agency assisting the Coroner and they sent it to us straight away. There is never any issue with that. It is just with police having—there seems to be, from our perspective, a lack of protocol, lack of training and lack of support. I regularly have conversations with police officers where they say, "I am the officer in charge, but I have never done an inquest before." It is just allocated to the person who takes the call and turns up, and then, all of a sudden, they have this enormous amount of work to take on in circumstances where they may not have any training or experience.

The Hon. PENNY SHARPE: Thank you. You have talked about the cost of transcripts. How much does it cost to get a transcript?

Ms TOOSE: As a recent example, for a five-day hearing I think it was about $2,800 or thereabouts. This is for a matter where we have one member. It was a part-heard hearing. We had a further three days, which was about $2,500 for those three days. It can be very, very costly for a not-for-profit organisation like ours.

The Hon. PENNY SHARPE: So the union picks up the cost for that on behalf of the member. Is that what you do?

Ms TOOSE: It is not a mandatory requirement that we pay for it. We need to make an assessment as to whether or not we need to get access to that available transcript. The difficulty we might have is that there might be circumstances where we have to make a decision, which is, "Look, it's actually not worth it to spend that money on the transcript because there aren't significant issues that are going to tip depending what is in the transcript." But the Coroner has access to the transcript. Counsel assisting has access to the transcript. Other parties may have access, and we may have to make a submission in the absence of access because of those prohibitive costs.

The Hon. PENNY SHARPE: That is a pretty important issue. I have got one more question. The root cause analysis is something very familiar in Health. It is an important part of any time a critical incident occurs. Then, obviously, there is the coronial inquest, where a lot of times there is recommendations made around system changes that occur. Are you able to provide the experience of [inaudible] when these recommendations have been made by the coroner, how they are actually considered and implemented by the department and the local health districts? There has been a case. There is recommendations made. What changes as a result of that? Do you have practical experience of that?

Ms TOOSE: Usually the changes that occur, that are shared with us are those that occurred before the recommendations occur, from one of those lessons-learnt-type statements. Following the implementation of recommendations, there is not really a good process for transparency in how those may or may not be implemented and the reasons why or why not. I do recall a few years ago there was a spreadsheet, I believe, created, maybe, by the Office of the General Counsel—but I could be mistaken on that—which sought to track the recommendations and the response. But that is the only thing that I have ever observed, which aimed to put those two things together.

The Hon. PENNY SHARPE: The issue of monitoring the recommendations that coroners make has been raised quite a lot through the inquiry. Thank you very much for that.

The CHAIR: Thank you, Ms Sharpe. Mr Roberts or Ms Cusack, do you have any questions?

The Hon. CATHERINE CUSACK: I do, Mr Chair, just pursuing Mr Shoebridge's questions in relation to the timeliness of investigations. Two years to be fast is very wearing on families and other stakeholders around it. But I wondered: Also, is it not very wearing on the worker who has this hanging over their head? The one that you referred to now, who has been waiting five years for this matter to be resolved. That must be a nightmare, surely.

Ms TOOSE: Absolutely. And what is really difficult is when people provide statements and they do not know whether they are going to be called to give evidence, often for a long time. The matter that you referenced, about the five years—this is someone who had no idea they were involved, in fact, until two months before the hearing. I was able to feed into them what we were talking about in terms of the collection of statements in a timely manner or from the interagency perspective, in terms of the agencies assisting the coroner, gathering evidence very close to the date of the hearing, making things difficult and that lack of resourcing contributing to delays. But for those members of ours who are providing statements quite early on or even within the first one or two years, yes, they often have to wait several years before knowing. "Am I going to be involved, or am I not?" That is a very difficult thing for them to have to experience professionally and personally.

The Hon. CATHERINE CUSACK: What should happen in terms of the workers during this period, while it is all dragging on? I live on the North Coast, where we have had some really terrible incidents. We have had death of a mental health patient at Lismore Base Hospital. We have had deaths in nursing homes. But then there are other deaths, that do not appear to have such clear negligence. When does a worker get stepped aside in the interests of public health outcomes? How should those matters be handled?

Ms TOOSE: Sorry. I am not quite sure I understand the last part of your question.

The Hon. CATHERINE CUSACK: In terms of whether you should allow somebody to continue to work in a role when there is reason to believe that something nefarious has occurred but the investigations are ongoing and likely to take two, three, four, five years. At what tipping point do you suspend the worker until the matter is resolved?

Ms TOOSE: There are multiple processes which occur. A coronial investigation is very rarely focused on one individual person who may or may not have done something. When there is a reportable death, it is also characterised as what they call a severity assessment code [SAC] 1 severity incident within a local health district. Other, private facilities would have a different sort of coding system whereby a serious adverse event is reported. That kickstarts a root cause analysis. But it also always involves some sort of internal review to work out, "Are there any issues that the LHD needs to look closely at in terms of a risk assessment for those staff who are involved?" If there are issues that they pick up in that early assessment, then those staff would be managed in accordance with the LHD policies, which may also include a referral to the Health Care Complaints Commission to consider whether or not the conduct of that particular staff member warrants investigation and whether or not

any immediate action needs to be taken by the relevant professional council in relation to that person's registration. But that is a really distinct process from the coronial process. Those things will often occur concurrently for some of our members, where it has been identified that there are professional issues.

The Hon. CATHERINE CUSACK: I do understand the root cause analysis and its importance in trying at an early stage to actually just get to the truth of what occurred. "The baby is dying because of the wrong gas being attached." Obviously, there is a whole legal process that unfolds from that. But people need to actually understand what occurred. But it does seem to me the coronial process is very much about getting to the truth of the matter as well. But then you have a separate tier, of legal actions and discussing criminality and doing prosecutions and all of that. It almost seems like the truth process and the justice process are quite separated and the justice process is really delaying everything to almost everybody's detriment.

Ms TOOSE: I do not know that I would agree with the premise of the Coroners Court being characterised as a justice process. My idea has always been that it is about identifying systems improvement and trying to avoid preventable deaths, by being able to analyse, with a lot of parties involved and experts, the manner and cause of death or the days or weeks or months leading up to a person's death, they are able to identify those really systemic issues which are contributing factors to a person's death and to avoid that from every happening again, particularly in those circumstances or similar, that people should be learning from that experience and things should change as a result.

The Hon. CATHERINE CUSACK: Should we have a benchmark in terms of the time period? Should there be a benchmark for resolving these issues? Can you suggest any specific ways in which those benchmarks could be achieved more easily?

Ms TOOSE: As I mentioned before, I think having a set time frame can be problematic in some circumstances because you can be in a situation where you are trying to gather evidence in a very rushed and hurried manner before a hearing is put on but also because sometimes hearings can be avoided. That is actually through the collection of more evidence in the lead-up to a matter. I have been involved in a matter that was set down for hearing. Statements were collected over a number of years. Right before the hearing, they started collecting some additional statements. It actually became clear that the issues that the coroner was trying to determine by way of hearing actually did not need a hearing to determine because they had sufficient information on the statements. That avoids a really stressful and expensive process because they have gathered the information.

There can be benefits in taking time to gather that information. That is not to take away from the difficulty that is experienced by everyone involved in a process that runs in a really long time. I think that, rather than having a benchmark and saying "This matter has to be heard within five years", you are far better off, investing resources in the collection of information early on, to actually identify systemic issues. With respect I do not think police officers, particularly those who are not trained or quite inexperienced, trying to work out who they need to get statements from in a complicated death in a health setting—it is probably not the best way to minimise the time between death and inquest because, I think, there is a lot of time that is probably wasted in that process where they are trying to work out what is going on here, what has happened.

They do not have, necessarily, any medical or nursing knowledge. They are trying to put together—"Who do I need to get statements from? What do we need to do?" They have got a deadline to get something to the coroner, but there may then be delays before a coroner can review that material as well. If we want to identify issues early on, I think, it should be a matter of changing how that process works from the get-go.

The CHAIR: Mr Roberts, I am just conscious of the time. Did you have questions, Mr Roberts?

The Hon. ROD ROBERTS: I did have one, Chair—thanks—if you do not mind. Thank you, Ms Toose, for giving evidence this morning. I am also mindful of the time. I just take you to page 8 of your submission. Might make it easier for you. Recommendation 5. You talk in the submission there about the unfortunate three deaths of nurses in New South Wales that occurred whilst on duty and the conflict between SafeWork and the police. Just wondered if you could talk to us a bit more about that and fill it in. I do not want you to go into depths about these three deaths, but they are work-related incidents of nurses. Were they?

Ms TOOSE: Yes. All three deaths were deaths that occurred whilst on duty. I should say that the information contained in that part of the submission I obtained from a colleague of mine, who provided me with their anecdotal experience about what occurred in relation to those two most recent deaths. SafeWork came and did an inspection and then declined to do an investigation. Part of the reason for that was that it was going to be investigated by the coroner, as though the coroner is somehow a substitute for a SafeWork investigation. That is why the recommendation is that there needs to a multiagency approach in terms of how investigations and industrial deaths occur, that there should not an assumption that the coroner is going to do the job of SafeWork.

The Hon. ROD ROBERTS: Thank you very much.

The CHAIR: Just to follow on from that in relation to those two deaths, in 2019 and 2020. Whereabouts did those two incidents take place?

Ms TOOSE: My understanding—one was in a client's home, during a home visit. The second was in a mental health unit at a metropolitan hospital, public hospital.

The CHAIR: That would be Penrith?

Ms TOOSE: No. To the best of my knowledge, it was Liverpool.

The CHAIR: Ms Cusack, did I cut you off? Did you have one last question?

The Hon. CATHERINE CUSACK: Was just one last question about an investigation going over a five-year period—there must be multiple changes of personnel managing the case—just in terms of wasted time. Must have numerous police handing over or not handing over, different skillsets and different approaches to the case. I just wondered if you could comment about multiple different personnel managing over a five-year period and the delays that must embed into the process.

Ms TOOSE: Absolutely. That does occur. It might go from one police officer to another. But also, once the matter is referred to the Crown Solicitor's Office or the Office of the General Counsel, those matters may change hands internally. Particularly the Crown Solicitor's Office, I understand, has a sort of a system whereby solicitors will rotate through different units. So you could have someone who is looking after a matter in the—I think the recent one that I had was someone who had been looking after a matter for a year in the lead-up to a hearing and then, two months before the hearing, we get a notification: "Well, it's got a new solicitor." The amount of work that must go into getting across a matter would be enormous. I cannot comment specifically on how that may or may not contribute to delays. I think we could assume that there is some delays. But we do not have anything concrete to say, yes, this causes a delay.

The CHAIR: But your point is that all of the other agencies that work around the coronial system also need to be properly resourced, whether it is the Crown Solicitor, whether it is LHDs and the health system, whatever it is. The Government needs to make sure they can also do their job to facilitate the coronial—

Ms TOOSE: What I am referring to with those agencies are the Crown Solicitor's Office, the Office of the General Counsel, which, I think, is now Department of Communities and Justice, and the police advocates as well, who work within the Coroners Court. Those are the three agencies that work as counsel assisting the coroner. Once a matter goes to hearing, they are the ones that are dictating how a matter is progressing. They are providing advice to the coroner. They are having those discussions with the coroner. I think that, if people are, obviously, moved around, that is going to impact how a matter progresses. But, naturally, obviously, staff will move around everywhere. We have to acknowledge and accept that and make sure that that is allowed for.

The CHAIR: Any last questions? If not, Ms Toose, thank you very much for giving evidence and providing—

Mr DAVID SHOEBRIDGE: I just had one question. Ms Toose, a report that is delivered five years after the event has happened, after a root cause analysis has been done and whatever other changes have been made—a report that is delivered five years after the event is going to have pretty minimal utility in most cases?

Ms TOOSE: I do not know that I would agree with that, because I think that all coroners' findings have utility. Like I said, sometimes the passage of time allows the gathering of a lot more in-depth evidence. It is a long time. It is a really long time. It is incredibly stressful and difficult for those involved. I do not want to ignore that fact. But also, in that time, if, say, a local health district has implemented changes, they are often able to demonstrate those changes through those lessons-learned statements before the coroner, which may negate the need in some circumstances for the coroner to make recommendations. I think what we all want actually is that systems improvement to happen early on. That might happen through the recommendations of the coroner, or it might happen because the LHD are able to clearly identify those systemic issues and act on them and change things for the better.

Mr DAVID SHOEBRIDGE: I just say this: Five years ago, a bloke called Baird was the Premier of New South Wales. Few, if any, people can remember. If you are investigating events that happened when Mike Baird was Premier—I have got to say the practical utility for the recommendations, I think, is much diminished.

The CHAIR: We can debate that, David. I do not think that is a question that the witness can answer sensibly.

Mr DAVID SHOEBRIDGE: In terms of the implementation.

The CHAIR: I understand. In any case, I note we are out of time. I think that is beyond the witness's scope. I thank the witness for coming to give evidence today. The Committee will resume at 12 o'clock.

(The witness withdrew.)

(Short adjournment)

ALEX CLAASSENS, Branch Secretary, Rail, Tram & Bus Union (NSW Branch), before the Committee via videoconference, sworn and examined

HELEN BELLETTE, Branch Organiser, Rail, Tram & Bus Union (NSW Branch), before the Committee via videoconference, affirmed and examined

MITCH WRIGHT, Media and Political Advisor, Transport Workers' Union, before the Committee via videoconference, affirmed and examined

The CHAIR: Thank you. I thank both organisations for the submissions they have made to this inquiry. The Australian Rail, Tram and Bus Industry Union [RTBU], New South Wales Branch, is submission number 55. And the Transport Workers' Union [TWU] of New South Wales' submission is number 53. Would either union like to give a brief opening statement in support of their submission, starting perhaps with the RTBU?

Ms BELLETTE: Yes, we would like to make a brief statement. We thank the Select Committee for the opportunity to address this vital part of the jurisdiction. Our submission will contain four recommendations, which are, briefly, the requirement for suppression of names of our members that have to appear in front of the coroner; the streamlining of reports; the coronial investigators' understanding on the complexities that involve the rail regulations, rules and other issues; and the issuing of one drug-and-alcohol test after an incident, rather than multiple. Our submission is based on the wording from our members, under some consultation. These are their stories. I would like to put on the record that we appreciate their assistance and generosity in sharing some traumatising events in their life. Thank you.

The CHAIR: Thank you. Mr Wright.

Mr WRIGHT: I will also make a brief opening statement. Thanks. I again thank the Committee for the invitation to participate today and also acknowledge the Darug people, who are the traditional owners of the land that I am joining this hearing from. I pay respect to their Elders, past, present and emerging. I also just extend the apologies of our State secretary, who is unable to attend today. The TWU represents thousands of workers in one of our State and nation's most deadly industries [inaudible] transport. This industry is consistently overrepresented among worker fatalities. While there is a number of factors contributing to the high fatality rates in the industry, the critical factor across all of them is the link between pay and conditions for drivers and safety outcomes. We have retail, supermarkets, oil companies and others at the top of transport supply chains continuing to apply increasing cost pressure throughout their supply chains. We are going to continue to see drivers and transport operators pressured into cutting corners on safety. That will be borne out in the road toll.

While this current inquiry is incredibly important in ensuring we have a system that is fair and provides justice for workers—and their families—who are killed in the workplace, including the dozens of transport workers who die in their workplace, we need to be doing so much more to reduce worker fatalities in the road transport industry in the first place. That being said, the submission that we have provided to this inquiry focuses on the ambiguous overlap between the coronial and work health and safety [WH&S] jurisdictions in relation to workplace fatalities, which, in our view, can lead to delays, confusion for families of victims of workplace fatalities, at what is, obviously, an incredibly difficult and distressing time for them. So I again thank the Committee for the opportunity and look forward to your questions.

The CHAIR: Thank you, Mr Wright. Committee members, over to you. I will just check the WhatsApp. Who would like to commence questioning? Mr Shoebridge?

Mr DAVID SHOEBRIDGE: I have a question to Mr Wright on the TWU submission. Thank all the witnesses for your assistance and your submissions. Mr Wright, your submission talks about the prosecutorial guidelines for SafeWork and the arrangement between SafeWork and the New South Wales police to, effectively, decide at the commencement of an investigation whether or not SafeWork or police will take the lead in an investigation involving a workplace death and therefore whether or not a potential manslaughter charge under the Crimes Act will be the subject of the investigation or, potentially, a prosecution under the WHS Act. Can you first of all describe that to us as best you know it, that process, and then tell me what you think about that decision being made so early.

Mr WRIGHT: Yes. I suppose the underlying principle here would be that there is not enough view from any of the regulators of road transport deaths being viewed as workplace deaths. More often than not, the path that is followed when either a transport worker dies in their workplace, be it being on the roads or they are involved in an incident in which someone else is killed—more often than not, police are called, they set up a crime scene, they notify the coroner. Coroner, more often than not, does not hold an inquest, because it is a stock-standard road fatality, so to speak. Then that's that. It is only the really most egregious examples of PCBUs not fulfilling their duties that we see SafeWork get involved. Our position as a union is just it is extraordinary

that, in the industry that is consistently either the most or second-most deadly, the work-health-and-safety regulator plays such a passive role more often than not.

Mr DAVID SHOEBRIDGE: Is it your experience that there is at least some engagement between police and SafeWork at the commencement, the way those guidelines envisage?

Mr WRIGHT: I do not have that answer to hand. I could probably take it on notice and see if we have any information, previous examples. But what we do know is that SafeWork prosecutions for fatalities that occur on the road are extremely rare. In the road transport industry it tends to be more around loading issues, where, in the process of loading a truck, someone is crushed and killed. Those, SafeWork are a bit more active in. But, when it occurs on the actual road, it is very rare for SafeWork to prosecute. You will occasionally get a police investigation and a more traditional criminal prosecution. So our evidence would be, I suppose, anecdotally, that, more often than not, is left for the police, not for SafeWork.

Mr DAVID SHOEBRIDGE: It is almost as though there is an unofficial carve-out in SafeWork's jurisdiction in this regard: that, once a truck has left the yard, it is really a matter for the police. Is that your experience?

Mr WRIGHT: In practice, that is effectively how it works. Only in most extreme circumstances [inaudible] the case.

Mr DAVID SHOEBRIDGE: I assume, from the public work the TWU has been doing and the advocacy, that that means systemic issues like fatigue have not been adequately reviewed by the Coroners Court.

Mr WRIGHT: Yes, absolutely. When the police are investigating a road incident of any kind, whether it involves a truck or not, they are looking to ascribe who is at fault in the incident. Even if the truck driver is at fault in the incident, what the police do not look at in the context of their investigation, that SafeWork should look at [inaudible] are those big system issues that you are talking about.

Mr DAVID SHOEBRIDGE: There are two options in that situation, if you had a fatality on the roads. They are not necessarily mutually exclusive. One is SafeWork do the investigation and look to see if there are some system issues that led up to the incident, the death. The other is that the police and/or SafeWork pull together a brief for the coroner and the coroner looks at any kind of systemic issues. Do you have a view about where that dividing line should be?

Mr WRIGHT: Our prevailing view is that workplace deaths are workplace deaths and, while the road transport workplace is very different to most others, it is still a workplace and there is still an underlying duty on PCBUs to ensure safety in those workplaces. So we do not see a reason why workplace facilities in the road transport industry [inaudible] be treated differently to other workplace fatalities in a legal sense after they have occurred.

Mr DAVID SHOEBRIDGE: I understand. Thanks, Mr Wright.

The CHAIR: Other Committee members, do you have questions for the witnesses? Ms Sharpe?

The Hon. PENNY SHARPE: Yes, I have a question. Thank you. Thanks for coming in today. Thank you for your submissions. My question is to Mr Claassens or Ms Bellette. I know particularly train drivers have significant issues with people harming themselves with trains and it is, unfortunately, not a rare enough occurrence. I was interested in the fact you said, that sometimes, after an incident, a worker goes through three or four different alcohol and drug tests. I was surprised by that. Can you just take us through what happens in those circumstances?

Ms BELLETTE: Thank you, Ms Sharpe, for the question. I do believe a lot of it is through miscommunication. Quite often, you will have the incident—I will speak to an example— where the incident rail commander will arrive on site. They are authorised to perform a drug-and-alcohol test, which they do straight-up. Then they will go off and do other things associated with managing that incident. Then the police will turn up. Quite often, the police—the first thing they will do is administer another drug-and-alcohol test, without knowing that it has already been administered by the incident rail commander. The impacted employee is usually sitting somewhere in an office at the station, if that is available, or in the train, which can happen, or next to the train, unfortunately, while they are subjected to—it has been reported to us that it has actually happened on a third occasion, where an impacted employee was actually tested three times, through lack of communication. I do not suggest there is any malice involved in this. I think it is just a lack of processes in place. Mr Claassens, if you would like to add anything.

Mr CLAASSENS: Only that, quite clearly, though, when the police generally turn up on site, they take control of the situation and it does not matter what anybody else has done. They will run their own processes.

Unfortunately, this situation has developed over a number of years. When we were all part of a vertically integrated railway, back in the days of State Rail Authority and even in the early days of RailCorp, there was always a general understanding: that the railway ran its own race. In fact, the police would actually get permission to come on site because, in those days, the police were not allowed anywhere near the danger zone as it was, because they have to be specially trained to be able to do that, to make sure that they are not hit by trains. The railway used to administer the alcohol-and-drug testing. They would also take all the statements in a format that was required by the police and the coroner.

Subsequently, though, what has happened is that, because of the breakup of the railways, the potential selling-off of parts of it et cetera, we have now ended up in this situation where we have got people being breath-tested on a number of occasions for the same incident. We have got different statements being taken in different formats. It is really disappointing for us that somebody who has already been involved in a traumatic experience is having to relive that experience several times over because of a bureaucratic nightmare that we have created. We did, some years ago, write to Gladys Berejiklian, when she was the transport Minister, and asked her to intervene and try and do something about the multiple agency requests for different types of information. Unfortunately, we have never been able to get past that. So we still have a situation where there will be a critical incident and then numerous people will come and approach us for different statements under different jurisdictions.

You will see in our submission we have asked for any statements to be taken under the rail safety legislation because that does give us some protections from self-incrimination. Obviously, the intent of that legislation is to try and make sure that everybody tells the whole truth and nothing but the truth, because, when you have got a critical incident, you want to actually get to the bottom of what has actually created the situation, so we can prevent it from happening again.

The Hon. PENNY SHARPE: It is very similar to what happens in Health with the root cause analysis, the process that you are describing, isn't it. My understanding of it is—this was previously the case—that the idea is that, yes, you want everyone to, basically, explain exactly what they believe happened, what they believe went wrong, without the fear of further prosecution. Is that correct?

Mr CLAASSENS: Yes, that is correct. Yes.

The Hon. PENNY SHARPE: We have talked a lot in this inquiry about the fact that often it can be years after an event before there is actually a coronial inquiry. Are those reports under the Rail Safety Act admissible and/or used by the coroner?

Mr CLAASSENS: I understand that that is correct. But I am not a lawyer. So you might want to double-check that. But my understanding is, generally, they can. They are available, aren't they?

Ms BELLETTE: To my understanding, they are. But we are happy to take that question on notice and respond back.

The Hon. PENNY SHARPE: The parallels with Health are something that we have talked a lot about, where, at the moment, the root cause analysis is not provided to the coroner, because there is a view that Health is dealing with it and the systemic issues are dealt with. Because of that issue around protection for the employee, the nurses had quite a different view. If you could just take on notice—I am just particularly interested about whether they are admissible and whether that is the common practice or not.

Ms BELLETTE: We will take both those points on notice.

Mr CLAASSENS: Thank you. Good point.

The Hon. PENNY SHARPE: Thanks for that. That is it for me for the moment.

The CHAIR: Ms Cusack or Mr Roberts, do you have questions? I might ask a couple of questions myself in relation to the RTBU's submission. I understand your submission in relation to streamlining the taking of a statement, to one statement only, and in relation to the drug-and-alcohol testing. In relation to coroners', investigators' training, what has been the experience of the union? Is it that the police investigators seconded to the Coroner's office do not seem to have the appropriate awareness of the rail safety regulations? Has that been your experience? Or is there a different experience?

Ms BELLETTE: Yes. Thank you. That has been reported to us by some of our members, not on every occasion. As you understand, the railways is a very complex system. It involves Federal legislation, rules, network rules and policies. With those complexities, there are questions that are asked, by the investigators, that really do not correlate with railway-speak and how one of our members would relate to that question. That causes further

stress to the member because they are trying to process what the question is and trying to relate it back to how it fits in in railway terminology, as every industry has its own idiosyncrasies and terminology. So it can be complex.

The CHAIR: More than that, in your industry you have got the Rail Safety Regulator, with its own statutory framework, which is far removed from just having the idiosyncrasies of its own sort of jargon. There is a whole series of different requirements.

Mr CLAASSENS: As I see it, we have actually got three. We have actually got the National Rail Safety Regulator. Office of the National Rail Safety Regulator, they call it. And it tries to apply national rail regulation right across the whole country. We have also got an independent New South Wales investigative body called the Office of Transport Safety Investigators [OTSI], which I personally really like. I actually think OTSI do an amazing job, as did Independent Transport Safety and Reliability Regulator [ITSRR]. We had our own independent transport safety regulator in New South Wales, called ITSRR. That, of course, was disbanded some years ago in New South Wales, because people wanted to use the national legislation. I actually think that that was a backward step. We got ITSRR as a virtue of Glenbrook, Waterfall and a number of really bad rail accidents, which said that we needed to put more extreme focus on a New South Wales basis. Those instruments have been taken away from us. Then, of course, you have got SafeWork. We have got all these different regulatory bodies coming at us. Then, essentially, you have also ATSB as well, the Australian Transport Safety Bureau, which, most of the time, will delegate to OTSI, as I understand.

So it is very confusing for a lot of people, as to who is actually going to do what. Like Ms Bellette has already said, the rail industry—most of us join this job for life. We have been fortunate enough to fall into a job that we all really like. Nobody wants to leave it. But we have got our own language. We got our own terminology, grown up over many years. So it is very confusing for a lot of people. So what we would like is to have some sort of consistency around the investigative model, some consistency around the terminology and for those things to be taken into account, because, at the end of the day, we actually want every incident really investigated. We want to prevent any future deaths. The only way we can do that is by actually getting to the basis of all the information very, very quickly. Anything that you can do in that space to help us with that would be certainly appreciated.

The CHAIR: Would it be of use if the Committee was prepared to recommend something like—when the coroner is doing the investigations, obviously, I think, under the Coroners Act they second police officers to be their investigators—whether they should have the same facility to second people from the State's safety regulators, who would actually have the existing technical knowledge, to assist the police?

Mr CLAASSENS: Absolutely. I think OTSI is certainly an organisation that is well geared to do that. As I understand it, they recently got a fairly good cash injection again from the State Government. So they are in a position to be able to provide advice in that space. I think that would be a very relevant step.

The CHAIR: One part of your submission is in relation to the suppressing of the names of transport workers. I would just like you to talk to us a little bit about that because, I guess, there is a number of inquiries, there is ICAC, there is criminal cases where people are witnesses, not always persons of interest, but none of their names, by and large, are suppressed. How should we view this request?

Ms BELLETTE: We understand that, under section 59—we are talking about under section 59. Bear with me because I am not a lawyer and I am not a legal expert. So, if I am wrong, I stand to be corrected, please. I do not want to be that person. Under section 59, where our members and employees are required to give evidence, their names become—because it is a State-owned institution, it automatically attracts media with it. The best description I can give to this as an example is—I did have authorisation to use—Damien Mulholland, whose name was up there with the Glenbrook disaster. He ended up with media camped on his lawn, which was extremely traumatising. We understand the railway is going to mitigate to a certain degree, but, when it comes to the inquest aspect, which is a number of years down the track—no pun intended—he had to relive that with his family being approached by media and reliving the details, inner details of the evidence he gave.

What we are requesting—we note, in section 74, the coroner does have power. However, this is tied to suppressing the whole evidence. We are not actually asking for the whole evidence to be suppressed. We are just asking for the name to be suppressed, to offer some extra insulation to our membership for when it comes, years down the track, after they have given their evidence and everything, that they do not have to relive—it is bad enough reliving the trauma in an inquest. But then to have the media and undergo all that scrutiny again, like Damien did, like the driver from Waterfall—his wife and family had that—through to Granville, the train driver in Granville—I do remember Granville. My dad was on that train. I remember vaguely. I was a child. But I remember the media around that. This is to add an extra layer. We know we cannot take care of everything, but, if we could just add that little bit of comfort around the coroner's end, bearing in mind it is years down the track, when it does come through to an inquest, it would add a bit of extra comfort for our members and their families.

The CHAIR: I think I understand the position of the union. In relation to when your members are interviewed by police as part of a coronial—does the union have much visibility or involvement of that with your members? Or do you find out afterwards that the members have already given statements or been interviewed?

Mr CLAASSENS: Generally, we are fairly—most people would recognise the fact that we are a high-density union. About 98 per cent of the members who can be a member are a member of the union. Because we are a big railway family, generally speaking, we are pretty close to the member all the way through the process, not always perfect, but, generally speaking, we are part of that whole process. So, when somebody has got to be interviewed four or five times, for example, we are there with them, to be there as much as we can as support, because it is a very traumatic time in most cases and it takes a lot. Any sort of incident on the railway is a tough one. But, when it involves the Coroners Court, it is automatically really, really bad, because we all have family, we all have loved ones, we all know what is it like when you lose somebody.

For some of us in the railway, when we first joined, it was a given thing. At some point you would be there at somebody's death. It is a very traumatic experience for most of us. We need all the help we can get in some cases. We have found that, through nobody's fault, I do not think—but, certainly, the break-up of the railways, the break-up of the regulatory model, the break-up of a whole variety of things have made that particular job really difficult for us, when somebody is involved in a critical incident.

The CHAIR: Do you represent your members when they have to give evidence at an actual coronial hearing? Or you provide them with other forms of support as well.

Mr CLAASSENS: Normally, we provide them with the support that they require. In each case it is slightly different. On occasion, we have had to hire lawyers to represent our members. On other occasions, it is just being there as a shoulder to lean on, that kind of stuff.

The CHAIR: Depends on the need.

Mr CLAASSENS: It depends on the circumstance.

The CHAIR: Thank you, Mr Claassens and Ms Bellette. I might now turn my questions to Mr Wright. What is the union's visibility with the coronial investigations with their members? Do you also have a high degree of visibility of the process through your members? Do they reach out to you if and when they are being interviewed or when they have to appear?

Mr WRIGHT: I suppose the first instance is that it is actually exceedingly rare for our members to actually even get to our stage. As I was saying in response to Mr Shoebridge's questions earlier, the number of road transport industry fatalities that actually make it to the stage of a full-scale coronial inquest is quite minimal. It is exceedingly rare. To the best of my knowledge, we do not provide them with representation at an inquest. We offer other support, as we do to all of our members.

The CHAIR: In relation to the question I was asking Mr Claassens about the different regulatory models, the different safety models or the different accountabilities—you describe, in page 4 of the TWU's submission, about the overlap between police, coronial and the WHS frameworks. Do you think it would provide assistance if the coroner was also able to access the expertise of SafeWork investigators when they are looking at road safety fatalities, as opposed to just relying entirely on the police, which is, as I understand it, what they do at the moment?

Mr WRIGHT: Yes, certainly. As I said earlier, SafeWork do not pursue investigations of road transport fatalities as much as we as the union would like them to. Whether that expertise within SafeWork that you are suggesting even exists I am not sure of, because it is not often that they do investigate road transport fatalities at SafeWork. But, absolutely, if there is that expertise in SafeWork, particularly when the WH&S Act prosecutions allow and almost encourage SafeWork to wait until the conclusion of an inquest before deciding to proceed to prosecution or not, it makes sense for people that are halfway through an investigation, waiting for an inquest to finish—if they can assist the inquest in any way, yes, it would absolutely make sense.

The CHAIR: And there should be a consistent framework as between the relationship between the coronial investigation and any criminal investigation and prosecution. There should be a similar relationship between any WHS proceeding and coronials. The legislation should be equivalent.

Mr WRIGHT: Yes. And our submission touches on a couple of the more minor things, like—the Coroners Act refers to obligations for the coroner to share certain information and statements collected with the DPP and specifically names the DPP. But, in the event of a workplace fatality, the DPP is seldom the one bringing the prosecution. You would like to hope that, in practice, that information is being shared between the coroner and SafeWork in instances where SafeWork are bringing the prosecution. But, if that framework does not exist, it should.

The CHAIR: Thank you. Committee members, are there further questions for any of the witnesses?

Mr DAVID SHOEBRIDGE: I had a question of the RTBU, to Helen and Alex. Thank you so much for your submission. I know that there is a strong interest from your members' side to just be asked questions once. But, given there are, likely, very different issues that are at play in the mind of an investigator looking at, say, a coronial investigation, looking at, maybe, the root causes of what went wrong in an accident, or a work health safety investigation, which might be looking at some of the very workplace-specific issues, as opposed to, maybe, a police and a criminal investigation, which may be looking at only the very short period of time leading up to an accident and potential negligence or the like, do you accept that there will be occasions when, even though it is not preferable, there will be a need for more than one interview of your members?

Mr CLAASSENS: The follow-up interviews are not unusual, because you are quite right. Depending on how long an investigation takes, it will require follow-up interviews. So we are used to that process. But if it is coming from the one location, that is okay. We can deal with that. We can live with that, because you certainly build up a level of rapport with the investigator anyway, when they are investigating things. It is certainly not unusual for them to contact you again somewhere down the track and say, "We need a bit more information around this particular issue." So we certainly accept that. We understand that that is a need. The issue at the moment is the different agencies that all want their piece. That is the problem, having five different agencies coming at our members, at different timings, with different needs. That is what is making it very difficult for our members.

Ms BELLETTE: Can I add to that, if I may. On top of those, then we end up with Sydney and NSW Trains coming and approaching our members because they are looking at disciplinary outcomes at the same time, while this is all occurring.

Mr CLAASSENS: That is true.

Ms BELLETTE: So, not only are our members addressing the serious concerns of statements, providing those informations, because they want [inaudible], also on the back of their mind is they are fighting for their jobs as well, which is very pre-emptive, considering there is usually not an outcome. But that starts straightaway. I know there is no jurisdiction for this [inaudible], but I just want to paint the full picture.

Mr CLAASSENS: That is true, because the last—maybe not the last. We had an infrastructure worker killed at Granville a couple of years ago. Within weeks, the railway were knocking on people's doors with disciplinary outcomes et cetera. That is a real concern, because we do want people to be able to be very honest and open when they are providing the information so that we can prevent another incident from occurring. It is not helped when they are worried about what their job is going to be and what their future looks like.

Mr DAVID SHOEBRIDGE: I will just give you a hypothetical example. If there is an accident at a level crossing and the suggestion may be that the person drove a vehicle while they were intoxicated and they had not stopped at the signs and an accident occurs, police may well be investigating just simply that very incident. You know, the culpability of the person driving, the alcohol content or looking at whether or not—if maybe the driver survived and the passenger died, the culpability of that driver. Yet, a coroner may actually look at a series of accidents at level crossings and actually realise that level crossings are the problem and then investigate and have a series of investigations directed to a totally different issue—not a totally different issue, but a significantly different issue. Do you accept that in those circumstances inevitably the driver would potentially be interviewed at least twice?

Mr CLAASSENS: Yes, look, we would have no real issue with that in that circumstance because, I mean—it is interesting that you pick level crossings because it is one that gets a hell of a lot of attention. We all want something done about level crossing accidents, absolutely. So anything anybody can do in that process we understand that and, you know, we would actually certainly be involved in assisting that process. But, again, it is not multiple agencies; it is just a follow-up interview, I suspect. That would be okay. That would be fine.

Mr DAVID SHOEBRIDGE: The first investigation may be done by, you know, police, but the second investigation may be done by work health safety or it might be [disorder].

Mr CLAASSENS: Yes.

Mr DAVID SHOEBRIDGE: They have different purposes of criminal prosecution and a coronial investigation, and often those different purposes will require a different line of inquiry and investigation. Do you accept that?

Mr CLAASSENS: Yes.

Ms BELLETTE: We do accept that, but I think that also feeds into having an investigator that is specially trained. Going back on Mr Searle's suggestion that perhaps seconded from the rail regulators might be

of great assistance because they do look at the big picture. I am not saying that to be obstructive. Please do not interpret it that way.

Mr DAVID SHOEBRIDGE: No, Ms Bellette, I did not interpret it that way at all. A number of people have suggested that one thing that is really needed is a body of expert capacity within the Coroners Court itself to have a look at some of these systemic issues, and that there be a pool of experts that the Coroners Court can draw on. Would you have a view about whether that might be duplicating something that is already existing or would be beneficial?

Mr CLAASSENS: Without thinking it through because you have just sort of dropped it on us, but—

Mr DAVID SHOEBRIDGE: By all means, take it on notice.

Mr CLAASSENS: Look, my suggestion is the one that I agreed to earlier. You have got the Office of Transport Safety Investigations in New South Wales already. It is already an agency that has been set up to look into this area and to look at all of our accidents. They have already got the resources in play. My strong suggestion would be to utilise those resources as and when the Coroner needs them.

The CHAIR: Just to Mr Shoebridge's point, we have received evidence through submissions that in Victoria they have a coronial support unit or investigations unit which assists the coroners there, do research and formulate more robust recommendations that might have some kind of robust or practical effects so that the coroners are not just looking at the evidence and their particular matter and sort of saying, "This would be a good idea." There is actually a, if you like, body of ongoing research that they can draw on and hopefully which will be shared through the national coronial database. Having something like that in New South Wales, which we do not currently have—a number of submissions have suggested that would be of great assistance in providing outcomes. Is that something any of your unions would have a view about, whether that should be a good thing?

Ms BELLETTE: We might need to take that question on notice and seek some further advice.

The CHAIR: Please do. Sure. Same to the TWU, Mr Wright, if you could take that on notice.

Mr CLAASSENS: Certainly, having expertise involved in helping the Coroner make the decisions would seem to be a sensible solution to many of our concerns.

Mr WRIGHT: Sorry, Chair, if I could just add to that.

The CHAIR: Mr Wright.

Mr WRIGHT: The thing for us is that you have got the coronial inquests which, you know, [inaudible] recommendations is and the Coroner is then obligated to provide copies of those to whoever the recommendation is related to. What is unclear for us as to how much it is happening and what is not happening that we think absolutely should be is where an inquest identifies a system failure of some kind and issues recommendations to resolve that, ensuring that SafeWork are provided with a copy of those recommendations and are then empowered to, sort of, pursue them in the context of ensuring that that PCBU actually adheres to them because, you know, it just seems like they are both trying to achieve the same purpose. Both organisations, rather, are trying to achieve the same goal there, but if that information is not being shared the Coroner is, sort of, issuing recommendations and SafeWork are not being notified and are not there to ensure that they are actually enacted upon and that that PCBU is fulfilling their duties under the Act.

The CHAIR: That is a good point, Mr Wright. Committee members, are there any last questions for these witnesses? If not, I thank the RTBU and the Transport Workers' Union for your submissions and for giving your time today and providing us with your oral evidence and further insights into the issues facing your industries. You are excused. Thank you very much. The secretariat will be in touch with you about the questions taken on notice.

(The witnesses withdrew.)

RITA MALLIA, State President, CFMEU Construction and General Division NSW, before the Committee via videoconference, affirmed and examined

IVAN SIMIC, Senior Partner, Taylor and Scott Solicitors, before the Committee via videoconference, affirmed and examined

GRAHAME KELLY, General Secretary, Mining and Energy Union, before the Committee via videoconference, sworn and examined

STUART BARNETT, State Practice Group Leader, Slater and Gordon Lawyers, before the Committee via videoconference, sworn and examined

The CHAIR: I welcome our next group of witnesses. This is the first bracket of witnesses where we have been able to hear the witnesses and they have been able to hear us without incident so far, which is good. Both organisations have made written submissions to this inquiry. The Construction, Forestry, Maritime, Mining and Energy Union [CFMEU] Construction and General division has provided submission No. 52, and submission No. 54 is from the Mining and Energy Union. I thank both unions for their written submissions. Would either organisation like to give a brief opening statement in support? I will start with the Mining and Energy Union, if you wish to give a brief opening statement.

Mr KELLY: No worries. Thank you. Ultimately, the Mining and Energy Union has been around since 1854. We can trace our lineage way back prior to the Eureka Stockade, so 168 years. We have had check inspectors in coalmine legislation since 1912. We basically [inaudible] local check inspector was the internal auditor and the district check inspector was the external auditor, who used to turn up to over time make the mine safer. The reality is that they were the champions of the industry. But, unfortunately, too many coalminers have been killed over numerous years, and as a result we are very—not pleased, but we are very willing to give [inaudible] to this inquiry so that a very important function is being [inaudible] for the mining industry and the mining union is properly funded and recognised for the role that it plays, and that is the coronial inquest.

Stuart Barnett and I are in the Cessnock office and there is a wall outside this office here with 1,800 names of men and boys and unfortunately one female who have been killed in coalmining in this district, which is a really large number which suggests that we have had a large number of coronial inquests. Stuart Barnett, who is with me, has done 84 deaths and 75 separate inquests for the union over his 30-year career, which we think is important because he has got a history of how this function of government can work and how it can be used to make a difference. In fact, off the back of the Gretley inquiry were some of the most major changes that came out of the coal industry to really ramp up its safety performance. We are very grateful for that.

I will just make one other comment, if I may, and that is that basically our union's mantra has always been about safety. That is our focus all the time. We are involved with Coal Mines Insurance—a workers comp company that is a monopoly insuring coal. We have got Coal Services Health, which is the largest health record of a workforce probably in the world, if not certainly in the country. They also have the Mines Rescue service. We play a really important role in every aspect of our industry. As I said, coronial inquests are very important to us. That is why we think our recommendations should be considered and taken on board by the inquiry as a pragmatic way to continue to improve the outcomes for people in our industry, an outcome of which is a better and safer industry. Thank you for the opportunity.

The CHAIR: Thank you, Mr Kelly. Ms Mallia, do you wish to give a brief opening statement?

Ms MALLIA: Yes, thank you. Thank you for the opportunity for myself and Ivan Simic to be heard today. We have provided a short submission in writing, but I will just highlight some quick points. The union believes there is a real utility in having within the jurisdiction of the Coroners Court the capacity to investigate the cause of workplace fatalities. From my quick look at the decisions of the Coroners Court on its website, the latest one that I could see that was not a police force related workplace death dates back to about 2017. So it has been a long time from our reckoning that the Coroners Court has actually played any role in exposing what has occurred as a result of a workplace death or what has caused a workplace death other than, like I say, its specific and key areas.

We believe that the Coroners Court is well placed if properly resourced to investigate workplace deaths, their cause and more importantly recommendations for reform in the process, or regulations that might prevent a repeat. In years of experience of speaking to families of loved ones lost, access to the Coroners Court to allow them to ask questions about what happened to their loved ones is very important for them in understanding how the death occurred. There is no other process available to them in a formal setting. Prosecutions and breaches of the Act are not a sufficient substitute and this function in providing answers does provide important closure.

I believe you have heard from Ms Patrizia Cassaniti about their experience in trying to get a coronial investigation into the death of Christopher.

For families who have lost a loved one in the workplace, the coronial process is an essential process that provides the best and most transparent evidence of what happened to their loved one and often comes with the opportunity of having to hear from and see workmates and supervisors and others who last saw their loved one or was with them when they died. It is also important to note that it can support whistleblowers and others in the workplace who might and can be protected and therefore be more frank in the giving of their evidence about what may or may not have occurred leading up to the death of someone at work. Prosecution by the regulator is also very important, but the manner in which a criminal prosecution is run and for good reason does not provide the opportunity to explore more widely the cause of death, the factors resulting or leading up to the incident, who was involved and what can be done to address the safety issues into the future, like I say, to prevent the reoccurrence of a similar incident.

In construction we still see—as they do in mining and energy—too many workers that are killed at the workplace. These incidences, from our perspective, are not fully investigated in terms of what could be done to prevent those deaths from occurring. For these reasons, a suitably resourced coroner to carry out this function is supported, and would contribute to the efforts that continues to be needed to prevent workplace deaths. We have also had the chance to read the Mining and Energy Union's submission and are also very supportive of the practical recommendations that they have made in that submission. Thank you.

The CHAIR: Thank you, Ms Mallia. I will open questions from committee members to these witnesses. Who would like to commence questioning?

Mr DAVID SHOEBRIDGE: I have a couple to start with, Chair, if that is okay.

The CHAIR: Mr Shoebridge.

Mr DAVID SHOEBRIDGE: Thank you to all of you for your evidence today and your submissions. If I am to understand it correctly, Mr Kelly and Mr Barnett, you have seen the coronial jurisdiction deliver systemic benefits in the mining industry after—is that right that there has been a historical element of recommendations from the Coroner actually delivering systemic benefits for safety, in particular in the mining industry?

Mr BARNETT: Yes. Over the years that has changed a little bit as the resource regulator has altered its position, but initially when I first started this type of work there was really only the coronial process to give rise to recommendations. To be fair to the industry, often by the time we got to that point the industry had implemented its own recommendations. But, yes, the coronial process has been very important over the years. One of the matters that we go to, though, is the inconsistency that you cannot always be sure what sort of hearing and what depth of hearing you are going to get. So I guess my experience is that you get some very thorough investigations and reports and recommendations and you also get some inquiries where frankly very little comes out of it. That is why some of our submission goes to that issue that there needs to be a follow-up and a formal follow-up. But, yes, the coronial process has been very important. I might add, on a personal note, from my observation it is very important from the families' point of view.

Mr DAVID SHOEBRIDGE: Would your observation be that say in the last 10 to 15 years it has been less common for matters to have the, kind of, fully resourced public hearing in the Coroners Court that would have been perhaps more common before then?

Mr BARNETT: Yes, no doubt about that. Again, by way of balance, it somewhat depends upon the quality of the report that is provided by the resource regulator, and on occasions those reports will be so comprehensive that it is difficult to argue that you need another week of hearing. On the other hand, it has not been easy to convince magistrates necessarily to give you the time and leeway to have a full coronial inquiry, in part I am assuming due to a lack of court time and so on.

Mr DAVID SHOEBRIDGE: But in your industry there is at least that other element, which is an inadequately resourced resource regulator, that is working in parallel on some of these safety issues and responding to fatalities. You have got that kind of dual track in your industry.

Mr KELLY: Yes, that is right, and that came off ultimately the back of the Gretley fatality, which was four miners killed back in about '96, from memory. The reality from that and the Wran review that occurred from it ultimately resulted in a properly resourced regulator who had a dedicated arm to only focus on the more serious or fatality driven arrangements. Mr Barnett is right. As he pointed out, we get reports now from the inspector even for serious injuries that are extremely comprehensive, bigger than we would have got pre-2000 in the coronial

inquest. You would not have had that sort of evidence provided there, when now you do. And so the need for us is not as great.

I appreciate what Rita Mallia was saying before about the families and the like. I know part of my job used to be when someone got killed at work to go and talk to them in the days after someone had passed away. Them understanding what happened is a critical point, and getting the opportunity to do that is really important to lots of people. In our industry, because of our check inspectors, we already have a fair idea of what happened and so we can give the family some comfort. But I hate to think how difficult that is in other industries that do not have that luxury.

Mr DAVID SHOEBRIDGE: I might go to you, Ms Mallia and Mr Simic. There is not that regulator focused on safety in the construction industry, is there? In absence of that, what kind of investigations are you finding happening after a fatality? We heard from Ms Cassaniti earlier today about those circumstances, but what are you finding is the practice?

Ms MALLIA: You have probably heard us in other inquiries being fairly critical of the approach that SafeWork takes with investigations and prosecutions. I guess the Cassaniti prosecution is a prime example. That was an extensive investigation and the inspectors on the ground did interview a lot of people from a lot of entities, but yet in the end there was one corporate entity that was prosecuted. It was very unclear from the prosecution really what ultimately happened because it was a case where the company pleaded guilty in effect and basically left so many questions unanswered in respect of what actually happened on that day in a very serious and significant scaffold collapse. That is repeated time and time again. I think Mr Simic can probably speak to a few more examples where he has had to assist families in the common law jurisdiction trying to work out what has happened for somebody to die at work.

Mr SIMIC: Yes, there is one particular issue that I would like to address the Committee about. This is not a criticism of SafeWork NSW, but they are basically a prosecutor. The problem you have with this prosecutorial model is that it is not about the cause of death or finding out what really happened. What happens in these situations—we have got no industrial manslaughter laws here in New South Wales. It becomes basically an exercise in damage control for corporations. Nobody ever goes to jail for a workplace death here in New South Wales. Investigations are totally conducted behind closed doors. The key witnesses to a death are surrounded by lawyers from the employer during their interview with SafeWork NSW.

As I said, just looking at the Cassaniti model, that is a perfect example. The matter is pleaded out, you know, as if it was a drink driving offence or something like that. We do not ever really get to the true cause because somebody has put their hand up and said, "I will cop that fine, sir," and that is the end of the process. That is why there is a—I do not even know if it serves any real deterrence in the sense of creating a better safe work environment. That is a major black hole that we have here in New South Wales. Ever since we stopped having coroners, we call people to a witness box and say, "Did you see what happened to him before he died?"

Mr DAVID SHOEBRIDGE: Ms Cassaniti's evidence was that after the plea-bargain had been accepted in that case, the actual court process was a matter of hours, if that.

Mr SIMIC: That is correct. I was there for the penalty hearing. It was reduced to a penalty hearing. I was there for the whole process and saw it firsthand as a neutral observer. That is no criticism of the court or the prosecutor, but that is what it was designed to do. It is not designed to do what a true coroner is [inaudible]. The function of a coroner is to actually investigate the cause of an unnatural death, full stop. The coroner has power to protect witnesses, and that is so important that they are able to give their evidence in open court without 50 solicitors—you know, a whole bunch of lawyers around basically telling you what to say for SafeWork NSW so we can minimise the fine, if you know what I mean.

The CHAIR: I have got a question for all of the witnesses. In Queensland I think they have 20 full-time coroners. I think in Victoria it is certainly over 10—I think it is 12, but we will find out on Friday when we go to visit the Coroners Court. But in New South Wales we are told there are 5.2 full-time coroners. Outside of Sydney country magistrates also fulfil the role of coroners, but 80 per cent of their coronial work is sent back into Lidcombe. This puts a lot of pressure on a limited pool of coroners and I see that the Mining and Energy Union has supported a standalone coroners court, if I can put it that way—an independent properly resourced court. Is that something that would go some way to alleviating that pressure and maybe leading to more workplace fatalities having a proper systems analysis provided?

Mr BARNETT: I might go first on that. It seems to me that a lot of the time and energy in any coronial inquiry in the lead up to it is about planning, administration and fitting it into the magistrates court system. A standalone system would allow day one to day end management of the process, which would include consideration for whether an inquiry is necessary and, if so, what length and what depth. At the moment I do not think it would

be disputed that magistrates in New South Wales I suspect would be the busiest judicial officers in the country. You know, having to deal with 300 traffic matters on a Wednesday, committal hearings on a Thursday and then perhaps squeeze in a coronial matter just seems to me does not allow—as good as the staff are, I must say, it does not allow for the proper planning. I would have thought a dedicated administration for that process would go a long way towards it.

Mr KELLY: The other advantage, if I can add, is that the challenge that the mining industry has overcome over the years has been the ability to get it out into the open what happened and to shine a light on it. If we can do that in other industries then their safety record, I would like to think, would improve. The more opportunity to do it—and that is what our recommendation that Mr Barnett has spoken to is about, having more opportunities to do it if it is needed.

The CHAIR: Ms Mallia and Mr Simic?

Ms MALLIA: We would agree with all of those comments. You just have to look at the types of things the Coroner in New South Wales has to currently look at. To think that those 5.2 people are also going to, in some comprehensive fashion, be given the resources and the time as it is currently set up to look at the cause of a workplace death or workplace deaths is an unreasonable request. Obviously part of our submission, as the other submissions are, is that these need to be properly resourced. We do not have any objection to it being an independent standalone jurisdiction that deals with these sorts of inquiries. There is plenty of work for it to be done. As a result we would like to see, as Mr Kelly said, a light shine on how these incidences and deaths occur, some real and meaningful discussion about how they can be prevented into the future, and also to provide those families with such an important opportunity to ask questions in a way that you cannot do in a criminal prosecution. They are completely cut out of the process, apart from a limited opportunity to make a victim impact statement if the court wants to hear one. I absolutely think that there is need for something like that to be properly resourced.

The CHAIR: That is one of the things that has come through quite clearly with the different evidence we have heard. Obviously a prosecution, whether it is a criminal prosecution into the mainstream criminal law or through the work health and safety legislation, is to do a very limited fact-finding to find whether entity "X" committed "Y" offence on a particular day. Sometimes that process will reveal the truth of what happened, but a lot of the time, particularly where there is a plea deal, if you like, reached between a defendant and the prosecution, key facts are obscured and you do not get to the truth. It seems to me that the great advantage in theory of the Coroner's jurisdiction is that it can try to get to the truth and the facts, without necessarily saying who is guilty of a particular offence. That does seem to need to be strengthened. In the workplace situation, if it has been years since there has been proper coronial consideration of workplace deaths, that must mean a lot of prevention that could be taken into account now is just not being known about, leading more people to be at risk.

Ms MALLIA: Yes, we could not remember the last one in construction that occurred. I do not know if Mr Simic can recall one, but it would have to be a very long time ago.

Mr SIMIC: It was and I can. It was actually a gentleman who fell off a construction of, actually, a public works job off a bridge and died, down near Ulladulla and Milton. Just to further endorse the comments of previous witnesses, asking a country magistrate in Milton to find four days to set aside for a hearing into the cause of this death—especially in this situation where we had a boss who told the witnesses to cross the border into Victoria—I mean, that takes a certain matter of sources and energy to fully and properly investigate. That was the death of a gentleman by the name of Mr Mark Hoy. But, yes, I fully endorse what Mr Barnett, Mr Kelly and Ms Mallia have said in their evidence.

The CHAIR: Committee members, are there further questions? Ms Sharpe.

The Hon. PENNY SHARPE: Thank you to both of you for coming in and for your submissions. This is raised in the miners submission, but it is also a question I think for construction as well. You make a recommendation in your submission about the right to appear at a coronial inquest for the union. My first question is that I assume because of the request it means that is not automatic, and I just wanted to know how that process goes and whether you sought to be able to appear previously and had not been able to. Can you take me through the involvement of the union through the processes, given the role that you play in supporting families?

Mr BARNETT: From the mine workers point of view, when you are acting for the family, of course, you are never going to be refused leave. Then comes the question whether the union should be separately represented. They often have members who are potential witnesses and, you know, I think the union would basically take the stance that the interests of the union lie in the interests of the family and vice versa, but there can be occasions where members might have an interest different to the family. In my experience, I have had occasions where there have been objections to me appearing on behalf of the union, but to date I have always been granted leave.

Before the current Coroners Act the schedule provided that the organisation with members in a mine site where a fatality had occurred would have a right of appearance. That did not find its way, I can tell, into the current Act. So in theory there could be an objection raised, for example, to take an extreme example, if the family of the deceased was not a member of the union, if the family had separate representation, if the company or the resource regulator—if they all objected to the appearance of the union, it would be simply in the hands of the Coroner as to whether the union is allowed to appear. The difficulty with that is whilst so far we have been given leave, come today it could well happen.

It is important in the mining industry that findings are relayed across the industry and, of course, the people with the most interest in the safety are the members and mine workers. Their interests need to be represented. I do not know why the schedule did not find its way into the new Act, but it was certainly there up until the current Act. I can actually say that I have had objections taken to my appearance in the past, but, as I said, each time the Coroner has gone our way.

The CHAIR: Just on that point, though, leaving aside—

The Hon. PENNY SHARPE: [Disorder]

The CHAIR: Sorry, Penny, continue.

The Hon. PENNY SHARPE: I just wanted to see whether Construction had a view about this as well.

Ms MALLIA: We would be very supportive of that right existing. We have not had a coronial inquiry into a workplace death on a construction site for a couple of years. Families are being told themselves that an inquiry is not needed, but of course the union can also bring other information to the table as a wealth of knowledge about how sites should operate. It may have also had personnel who are present shortly after an incident has occurred, which would raise separate questions and separate issues than perhaps a family member or another person interested in the proceedings might have. So I think it is actually very useful in those serious circumstances to have the union there, and it would not in any way I think make it a problem for the Coroner to do its work.

The Hon. PENNY SHARPE: I have got one more question and then I will go back to the other committee members. Again, it is to another recommendation in the miners submission, which is about self-incrimination and the treatment of evidence. The inquiry has heard within the health system where there is root cause analysis or where a critical incident—it is very much people being able to tell everything that they know on the basis of trying to understand what went wrong as soon as possible, and also deal with all the systemic issues straight away. There are some strong protections for nurses and others within that process. Similarly, the rail safety regulator has a similar process. Within your regulator, I just wanted to understand how it works in the mining industry and the use of any review—I think you have talked about there being really significant and detailed good investigations. Talk me through your submission and how that works with your regulator reports that go to the Coroner.

Mr KELLY: I will just make a couple of comments and hand over to Mr Barnett, who is more across the detail. At a really high level the really important part of the—everyone has got rights, and being able to protect from self-incrimination is really important. One of the things, again, to the theme of shining light on matters is to make people give full and frank accounts. What happens in our world is the inspector can give a witness a certificate and that certificate is then able to be used to allow them to give all the evidence that needs to be provided and that evidence cannot be used against them, which ultimately gets to the root cause of the problems.

Our submission of course is that should also extend into the Coroners Court because it currently does not. Just as a side note, the union takes it extremely seriously. If we are worried that one of our members is not going to tell the whole truth, then we will actually take them outside and have a chat to them. We appreciate they have got rights, but they are also protected by the use of certificates. We want to know what happened. If that is good or bad does not matter. We want to know what happened.

Mr BARNETT: In the mining jurisdiction, the resource regulator inspectors can require any person who may have information relevant to the incident to provide written evidence. There is no choice on that. However, where it falls apart in my observation is that some of the most distressing reactions I have seen over 30-odd years at an inquest have been when a witness refuses to give evidence on the basis that it may incriminate them. It is very distressing for the family and is probably the area where I have seen the most reaction over all those inquests.

Our concern is there is a mechanism there that effectively follows the same process in the mining industry, that the Coroner can require the witness to give evidence and can provide them with a certificate to the effect that the evidence will not be used against them unless they tell an untruth. My observation is the application of that is so inconsistent you do not know until the day what is going to happen. That is bad for the family, but it

is also bad for those advising the witnesses and the witnesses themselves. Taken to extreme, I have been at inquests where counsel has simply stood up and said, "My client does not wish to give evidence on the grounds that it may incriminate them," and the Coroner has said, "Very well, they are excused." I have had other extremes where the witness is taken question by question, which I think is probably the correct legal way to do it, and a judgement is made on each question as to whether that question and answer may tend to incriminate them, and then of course all the way in between.

The Coroner is not always prepared to give a certificate. Again, that is something you only find out on the day. It seems to me that given evidence can be compelled by the inspector in the mining industry but then not necessarily tested in a coronial inquest, that must take away some of the importance or meaning of that evidence. If we want to know exactly what happened and it is to be tested by the parties, it seems to me there should be a consistent process whereby every witness is compelled to give their evidence.

The Hon. PENNY SHARPE: Thank you. Does construction have a view about these issues generally? Again, I know that you have not been through—

Ms MALLIA: We probably would not disagree. It is important to protect people's rights and it is important to, in the course of that, encourage people to come and tell the truth and tell what happened and how someone has lost their life as a result, or a number of people.

Mr BARNETT: I might just add, of course if they get to a stage where someone is likely to be recommended or the paper is referred, as they used to say, for prosecution, the Coroner can of course shut down the inquest at that moment. So there is that further protection for a witness or an organisation if the Coroner forms that view part way through the evidence as well.

The CHAIR: Indeed. Committee members, are there any further questions for these witnesses?

Mr DAVID SHOEBRIDGE: I had a question about timing, if that is okay. Do you have a view about what is a reasonable time within which a coronial investigation should be concluded, given the importance that particularly family members can place on getting some answers for a coronial investigation? Do you have any current experience with the length of time for civil proceedings or work health prosecutions that might shed some light on that? I might go to the CFMEU first.

Ms MALLIA: We would say they should be done as soon as possible after. Keeping in mind the complexity of investigations and interviews, et cetera, and that people have various rights in that process as well, but the matters should be brought before the Coroner as soon as possible. As Mr Barnett said, that could be at the very beginning and then there would be a timetable in which the regulator might have to have more time to provide information or in putting together the evidence if it is a very complicated matter. I know for example in the Cassaniti case there were hundreds of people that were interviewed because I sat in a lot of the interviews on behalf of our members.

That can take time and you do not want that to be rushed and you want it to be done properly. But when you get to the point, as in the Cassaniti case, that the prosecution via SafeWork has been run and finalised and the Coroner then says to the family, "Well, now that process is finished, I am very sorry you cannot now have a coronial inquiry. There seems to be no utility in that." That two years after the event is obviously a system failure from our perspective. Obviously a time frame within reason and ensuring that investigations occur properly and thoroughly as soon as possible. It comes back to that submission of the Mining and Energy Union about having a properly resourced court or process that does that from beginning to end so that these things do not go on for years and years, waiting for some comfort and questions being answered for the families.

Mr DAVID SHOEBRIDGE: If you look to coronial proceedings from three decades ago and pretty much all of history of coronial proceedings prior to that, coronial hearings were being held within a few months of a death. That was the traditional time frame. Now the modern coronial hearings are unlikely to get a start before three years after the death and sometimes some five years after the death. Is there such a degree of complexity that we should be accepting that?

Mr BARNETT: My observation is that in deaths in industry—and I think someone might have mentioned this before—it becomes really a large part about management of the various interested parties and looking after their interests as opposed to what happened. You are correct. It would be unusual in my experience to get a hearing lasting more than half a day for a coronial inquest inside 12 months. I see some of the other evidence of about two to three years. I might say this: The trouble with, sort of, 12 months to two years is that it's sod's law that it seems to come up at about the time of the anniversary. So often you are dealing with the family and all of a sudden they are dealing with an anniversary but they are also dealing with the inquest, so it keeps the thing alive.

Civil proceedings these days, if they run in the Supreme Court to a hearing, are going to take two years. In my experience in the mining industry, the prosecutor or the regulator normally waits until the coronial inquest is over and then initiates if they are going to a prosecution, which means you could be talking about four years before the whole episode is put to bed. I think it goes a little bit back to the issue of the evidence being compelled to give the truthful evidence. You know, do people need a year or two to prepare to give that evidence? I think the fact that they seem to speaks a little bit to why they are taking that time. It must be self-interest, I think.

Mr DAVID SHOEBRIDGE: Mr Simic, do you have any view about whether or not the delay is partly explained by those interests? Some of them no doubt legitimate [disorder] having that apprehensive approach to the hearing?

Mr SIMIC: Yes, absolutely, from my experience with construction fatalities. As I said, the process is a prosecutorial model and the emphasis is all on damage control and pleading the matter out. SafeWork have got a two-year time limit. One would have thought the best way to find out what happened and what caused the death is to get that evidence in before the Coroner as quickly and as practically as possible. We can do that with the Coroners Court because as you have heard before the Coroner is able to give protection to witnesses. It is so important to get what I call the unfiltered evidence of witnesses before they have spoken to about 50 or 60 people sometimes, you know, literally, when you are talking about something that gets strung out for two or three years. It certainly would be unacceptable in criminal prosecutions and I do not understand why we sort of put up with it or accept it as the norm with a workplace death, which is just as serious as any other death on the road or any other manslaughter. I think it is just really important to get those witnesses to give their evidence as frankly as possible in an open court so it can go down on transcript on record and people can make their findings from there on.

Ms MALLIA: And whilst it is fresh in their minds.

Mr SIMIC: Whilst it is fresh in their minds. And, can I say, it is also in the best interests of the poor workers who were there and who witnessed it. They do not want this thing to go on and be strung out forever. This is only anecdotal evidence, but my experience is that people just want to spill their guts and say what they have got to say and move on with their lives. That is how they cope with it. Seeing a workmate die—anyway, you do not need an expert to tell you about that.

Mr DAVID SHOEBRIDGE: If we were to make recommendations for amendments to the Coroners Act or a reformed Coroners Act, one of the core objectives should be as timely as possible determination of coronial matters. That should be one of the clear objectives.

Mr SIMIC: Absolutely. Can I just strongly emphasise this: We do not have industrial manslaughter laws in New South Wales where people are incarcerated. Most people that can give helpful evidence are not going to be in the gun, you know. They are not going to be in the gun. They are not at risk of being prosecuted. They do honestly want to just be able to tell whatever they have got to tell and deal with the process as quickly as possible. They do not want to be strung out waiting for years and having to see numerous investigators and numerous police, et cetera. That is my humble opinion.

The CHAIR: We may not have those laws, but I guess a number of the witnesses may be managers or directors of companies that have got financial interests at stake. That might be a factor. Mr Shoebridge?

Mr BARNETT: I might just add something to Mr Simic's comment. Putting a recommendation in regarding the time lines for determination might also through the back door force better resourcing so that the various government organisations can meet those deadlines. In other words, it might force the issue and force the financing of it.

The CHAIR: I ask the witnesses this question: Is there a consensus at least amongst you to have the coronial first with all of the extra powers, the ability to direct the giving of evidence and the protection through certificates and what have you to try and find the truth? It is best to have that done first so that if there are then civil actions or criminal actions—obviously it is a matter for people then to find admissible evidence in a court, but if the truth or the facts are established for the benefit of the victims and their families, that would be in the public interest.

Ms MALLIA: Absolutely. If you think of the construction industry and, you know, yes there are some organised sites where it is very clear who the principle contractor might be, who the subcontractor might be, who an employee might be and who a sub subcontractor might be, but there are many deaths that happen in this workplace where it is entirely unclear who was in control of the site or who the person who has been killed is employed or engaged by and under what circumstances. Of course, those investigations at that incident and when you have got people available—the other thing is that people in our industry come and go. We have a highly itinerant workforce and a high rate of non-citizens and non-permanent residents working in this industry. They do

not hang around for very long. You really want to have a system that can pull all of that information together very quickly and up-front so that it is very clear then what might be available to the regulator, what might be available to the family of a loved one lost and what then might be available to the unions to make submissions to government and industry about how these things could be addressed in the future to prevent the repeat of the fatality. It is very important I think that that happens up-front and is done well.

The CHAIR: If it were done well and done early a lot of those basic queries—for example, who is in charge of a workplace or indeed whether anyone was in charge of a workplace—might actually then be able to inform other process. But it is a bit hard to do that if you do not have the basic facts.

Mr SIMIC: I strongly agree with the proposition you put there, Mr Searle. If we can get the evidence out first then all these other processes can work their way through the system, whether they be civil or prosecutorial. The whole object of the Coroners Court is to actually properly get the best evidence about what caused the death. That is my understanding of the Coroners role.

The CHAIR: And to identify systemic issues, hopefully.

Mr SIMIC: Yes, sorry, correct.

The CHAIR: No, I mean, that is something that the coroners can do. We have received some evidence that again the practice of coroners is inconsistent across whether they take a limited view about manner and cause of death or identify and elucidate the systemic context, I guess. Committee members, are there any final questions, noting we are nearly done for time? I thank the witnesses for their submissions of the two unions and for coming today and giving us the benefit of their learning and insights informed by their experience of their different industries. I have found what you have had to say today very useful and informative, and I am sure the Committee generally will do so as well. Thank you for your time. I do not think any questions have been taken on notice, but if they have been, the secretariat will be in touch about those and the time frames for response. Thank you very much.

(The witnesses withdrew.)

The Committee adjourned at 13:28.