WORKSAFE NEW ZEALAND - Regulatory Function

An Independent Report

Investigation and Prosecution - Reflective Learning Assessment

Gavin Jones (25 July 2019)

CONTENTS

PREFACE

This report has been prepared by Mr Gavin Jones at the request of Mr Simon Humphries, the Head of Specialist Interventions, WorkSafe NZ.

Although significant recent work has been completed in terms of how regulatory functions are administered, WorkSafe NZ (hereafter referred to as "WorkSafe") recognises that 'end to end' investigation processes and systems are not operating to their full potential as they are yet to be fully optimised.

WorkSafe aspires to be a world-class regulator and commissioned this assessment to provide a snapshot of the current state of its investigative capability so that any necessary improvements may be identified. On that basis, this assessment has sought to identify any skills, knowledge and service delivery gaps so that the desired aspirations may be realised.

This report is the product of that assessment.

About the Assessor

Gavin Jones MNZM has a background in law enforcement. He retired from NZ Police (NZP) in 2009 at the rank of Assistant Commissioner (Investigations and Intelligence). Since his retirement through to 2018, Gavin continued to work for NZP in an advisory capacity, in the team which led NZP's transformational change programme, Policing Excellence (PE). Gavin was a founding Board Member (Director) and Trustee of Crimestoppers NZ – (2009 – 2016); and is currently a raceday panellist for the Judicial Control Authority (JCA), an independent statutory authority constituted under the Racing Act.

SUMMARY

Issues raised and main findings

This report outlines the recurring themes that I identified during this assessment.

Overall, on the basis of the cases assessed, I found that WorkSafe investigators produce cases of a good quality that on the whole meet best practice investigative standards, albeit I found instances of inconsistent application of national policy. Further, cases prosecuted investigated and prosecuted by WorkSafe have an exceptionally high success rate. But despite this positive evaluation there are signs of issues emerging that are potentially holding investigators back from operating to their full potential. This has flow on implications for legal group in terms of their ability to meet tight timeframes. The issues are:

1. Demand, workload and caseloads
2. Investigation and investigator management
3. Case Management business model
4. Victim Focus
5. Alignment and national consistency

Demand, workload and caseloads

The Specialist Intervention workforce has a resource allocation target (RAT) of 70 full-time equivalents (FTE's), but at the present time is not operating to full capacity due to some investigators and managers being on long term secondments or relieving duties.

The total number of cases held by investigators, as at July 2019, is 285, with 192 of those cases having commenced in the 2018/19 year. Legal group currently deploys 16 advisors with much of their workload originating from cases referred from investigators. In 2018/19 58 cases were referred to legal group for review and as of June 2019 there are 86 cases in the court process. In addition, as at July 2019, there are a further 62 cases in the pipeline awaiting referral to legal group. This demand picture does not include latent demand which currently impacts on the through-put of cases and or investigator and legal group productivity.

Although the volume of incoming cases is trending slightly downward[1], case complexity continues to increase; investigator capacity, capability and experience is reducing and the number of defendants pleading not guilty has risen sharply. The combined effect is that managers, investigators and prosecutors are increasingly concerned that their respective workload pressures are not sustainable.

Reduced investigative capacity is compounded by the fact that a number of managers are currently acting up in relieving roles; but in addition, they are still actively investigating their own cases. This comes at the expense of devoting their full managerial effort toward supervising, coaching, training and developing their staff; many of whom are relatively new to the investigations group.

Further, it is clear that the actual number of available investigative inspectors, due to some being on relieving duties and others on secondment, is a contributing factor to the pressure on legal group. And this goes some way to explain why investigators are currently struggling to refer completed cases to legal group in a timely manner; moreover, within the 8-month timeframe mandated by policy.

[1] WorkSafe website date April 18 to April 19 (investigation by all industries by region, non-fatal injuries and illnesses for all regions; and workplace fatalities).

Investigations and investigator management

Not all determinative decisions, particularly the rationale for them, are well documented. This appears to be the product of not fully understanding the purposes and relative differences between the various record keeping instruments, such as investigations plans, investigations logs, notebook entries, job sheets, decision logs and formal (evidential) statements.

The variety, complexity and numbers of cases assigned to WorkSafe investigators are only slightly below the load and expectations placed on New Zealand Police detectives. This is indeed a high standard, particularly given that the training afforded to investigators nowhere near matches the training provided to detectives before they qualify.

WorkSafe aspires to be a world class regulator. If this ambition is to be realised, WorkSafe must develop world class investigators; who require specialist investigative training and support; who in turn will produce world class investigations. This is an achievable aspiration, but will not be met unless:

a) There is further investment in the training and development of investigators.

b) There is a greater level of performance monitoring over their core activities (i.e. scene examination, management of exhibits and interviewing);

c) There is an improved understanding of case management and the extent to which forensics and technology can facilitate and support investigations in a much more sophisticated way than currently exists.

Investigators are a finite resource and there are limited stocks of investigators on the open market. They are costly to develop and difficult to acquire, train, and retain. It is expected that the future cost of producing quality investigators will rise as workloads and case demands increase.

WorkSafe needs to compete for the best people to maintain an investigative workforce that is able and equipped to deal with changing requirements. The status quo as it is right now will not be good enough 3 to 5 years out.

Aspects of managerial supervision and guidance can be improved. There is evidence of some supervisors proactively involving themselves in an investigation from the outset, including attendance at the scene. But by and large there is a distinct lack of evidence suggesting supervisory oversight of cases as they unfold. Discussions between supervisors and investigators are not well documented and they are not reflected in case reviews.

Concerns about exhibit management were raised several times during interviews. Case reviews did not identify any particular problem with exhibit handling from a scene to exhibit store. But what I did not assess was how tightly the exhibit room is managed there on in; including (a) access control; (b) frequency of internal control audits; (c) timely return of exhibits; and cases closed with exhibits outstanding.

Victim focus

WorkSafe has a statutory obligation to ensure compliance with the Victims Rights Act (2002) and Victims Code (2015). Investigators demonstrated a general awareness of the Victims Rights Act but they had virtually no appreciation of the 'code'. I am confident that once a case enters the justice pipeline victim's needs are considered and met.

Case assessments identified inconsistencies in both the quality and recording of victim contacts. The victim logs, on the files assessed do not always specifically include what advice victims have been given in terms of support and services available to them.

During interviews managers and investigators expressed their dislike for having to deal with victims as part of an investigation. Dealing with victims was identified by investigators as the most stressful part of their job. Investigators advised they have received little, if any, formal training on dealing with victims (particularly victims of serious harm or fatalities).

There is strong support for a dedicated Victim Liaison Officer (VLO) to be attached to every fatal investigation and the ability to have ready access to Victim Support. The Dynes Transport, double fatality investigation was held out as an example of good practice in terms of team work and use of a dedicated VLO.

Case management business model

Based on what I was told and observed there is no discernible (investigations specific) case management business model. The current platform for managing cases does not support investigator needs. Cases are managed via individual (regionally) based spreadsheets and a (shared) T drive, none of which are interoperable. Too much investigator productivity time is being expended on data entry requirements associated with the spreadsheets. Perhaps it would be an opportune time to assess the necessity, value-add and benefits of entering information onto the spreadsheets. It may well be that the time spent could be better utilised on higher priority work, thus reducing investigator workload.

The Napier office has been trailing PDF documents software which has been adapted to meet investigators needs until a permanent solution is found. Care needs to be taken around the use of this temporary solution. In the first instance the investigations group needs to be clear about its requirements for an 'end to end' model – from receipt of call through to final disposal of case. Once the model is agreed, the next step should be to identify a supporting platform i.e. functionality that will support the model.

A case management business model will deliver a number of benefits including:

- tighter control around the acceptance, screening, prioritisation and allocation of cases;
- enable cases to be tracked, monitored and 'red flags' identified early; and
- provide clear and unequivocal criteria for threshold and number of cases held by investigators in order to avoid investigative delays and a mis-match between investigator capability and case complexity.

Alignment and national consistency

WorkSafe has comprehensive, appropriate and 'fit for purpose' investigations policy and practice guidelines.

Case assessments identified some inconsistencies in the application and use of guidelines. This I believe to be the result of 'local' interpretation and practices that overtime have evolved unchecked. I am told, but have not confirmed, that some of the practice guidelines on the intranet, are not easy for investigative staff to identify and locate.

There is limited consciousness among investigators of how their investigative effort is contributing to corporate goals[2].

The assessment found little evidence of any formal information gathering or sharing as part of any structured process to build an intelligence picture. I was told that in the offices where assessors and

[2] Governments target to reduce workplace fatalities and serious injuries by 25% by 2020.

investigators are co-located informal sharing arrangements exist, on an ad hoc basis, but the overall the exchange of information is said to be patchy.

During the course of their work assessors and investigators gather high value industry information. There is huge potential for this information to be leveraged and formally fed in to a collection plan and used to inform targeted deployment, prevention/education or investigative decisions.

Opportunities for change

In response to the identified issues I have outlined a number of opportunities for change, see Part I of this assessment.

The Niko Brooking investigation

In Part IV I have responded in detail to the concerns that have been raised about the investigation and non-prosecution decision in relation to the workplace death of Niko Brooking on 23 August 2016.

I cannot provide answers to or satisfy all of the issues that have been raised. Part of the reason for this is that it is outside the scope of my terms of reference to re-litigate outcomes or consider whether any closed case should be re-opened.

However, I can comfortably submit that in my opinion all reasonable avenues of enquiry were considered by the lead investigator Mr Broad, albeit some of the concerns that have been raised will need further explanation. At the time of completing this report Mr Broad advised me he was about to embark on his response to those issues/concerns.

Ultimately, the question that will linger is not whether all avenues were considered, but whether or not all avenues were fully explored to everyone's 'satisfaction'.

PART I

A. Introduction

B. Framework for this report

- **Terms of reference**
- **Objectives and scope**
- **Approach and methodology**
- **Key references**
- **Limitations**

C. Diagnosis and conclusions

D. Opportunities for change

INTRODUCTION

Background to Assessment

[1] Two recent matters have led to an increased focus on improving WorkSafe's investigations and prosecutions capability, namely:

i. The investigation and non-prosecution decision in relation to the death of Niko Brooking on 22 August 2016

ii. The investigation and unsuccessful prosecution of Athenberry Holdings Limited and Hume Pack-n-Cool Limited, the first trial under the Health and Safety at Work Act 2015, following the death of Yvonne Rogers on 13 May 2016.

[2] In light of this, as well as WorkSafe's desire to improve its overall investigative capability and to better understand and leverage the lessons learned, this assessment was commissioned by Head of Specialist Interventions, Mr Simon Humphries.

[3] Shortly after the commencement of this assessment, by agreement, the Athenberry Holdings Limited and Hume Pack-n-Cool Limited case was removed from scope and replaced with four other cases[3]. The prime reason for this was to expose me to a wider variety of investigation case categories of the type routinely managed by investigation's inspectors.

[4] Although different in nature, the cases are said to be a fair representation of the quality and standard of investigations produced by investigators. The cases were also said to have been carried out within WorkSafes investigative policy, practice and prosecution decision making guidelines.

[5] It is of note that since 2016 considerable work has been completed by WorkSafe in terms of how regulatory functions are carried out. In particular, I am advised that many of the policy and practice guidelines for investigators and Legal Advisors' have either been refreshed or re-written to better reflect the current operating environment.

[3] Ryman – fatal (civil construction – worker)
Cotton Soft – injury (manufacturing - worker)
Singh Builders – fatal (Construction – other person)
Quick Earth – no harm (Construction)

Terms of Reference

[6] The terms of Reference for this assessment are set out in detail at Appendix A. Refer below scope 'in' and 'out'. This in essence sets the framework and boundaries for the assessment.

Objectives and Scope

[7] The objectives for the assessment:

i. To provide a practical independent perspective on WorkSafes operational practice;

ii. To identify learning's; and

iii. To identify opportunities for improvement.

Scope (in)

[8] The terms of reference require me to consider:

- scoping and planning of investigations
- how the investigations were carried out, including resourcing and availability of expertise
- management oversight of investigations, including documentation of decisions
- victim interactions and management, including the role of third parties
- timeliness of investigations and the making of prosecution decisions
- interactions between Operations and Legal teams; and
- consider operational practice as it has been applied during these investigations and prosecutions

Scope (out)

[9] The terms of reference preclude me from considering:

- re-litigate processes or outcomes of individual case studies
- consider whether any specific prosecutions should or should not have been commenced by WorkSafe
- consider the correctness/quality of any legal advice provided
- consider whether amendments should be made to existing legislation
- consider whether any closed cases should be re-opened
- draw conclusions or make recommendations that are specific to individuals or parties other than WorkSafe
- consider any transfer of functions to or from WorkSafe
- make recommendations concerning WorkSafe's organisational structure

Approach and methodology

[10] I commenced this assessment on 20 May 2019.

[11] As a pre-cursor and as part of my overall preparation, I scanned WorkSafe's public facing website. As an 'outsider' I found the site relatively easy to navigate. It was particularly useful in that it provided me with a broad insight into the operations of WorkSafe.

[12] I inspected a selection of WorkSafe's investigation files (cases).

[13] I completed face-to-face discussions with a range of investigative and legal group staff as well as other interested parties. Interviewees included representatives from:

- Management and investigators based in Auckland, Hamilton, Rotorua, Napier, Manawatu and New Plymouth;
- Legal Group staff for Auckland and Wellington
- The whanau of a victim of a workplace death (including their legal advisor and representation from the CTU).

[14] The face to face interviews with staff largely focused on the key areas listed (a to g below). Responses to the questionnaire are set out in Part 2 of this report and the interview guide can be found at Appendix B.

a) Role, purpose and responsibilities

b) Demand drivers

c) Distribution of Workload

d) Effectiveness

e) Investigations

f) Risks

g) General – continuous improvement and change

[15] My last task was to draft and finalise this report setting out my conclusions and opportunities for change.

Key references – relevant legislation, policy and practice

[16] During the course of this assessment I drew guidance from the following documents:

- ACOP (Approved Code of Practice)[4]
- Coroners Act 2006 and case study from recap[5]
- Health and Safety at Work Act 2015
- New Zealand Government. Performance Improvement Framework (2015)[6]
- New Zealand Police Manual[7]
- New Zealand Police Investigative interviewing (witness and suspect guide) [8]
- Policing Vision 2025 (National Police Chiefs Council)[9]
- Policing – A Vision for 2025:[10]
- The Core Investigative Doctrine[11]
- WorkSafe NZ Investigations Policy[12],including NZ policy updates[13]: (since 2016)

[4] ACOP (Approved Code of Practice) - https://worksafe.govt.nz/topic-and-industry/forestry/safety-and-health-in-forest-operations/

[5] A summary of coronial recommendations and comments made between 1 July–30 September 201 https://coronialservices.justice.govt.nz/assets/Documents/Publications/issue4-case-study-forestry-coronial.pdf

[6] A key indicator of what good looks like in a government organisation

[7] NZPoliceManual: https://fyi.org.nz/request/916/response/4271/attach/html/4/thomas%20daniel%20crime%20scene%20examination.pdf.html

[8] NZPolice Investigative interviewing (witness and suspect guide)

[9] Policing Vision 2025 (National Police Chiefs Council): https://www.npcc.police.uk/documents/Policing%20Vision.pdf

[10] Policing – A Vision for 2025: https://www.mckinsey.com/industries/public-sector/our.../policing-a-vision-for-2025

[11] Core Investigative Doctrine - https://www.app.college.police.uk/app-content/investigations/linked-reference-material/

[12] WorkSafe NZ Investigations Policy - https://worksafe.govt.nz/laws-and-regulations/operational-policy-framework/regulatory-function-policies/investigations-policy/

[13] WorkSafe NZ policy updates: (since 2016)

Structure of Report

[17] This report comprises 4 parts and appendices.

i. Part I includes introductory matters; my diagnosis, conclusions and opportunities for change.

ii. Part II includes the responses that were provided by managers, investigators and legal group staff during their interviews.

iii. Part III includes my assessment of the cases said to be representative of the type and category of investigations routinely undertaken by WorkSafe investigators.

iv. Part IV includes my assessment of the concerns raised about the Niko Brooking investigation.

Limitations

[18] This is an assessment of investigative capability and selected cases only; and by exclusion is not a review. I have not undertaken any investigative interviews or re-investigation of any aspects of the cases. A review by its very nature would have required a much broader and deeper analysis of the investigation material than I have been able to achieve within the scope of the terms of reference.

[19] This assessment was essentially a paper-based examination of investigative (WorkSafe case) reports. I benchmarked those reports by referencing policy and best practice guides from other agencies and jurisdictions including investigative functions undertaken by police in New Zealand and the United Kingdom.

[20] Other than a cursory glance I have not completed detailed analysis of WorkSafe data, statistics, or workload throughput. In drawing conclusions, I have relied on a combination of my own investigative experience and judgment, as well as the probity and reliability of what I have been told.

[21] Re-litigation any of the case decisions is outside of the scope for this assessment.

Acknowledgments

[22] I wish to acknowledge the WorkSafe (investigations and legal group) staff who participated in this assessment. Their candid commentary was helpful in providing me with an appreciation and understanding of WorkSafes business as it relates to investigations and Prosecutions.

[23] I also acknowledge the assistance and information provided to me by 9(2)(a) Collectively they were able to provide me an insight into how WorkSafe is viewed from a victims and stakeholders perspective.

[24] Finally, the ongoing logistical support provided to me by Mr Hayden Mander and Ms Danika Morris-Brown has been of immense help.

Issues raised and recurring themes

General Comments:

[25] Emerging from the interviews, the case assessments and the meeting with 9(2)(a) were some recurring issues and themes.

[26] In my view these issues are holding the investigations group back from operating to their full potential. In turn, the consequential impacts are having an adverse effect on the workload of the Legal Group.

[27] The issues and themes are listed below in no particular order of importance. They are discussed in more detail in the next section under the heading 'diagnosis and conclusions'.

- Demand, workload and caseloads
- Investigation and investigator management
- Case Management business model
- Victim Focus
- Alignment and national consistency

Diagnosis and conclusions

[28] As I have already alluded to in the previous section there are five issues that are potentially holding back investigators from operating to their full potential; and as a result, this has flow on implications for legal group in terms of their ability to meet tight timeframes. The issues are:

1. Demand, workload and caseloads
2. Investigation and investigator management
3. Case Management business model
4. Victim Focus
5. Alignment and national consistency

[29] I should point out from the outset, that overall, on the basis of the cases assessed, I found that WorkSafe investigators produce cases of a good quality that on the whole meet best practice investigative standards (refer Appendix D). Further, I note that cases prosecuted by WorkSafe have an exceptionally high success rate.

[30] These are two very important measures of success. But on the downside once you dig more deeply beyond these two success criteria there are signs of problems emerging in the areas I have identified. The upside is that the identified problems are, with a little effort, all treatable.

Demand, workload and caseloads

[31] Specialist Interventions has a workforce resource allocation target (RAT) of 70 full-time equivalents (FTE's) of which there are 7 manager, 50 investigator and 10 support positions. A number of positions are being backfilled due to relieving (up) and secondments. See Table below 1 and the explanatory note.

Table 1: Summary of investigations workforce

Position	RAT	Actual	% actual of RAT	Secondments	Vacancies
Head of Department	1	1	100		0
Chief Inspector	2	2[i] (50%acting)	100		1*
Manager	7	7*[ii] (42%acting)	100	2[iii]	1*
Inspector	50	43.8[iv]	87.6	6.2[v]	0
Senior Support Officer	3	3	100		0
Support Officer	7	6.6[vi] (1 temp)	94.28		0

Explanatory note: Source Simon Humphries

i. 1 Manager is in an acting capacity as a Chief Inspector (Hayden Mander)
ii. 1 Investigator from Central 1 (Chris Floyd) is acting as Manager for Northern 2
1 Investigator from Central 2 (Casey Broad) is acting as Manager for Central 2
1 Investigator from Southern 1 (Steve Baddock) is acting as Manager for Southern 1
iii. 1 Investigation Manager from Southern 1 (Lee-Anne Milne) has been seconded to Detailed Arrangements
1 Investigation Manger from Northern 2 (Hayden Mander) has been seconded to Chief Inspector Northern
iv. Investigator from Northern 1 (Jeff Matthews) has reduced capacity due to further education (0.2 down)
2 Investigators from Central 2 (Andrew Sabin Hope and Dipak Makan) have been seconded to Response
1 Investigator from Central 2 (Kim Severinsen) has been seconded to Regulatory Practise
v. 3 Inspectors are acting as Managers (Chris Floyd, Casey Broad, Steve Baddock)
vi. 3 Inspectors are seconded (Andrew Sabin Hope, Dipak Makan, Kim Severinsen), all from Central 2

1 Inspector on reduced hours for study leave (Jeffrey Matthews)

vii. 1 Support Officer from Southern 2 (CJ Henderson) has been seconded to a Senior Support Officer for the Chief Inspector Southern
1 Support Officer from Southern 2 has been back filled by a temp (Wendy Thomson)
1 Support Officer is working part time 0.6 (Jenny Fitzwater).

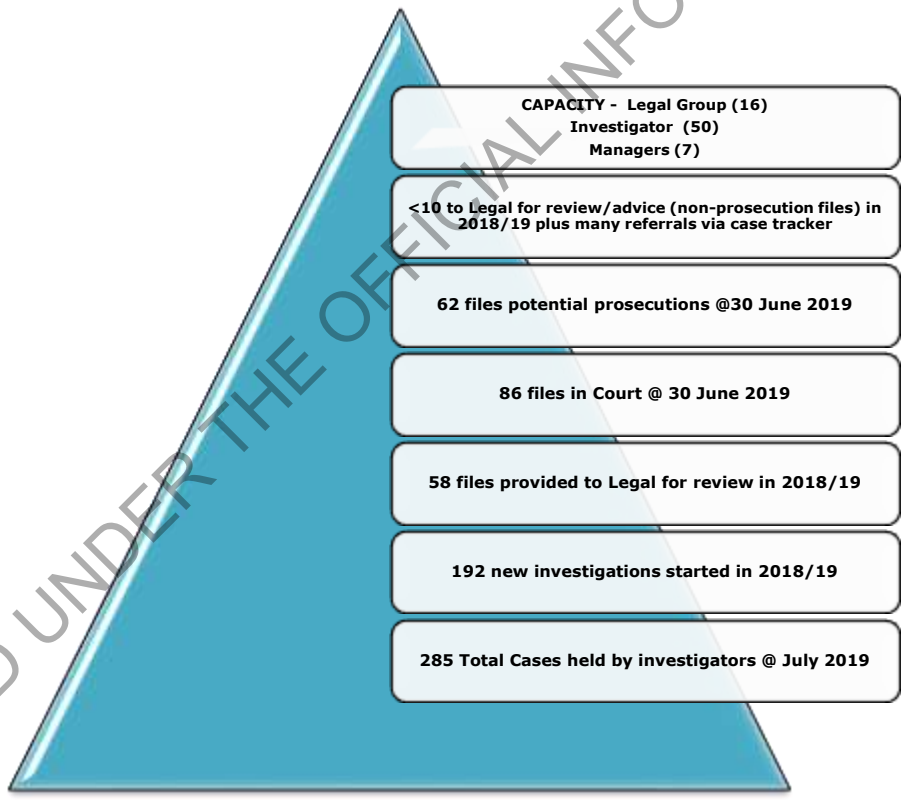
viii. Management vacancies are currently not being filled permanently as Operations continues to develop its Detailed Arrangements programme.

[32] The total number of cases held by investigators, as at July 2019, is 285, with 192 of those cases having commenced in the 2018/19 year. I assume this total is mostly made up of Level 1 investigations.

[33] Legal group currently deploys 16 advisors[14] with much of their workload originating from cases referred from investigators. In 2018/19 58 cases were referred to legal group for review and as of June 2019 there are 86 cases in the court process. In addition, as at July 2019, there are a further 62 cases in the pipeline (potentially) awaiting referral to legal group.

[34] It is worth noting that the when considering the number of cases as a measure of demand, it does not take into account 'latent' demand i.e. all those hidden or lower value tasks or activities that investigators and legal group staff are required to do but which is not necessarily considered when assessing their through-put or productivity.

See Picture and explanatory notes below



Source: WorkSafe (Iona Cameron 11/07/19)

[35] It is also worthy of mention that the volume of incoming cases is trending slightly downward[15]. But I am advised against that background case complexity continues to increase; investigator capability and experience is reducing and the number of defendants pleading not guilty has risen sharply. The

[14] Solicitors.

[15] WorkSafe website date April 18 to April 19 (investigation by all industries by region, non-fatal injuries and illnesses for all regions; and workplace fatalities).

combined effect is that managers, investigators and prosecutors are increasingly concerned that their respective workload pressures are not sustainable. This is consistent with the tone of the various comments I received from managers, investigators and legal group during one on one interviews. One said *"We are sinking under the pressure work";* another said *"I am approaching burnout due to workload".* And one other said "*Good people are leaving the organisation because they are overworked and stressed".* The pressures arising from demand and workload was a recurring theme.

[36] Investigative capacity is influenced by the fact that a number of managers are currently acting up (investigators); but in addition, they are still actively investigating their own cases. This comes at the expense of devoting their managerial effort toward supervising, training and developing their staff; many of whom are relatively new to the investigations group. This too is not sustainable.

[37] It is clear is that the actual number of investigative staff (inspectors), due to some acting up and others on secondment, is a major contributing factor to the pressure on legal group. And this goes some way to explain why investigators are currently struggling to refer completed cases to legal group in a timely manner; moreover, within the 8-month timeframe mandated by policy.

[38] Beyond either reducing demand or increasing capacity there is no one silver bullet solution to this dilemma. The reduction in demand, or any increase in capacity are not realistic options (a) because incoming demand is influenced by external factors often outside the organisations sphere of influence; and (b) any increase in capacity is costly. Perhaps a third more pragmatic solution would be to:

- Streamline some of the process steps; and cut back on some of the data entry requirements on investigators, thus freeing them up to devote more time to core investigative functions
- develop a prioritisation matrix for case assignment
- establish file briefers for all not guilty cases, thus freeing up legal group by presenting them with a fully briefed file.

Investigations and investigator management

[39] The Police Effectiveness Review[16] (PEEL, 2016, p 43) identified that successful investigations are underpinned by clear plans, actions and good victim care, carried out by skilled and experienced investigators. This provides a good starting point for my consideration of WorkSafe's investigations and investigator management.

[40] Given the impacts that investigations and the resultant prosecutions have on the various parties involved; the management of ethically planning, at the start of an investigation is most critical to the pathway the investigation will follow. So too is the management and recording of the 'big decisions' that flow out of an investigation as it progresses. Those decisions are important not only to the end result for all the parties involved; but also because of the impact that decisions have on the efficacy of the final outcome of an investigation.

[41] I found that not all decisions, particularly the rationale for them, are well documented. This appears to be the product of not fully understanding the purposes and relative differences between the various record keeping instruments, such as investigations plans, investigations logs, notebook entries, job sheets, decision logs and formal (evidential) statements - see Table over-page.

[42] It is not too difficult to see why there may be some ambiguity in the minds of investigators in relation to the use of the various forms. This is an area that requires some clarity, guidance and training.

[16] PEEL 2016 HMIC National Overview at p43

Table 2: Summary of instruments for recording decisions and actions

Notebook	Practice guide (Oct 17) provides that: *all notes made by an Inspector must be recorded directly into the Inspector's notebook. An Inspectors notebook is:* • *A permanent record* • *An investigation and assessment tool – notes can be reviewed and compared during the course of an investigation or re-assessment* • *A record of evidence – notes can be used to assist Inspectors to give evidence in court*
Investigation Plan	Practice guide - 'Forms' (July 19, p 9) *This form can be handwritten or typed. Recommended to include in all your investigations but the format you're planning is completed is optional. You can use this form or you can use a mind map, brain storming session, notes from your notebook etc., it is evidence that you have completed sound planning. This document will provide you with likely topics to cover as part of your investigation and some examples of Elements matrix you may regularly use.* My view is that an investigation Plan should be used to document the planned approach (strategy) for executing the investigation. It enables the senior investigating officer to estimate tasks, activities, resource requirements and timelines.
Investigation Log	Practice guide - 'Forms' (July 19, p 9) *This form can be typed or handwritten. Recommended to include in all your investigations (but not compulsory). Includes as much or as little detail you are happy with. This is a good tool to use for creating a Formal Written Statement if required.*
Job Sheets	*NZ P Policy statement (2018)* Job sheets should be completed daily, when action is completed, or an observation is made, but not: - relied on as a contemporaneous document to refresh memory while giving evidence in chief at Court - used to record interviews. <u>Documenting investigative activities</u> Investigative activity that is likely to be given in evidence in court should be recorded by way of formal statement. Detailed contemporaneous notes should be recorded in a notebook. Other investigative activity may be recorded in a job sheet. A job sheet should be completed as soon after the investigative activity as possible.
Decision Log	During the course of investigating a serious crime or incident decision logs are used to document and explain all determinative decisions made. According to the Core Investigative Doctrine (2005) auditable decision-making means: • *Recording what has been done and why it was done; the reasons for taking particular investigative actions and what the outcome was;* • *Providing an audit that can be followed in the event of review, scrutiny or new material coming to light.*

[43] Having now observed the variety and complexity of cases assigned to WorkSafe investigators I equate the demands placed on them to be only slightly below the load and expectations placed on NZP detectives. This is indeed a high standard, particularly given that the training afforded to investigators does not match the training provided to detectives before they qualify. Detectives In addition to their recruit and permanent appointment training (about 2 ½ years); train for a further minimum period of 2 ½ years, whereas WorkSafe investigators undergo 6 months training on top of their Cohort training.

[44] WorkSafe aspires to be a world class regulator. If this ambition is to be realised, WorkSafe must develop world class investigators; who require specialist investigative training and support; who in turn will produce world class investigations.

This aspiration is achievable, but will not be met unless:

- There is further investment in the training and development of investigators.
- There is a greater level of performance monitoring over their core activities (i.e. scene examination, management of exhibits and interviewing);
- There is an improved understanding of case management and the extent to which forensics and technology can facilitate and support investigations in a much more sophisticated way than currently exists.

[45] It is incumbent on management to ensure investigators are productive; and gainfully deployed on core investigative tasks and duties as opposed to non-value adding activities such entering non-essential data onto spreadsheets and other desk bound tasks.

[46] In response to the difficulty in attracting sufficient investigative staff one manager said: "*(we) need to incentivise people to become investigators. People look at how busy we are and are put off straight away. Particularly when they can do other jobs in the organisation for the same money".*

[47] Investigators are a finite resource and there are limited stocks of investigators on the open market. They are costly to develop and difficult to acquire, train, and retain. It is expected that the future cost of producing quality investigators will rise as workloads and case demands increase.

[48] Already there is competition between central agencies for quality investigators and WorkSafe will need to compete for the best people to maintain an investigative workforce that is able and equipped to deal with changing requirements. The status quo as it is right now will not be good enough, 3-5 years out.

[49] Aspects of managerial supervision and guidance can be improved. There is evidence of some supervisors proactively involving themselves in an investigation from the outset, including attendance at the scene. But by and large there is a distinct lack of evidence suggesting supervisory oversight of cases as they unfold.

[50] Discussions between supervisors and investigators are not documented and they are not reflected in documented case reviews. This is a potential area of risk, particularly if a case fails in court due to non-compliance with investigations guidelines or standards.

[51] Concerns about exhibit management were raised several times during interviews. Case reviews did not identify any particular problem with exhibit handling from a scene to exhibit store. But what I did not assess was how tightly the exhibit room is managed there on in. Some of the concerns raised included:

- Access control
  - lack of policy and protocols
  - No register of who has signed in/out of storage area
  - Multiple key holders
- Internal control - Infrequent exhibit room audits
- Failure to return exhibits in a timely manner
- Cases closed without exhibits returned

Victim focus

[52] WorkSafe has a statutory obligation to ensure compliance with the Victims' Rights Act (2002) and Victims Code (2015). Although investigators demonstrated a general awareness of the Victims Rights Act, they had virtually no appreciation of the 'code'.

[53] As a result of what I was told by legal group staff I am confident that once a case enters the justice pipeline victim's needs are considered and met.

[54] Case assessments identified inconsistencies in both quality and recording of victim contacts.

[55] The victim logs, on the files assessed do not always specifically outline what advice victims have been given in terms of support and services that are available to them. A brief note of any advice given would suffice.

[56] During interviews managers and investigators expressed their dislike for having to deal with victims as part of an investigation. Dealing with victims was identified by investigators as the most stressful part of their job.

[57] Investigators advised they have received little, if any, formal training on dealing with victims (particularly victims of serious harm or fatalities). This includes a lack of training in the preparation of Victim Impact Statements (VIS). VIS's play an essential part of enabling victims to have a voice and meaningful role in the justice process.

[58] There is strong support for a (mandatory) dedicated Victim Liaison Officer (VLO) to be attached to every fatal investigation and the ability to have ready access to Victim Support. There is an underlying belief held by many managers and investigators that they should remain independent from and have no contact with victims.

[59] The relatively recent Dynes Transport investigation was held out as an example of good practice in terms of team work and use of a dedicated VLO. I was told by staff who worked on this case that the use of the VLO took away all the stress and emotion in having to deal with victim(s); and enabled the team to concentrate on the investigation.

[60] Some quotes:

- *"It's better for us to remain independent".*
- *"Most distressing and unpleasant tasks is dealing with victims".*
- *"I think it would be good if investigators didn't have to deal with victims or their families. This can put a lot of pressure on the investigator who should really be able to just concentrate on doing their investigation without worrying whether the outcome will be good for the victim or not".*
- *"Managing victims is problematic for us. Often the PCBU is a victim; co-workers are victims as well as the actual victim's extended family and its best that we don't favour one or the other".*

Case Management Business Model

[61] Based on what I was told and observed there is no discernible (investigations) case management business model.

[62] Case management enablers; include all the workgroups that contribute to the successful outcome of a case from receipt of call through to final disposition (case closure). At the front-end Response Group receive and triage calls for service; and either close cases at source or refer them for follow-up investigation. And at the other end legal group review completed investigations for evidential

sufficiency. Investigations group sit in the middle of this continuum. Whilst each workgroup is clear about their roles and responsibilities; it seems they tend to operate in isolation of each other rather than as a component part of a joined-up case management business model.

[63] I was told that the current platform for managing cases is simply a file and statistic recording system with no specific investigations case management functionality. Cases are managed via individual (regionally) based spreadsheets and a (shared) T drive. None of which are interoperable, meaning that, for example an investigator in one region may not have direct access to a case under investigation in another region. Too much investigator productivity time is being expended on data entry requirements associated with the spreadsheets. Perhaps it would be an opportune time to assess the value-add and benefits of the information being entered onto the spreadsheets, as it may well be that the in-put time could be better utilised on higher priority work, thus reducing investigator workload.

[64] The Napier office has been trailing PDF documents software which has been adapted to meet investigators needs, (for sorting / merging documents), until a permanent solution is found.

[65] Some care needs to be taken around the use of this temporary solution. As a first step the investigations group needs to be clear about its requirements for an 'end to end' case management business model – from receipt of call through to final disposal of case. Once the model is agreed, the next step is to identify a supporting platform i.e. functionality that will support the business model.

[66] A case management business model would provide a number of benefits including:

- The provision of tighter control around the acceptance, screening, prioritisation and allocation of cases;
- The provision of a means that will enable cases to be tracked, monitored and 'red flags' identified early; and
- The provision of clear and unequivocal criteria for threshold and number of cases held by investigators order to avoid overload, investigative delays and a mis-match between investigator capability and case complexity.

Alignment and national consistency

[67] WorkSafe has comprehensive, appropriate and 'fit for purpose' investigations policy and practice guidelines.

[68] Case assessments identified some inconsistencies in the application and use of guidelines. This I believe to be the result of 'local' interpretation and practices that have evolved and have been left unchecked. This is amplified in both rural and metropolitan offices where each tends to have their own views on how things should be done.

[69] I am told, but not confirmed, that some of the practice guidelines on the intranet, are not easy for investigative staff to identify and locate.

[70] I sensed that there is limited consciousness among investigators of how their investigative effort is contributing to corporate goals[17].

[71] I found little evidence of any formal information gathering or sharing as part of any structured process to build an intelligence picture.

[72] I was told that in the offices where assessors and investigators are co-located informal sharing arrangements exist, only on an ad hoc basis, but the overall flow of information is patchy.

[17] Governments target to reduce workplace fatalities and serious injuries by 25% by 2020.

[73] During the course of their work I am told that assessors and investigators gather high value industry information. There is huge potential for this information to be leveraged if it were to be formally 'fed in' as part of a collection plan. Once analysed this information could be usefully used to inform targeted deployment decisions; education / prevention opportunities or as part of a wider intelligence picture to inform the direction or scope of an investigation.

[74] Some managers and inspectors have given a lot of serious thought to the creation of regionally based Field Intelligence Officers (FIO's) to coordinate the considerable 'untapped' information within the regions, but are unsure how pursue this idea.

[75] The combined factors, as highlighted above are a barrier to alignment.

Opportunities for change

Demand and workload

[76] Closely monitor the impact that relieving and secondments are having on the workload of investigative staff who are required to fill the void.

[77] Although the current secondment and relieving arrangements provide excellent development opportunities for investigators and managers, it must be acknowledged their share of the work inevitably passes on to the remaining investigators and still needs to be actioned in their absence. This a factor in timelines not always being met and with additional pressure being placed on legal group, who are already burdened with having to meet tight court-imposed timelines.

[78] Although it is not possible to produce additional investigators at short notice, consideration must be given to easing investigators load and the flow on effects. Opportunities for this to occur include:

- cutting back of some of the spreadsheet data entry requirements, thus freeing investigators up to devote more time to their core investigative functions
- develop a prioritisation matrix for case assignment so that investigative effort is targeted at the highest priority investigation categories
- prepare and submit a business case seeking funding for the establishment of file briefers[18] for all not guilty cases. If approved this will free up both investigators and legal group by presenting them with a fully briefed file (so long as formal statements are recorded at source)
- options for direct entry of suitably qualified investigators
- review investigator allocations for each region to ensure resources are equitably distributed and to make sure allocated numbers are consistent with current workload pressures (given that population demographics and demands are changing in different regions).

Investigation and investigator management

[79] Ensure investigations managers are provided with the time and the opportunity within their workgroups - to develop their staff; to identify and grow talent and manage performance. This is essential to ensuring that the people with the right capabilities are in the pipeline to advance into investigator positions. If WorkSafe truly aspires to be a work class regulator the status quo will not be sufficient. Therefore, for the aspiration to be met, leverage the following opportunities:

- make further investment in the training and development of investigators
- provide for a greater level of performance monitoring over investigators core activities (i.e. scene examination, management of exhibits and interviewing); and
- improve managers and investigators understanding of case management; and the extent to which forensics and technology can facilitate and support investigations in a much more sophisticated way than currently exists.

[80] Adopt a manager led, team approach during the early stages of an investigation, (such as a fatality or serious harm). This approach will assist in building investigator capability, confidence and high performing teams that others within the organisation will aspire to join.

[18] A criminal justice support unit (CJSU)

[81] Prepare and submit a business case seeking funding aimed at modernising interview practices. In law enforcement the use of audio taped interviews, which are still widely used by WorkSafe investigators, is an outdated practice. Videotaped interviews have been in vogue, in most jurisdictions world-wide for more than 30 years. They are reliable and well tested in court. At a cost of less than $9000 per unit an opportunity exists for WorkSafe to consider the tactical placement of (either fixed or mobile) interview units across the regions. Supplemented by relevant training[19] this initiative alone would take investigators to the next level.

[82] Improve and better support the decision-making process by clarifying the purposes and relative differences between the various record keeping instruments, such as investigations plans, investigations logs, notebook entries, job sheets and decision logs and formal (evidential) statements. Currently there are too many options; and too much ambiguity as to which of the forms are optional, and which are mandated.

[83] Improve exhibit (storage) management by:

- Tightening access control
    - review and implement access policy and protocols
    - implement an access register
    - reduce the number of key holders
- Implement exhibit room audits as part of internal control
- Return exhibits in a timely manner and do not close cases without exhibits having been returned

Case management

[84] The lack of fit for purpose case management functionality is partly responsible for investigators inability to meet timelines. The PDF documents software which has been adapted (and piloted in Napier) to meet investigators needs is very much a temporary solution.

[85] The investigations group needs:

- to be clear about its business requirements for an 'end to end' case management model – from receipt of call through to final disposal of case; and
- Once the model is agreed, the next required step is to identify a supporting platform and functionality that will enable the business model to:
    - provide tighter control around the acceptance, screening, prioritisation and allocation of cases;
    - enable cases to be tracked, monitored and 'red flags' identified early; and
    - set clear and unequivocal criteria for threshold and number of cases held by investigators order to avoid investigative delays and a mis-match between investigator capability and case complexity.

[86] The establishment of a file briefing unit (as discussed paragraph 80) would operate as an enabler in support of the case management model.

[19] Up to L3 interview training

Victim focus

[87] There is an opportunity improve victim focus through additional training (or re-training):

- to reinforce investigators obligations pursuant Victims' Rights Act (2002) and Victims Code (2015)
- to ensure victim log entries include a brief note on any advice given or support offered
- to remind investigators of the important role that VIS's play in enabling victims to have a voice and meaningful role in the justice process; and

[88] In addition, the investigations group should consider the viability of deploying a dedicated Victim Liaison Officer (VLO) to every fatal investigation.

Alignment and national consistency

[89] There is an opportunity to improve alignment and national consistency by:

- mandating the use of and application of policy and practice guidelines
- confirm (or negate) the suggestion that practice guidelines on the intranet, are not easy for investigative staff to identify and locate
- consider establishing a regionally based (field) intelligence capability in support of improved information sharing and interoperability
- demonstrate to investigators how their investigative effort is contributing to corporate goals[20].

[20] Governments target to reduce workplace fatalities and serious injuries by 25% by 2020.

PART II

SECTION 1 - Manager and investigator Interviews

SECTION 2 - Legal Group interviews

INTERVIEWS

SECTION 1 - Manager and Investigator Interviews

[90] The questionnaires and checklists that were used as a guide for the interviews of Managers, investigators and Legal Group are attached at Appendix B.

Roles and responsibilities

[91] **Responses – *this is what I learnt***

- Investigative inspectors said that although their role, purpose and responsibilities are clear to them; at times their practices are not always in conformity with WorkSafe's investigations policy position.
- Most investigators believe their primary role is enforcement focused. They have a narrow appreciation or understanding of how their enforcement activities contribute to prevention.
- Enforcement is viewed as a function rather than an option, therefore other tactical options such as prevention, education and alternative resolutions are viewed as being the domain of other work groups within the organisation and outside the role or responsibility of an investigator.
- The prevailing mindset is that investigative work is mostly reactive, in the main driven by the view that due to incoming demand there is limited time available to deploy proactively.
- Managers and inspectors said that the synergy between the general and investigative (inspectorates) differs from region to region and is largely dependent on (1) personalities; (2) whether or not they are co-located; and (3) to extent to which there are opportunities to work together on joint operations. Otherwise there is a tendency for each inspectorate to operate in silos.
- There is a limited appreciation of the worth of information sharing (intelligence) between the inspectorates or other workgroups. The extent to which shared information is fed into decision making is limited; and only occurs on an informal basis. The overall the flow of information between inspectorates is at best patchy; but, based on what I was told; there is a genuine willingness and appetite for improvement.
- Some managers and inspectors have given serious thought to the creation of regionally based Field Intelligence Officers (FIO's) to coordinate and leverage the considerable 'untapped' information within the regions, but they advise that they are unsure how pursue this desire up the chain to the 'decision makers' so that they it can make it happen.

Demand

[92] **Responses – *this is what I learnt***

- There is an overwhelming consensus, from managers and inspectors alike, that they are struggling to cope with the workload.
- Most identified the drivers of demand arising from:
  - Managing multiple components of an investigation at the one time (from scene examination, witness interviews, experts through to victim liaison)

- spending too much time on (duplicate) data entry
- an increase in not guilty pleas is necessitating more time to be spent on briefing cases for court (including meeting additional disclosure requirements)
- a disproportionate amount of time spent on general correspondence and paperwork at the expense of field investigative work
- writing lengthy reports on what are clearly "go no-where files"
- staff shortages

- Managers and investigators said that a consequence of the above drivers is that their actual (productivity) time available to undertake out of office enquiries is shrinking; and this is placing more pressure on them to meet tight timeframes; (i.e. either the timeframe for a file to be referred to Legal Section [8 months] or the 12 month statutory time limit for a charging document to be filed.
- The lack of a management model or fit for purpose case management functionality was highlighted by most of the interviewees' as a significant barrier. It was suggested that this has resulted in each region using stand-alone systems[21] and "doing things our own way".
- Some of the managers and investigators (ex-police) were aware of the value of File Briefers or Criminal Justice Support Units (CJSU) and felt that a CJSU or something similar would go some way to alleviating many of the demand/workload pressures.

Some quotes

- *"We are sinking under the pressure work".*
- *"I am approaching burnout due to workload".*
- *"We do things our own way*".

Distribution of work

[93] **Responses – *this is what I learnt***

- I was told there is no formalised prioritisation matrix for the assignment of cases. Rather in most instances, cases are assigned on the basis of who happens to be working and available at the time.
- Managers said that it was a rare occurrence for them to be able match case complexity with investigator capability. They added senior and experienced investigators are not always available and it is not always possible, due to workload and sometimes geographical distance, to provide hands-on supervision to lesser experienced investigators.
- Taking into account case complexity and the various stages each case is at, within the case management / investigation pipeline, the majority of the managers and investigators felt that a caseload of no more than 5 (active cases) was safe and manageable. Note: Cases in the pipeline include (1) current and active investigations; (2) those pending court action; and (3) those held pending case disposal (i.e. return of exhibits).
- It was further stated that a more comfortable workload would be less stressful and would enable cases to be referred to legal group in a timelier manner. An added benefit would be that inspectors could be freed up to mentor new staff, be more proactive and more time could be devoted to personal development, training or project work.

[21] Use of excel spreadsheets, line by line data entry requirements, T-shared drives with limited organisation-wide access or availability

- Managers and investigators said that it was due to ongoing incoming demand and the constant pressure arising from meeting prosecution timeframes that there is a limited ability to close old cases. Investigators report that exhibits can be held for years pending return.
- They added that problems associated with closure and the return of exhibits is often exacerbated when the O/C case has 'moved on' or left the organisation, often with no one being tasked to 'officially' close the case. A consequence of this is that case holding statistics can be artificially inflated or skewed as they are often (erroneously) reflected in statistics as being active cases.
- There is a strong desire to develop an early case closure model (ECC) as a means of freeing up investigator capacity – for circumstances where it is obvious that cases will not end up in the justice pipeline - Perhaps linking ECC to the Duty Holder Review regime.
- I was advised that rostering to meet demand was not an issue. Investigators said that they enjoyed considerable flexibility in terms of their work hours, ensuring that interviews and general enquiries can, if required by scheduled, be for outside 8 to 4, Monday to Friday.

Some quotes

- "*due to work pressures and other priorities we may not be able to return exhibits for years"*
- *"PDF document management system will help us to manage cases, but it is only a temporary fix".*

Effectiveness

[94] **Responses – *this is what I learnt***

- Some managers and investigators said they are conversant with WorkSafes strategic target of reducing fatal and serious non-fatal work-related injury by 25% by the year 2020, but most were not entirely clear how their work contributed to those targets.
- Most staff did not appreciate how the targets flowed from their work into their performance appraisals. Some said they had not had a recent appraisal completed and of those that have had recent appraisal, they said that structured performance meetings were rarely conducted.
- Workload was continually raised as a barrier to them better understanding their contribution to delivery of corporate targets.
- Investigators felt that overall there was an opportunity for one on one meeting's between manager and investigator to be more formalised. There was also a strong desire from investigators for managers to be required to attend all fatal scenes.
- Formalised one on one case review meetings is also sought by investigators (as opposed to an informal chat as to how the case is progressing).
- I was told that case debriefs – either 'hot' (immediate) debriefs post an incident or more structured formal debriefs rarely occurred prior to a case being closed.
- Some staff said that they often recommended improvements when wrapping up investigation reports but they were unclear what happens with their recommendations and are not aware of a lessons learnt process within the organisation.

Some quotes

- "*My manager is too busy to provide me with any supervision".*
- *"A minimum of 2 investigators should be assigned to every fatal".*

Investigations

[95] **Responses – *this is what I learnt***

Refer attached check sheet for questions / themes re- investigations.

- *Planning* - scoping and planning of investigations
- *Execution* – The investigation process - how the investigations were carried out, including resourcing and availability of expertise
- *Victim Focus* - victim interactions and management, including the role of third parties
- *Meeting Timelines* - timeliness of investigations and the making of prosecution decisions
- *Interactions* - between Operations and Legal teams in the making of prosecution decisions

Planning

- Inspectors, generally do not use the 'appreciation' technique for pre-planning (i.e. aim, factors, courses open and plan). The exception being those who were police trained, but even some of them said they approached planning "instinctively". Most said they tend to tackle the initial planning phase by making a mental note of what needed to be done.
- I was told that the use Investigation Plans are not mandated and are not used by all investigators and not prepared for all investigation types. Some viewed the use of plans as *"further unnecessary paperwork"*; and another said *"personally I don't like them and don't use them. I can generally workout what needs to be done in my head"*.
- Those who do routinely prepare investigation plans said they tend to populate the plan template retrospectively and more often than not, the plans are not assented to or signed off by a manager, nor are they always monitored or checked for compliance as part of ongoing case reviews.
- Most investigators said they maintain logs and/or notebook entries – sometime both depending of the type of investigation.
- Investigators said that when they are called to a scene; more often than not, Police are already present and generally there is a clear understanding which agency has lead responsibility.
- I was told that in all cases there is a timely 'handover' but not all handovers included a 'hot' debrief. Nor are handover decisions always documented.
- Some examples of good and poor 'handover' practice were raised. I was told that in the Manawatu all fatals are attended by a senior Police investigator (DI or DSS) who will only handover jurisdiction and responsibility once causation and culpability are clear. This practice, I am told followed lessons learnt between Police and WorkSafe following the investigation into the death of Lincoln Kidd (2013: Forestry).

Execution

- During the initial action phase of an incident where both Police and WorkSafe have an interest, i.e. a workplace fatal, for example, capability and expertise is shared (e.g. photographs/video, forensics, cultural considerations and mapping).
- For non-police matters I was told that a range of expertise is available including ESR. Managers and investigators said that use of expert advice was generally not a problem; except in circumstances where local expertise was not available or if available, they are potentially conflicted.
- Given the wide range of potential investigation types, several investigators raised the suggestion of having immediate access to a nationally maintained list of experts.

- Some investigators raised concerns about the availability of scene examination kits; as well as properly fitting clothing for scene attendance (apparently the suits and booties that are available are far too large for women).
- I was told that scenes are not routinely videoed, nor do are reconstructions routinely completed.
- Exhibit management was regularly raised as a concern by managers and investigators (this is referred to in greater detail elsewhere in this report).
- Some of the less experienced investigators advised that they lack confidence in exhibit handling, packaging and storage. Some also said that they are sometimes unclear about how to assess an exhibits relevancy or probative value.
- Investigators said that witness interviews are generally carefully planned – their mode of statement taking varied according to the circumstances (from audio taped, hand written or typed). There is recognition that audio statements can ultimately be time consuming when, for example if a 50-page audio statement has to be converted into a formal statement and later assented to and signed.
- There is a desire among for some investigators guidance on 'best practice; position to be settled on and mandated.
- Investigators said that they always carefully plan suspect/duty-holder/ PCBU interviews and prefer that they are recorded.
- All investigators said they are L1 trained with a limited number L3.
- I was told that the use of intelligence plays little or no role in investigations. This is due to having no field intelligence capability (including analysts) within the Investigations Group. Information tends to be sparse and is communicated word of mouth.
- Scene examination kits are available – I was told that suits and booties but are 'one size' and are generally too large for most women – thus uncomfortable and inappropriate.

Victim Focus

- Victims are updated, more so initially and contact tends to less frequent the longer the investigation goes on. Based on what I have been told and on what is disclosed on the representative cases assessed, the victim logs do not expressly include what advice victims have been given in terms of support and services available to them.
- Dealing with victims was identified by investigators as the most stressful part of their job.
- Investigators advised they have received little, if any, formal training on dealing with victims (particularly victims of serious harm or families of fatality victims).
- Although there is an awareness of the Victims Rights Act, there is limited understanding of the Acts obligations/requirements; and virtually no appreciation of the requirements of the Victims Code.
- Many investigators readily admitted that dealing with victims was secondary to their primary function of investigating liability.
- As far as possible victim contact logs are maintained.
- There is strong support for a (mandatory) dedicated Victim Liaison Person to be attached to every fatal investigation and the ability to have ready access to Victim Support. There is an underlying belief that investigators should be independent and have no contact (at all) with victims.
- It was suggested that WorkSafe could look to other jurisdictions to see how they deal with victims – for example it was said that regulators in the UK and Australia may have dedicated staff for dealing with victims.

Some quotes

- *"It's better for us to remain independent".*
- *"Most distressing and unpleasant tasks is dealing with victims".*
- *"I think it would be good if investigators didn't have to deal with victims or their families. This can put a lot of pressure on the investigator who should really be able to just concentrate on doing their investigation without worrying whether the outcome will be good for the victim or not".*
- *"Managing victims is problematic for us. Often the PCBU is a victim; co-workers are victims as well as the actual victim's extended family and its best that we don't favour one or the other".*

Iwi / Pacific & Ethnic Liaison

- Investigators advise they have ready access to cultural support – i.e. Kaumātua for blessing scenes of fatals.
- There is a view that within the metropolitan cities there is a growing need for greater support for investigations involving 'other' ethnicities. Auckland's changing demographics, particularly on worksites was highlighted. I was also told that this need for greater support for 'other' ethnicities is also emerging as a factor in the provincial regions.
- I was told that that flow on impacts has prompted the need for a greater understanding of cultural sensitivities, protocols and the use of interpreters.

Meeting Timelines

- Investigators said they often struggle to meet timelines for the completion of cases prior to referral to Legal Group. They cited the following factors as impacting on their ability to meet timelines:
  - Heavy workload (individual and group caseloads)
  - Timeframes too tight
  - Unavailability of expert witnesses
  - Multiple PCBU's
  - Correspondence – i.e. the Investigation Report template is too lengthy, this is a requirement for too much data entry; disclosure requirements, and prepping not guilty cases.

Interactions – Operations and Legal Section

- Overall, I noted a healthy mutual respect between investigators and legal group. But it must be said that legal group are heavily reliant on the efficiency of investigators in order that they adequately meet tight, and often court imposed timelines.
- Some investigators felt their access to a legal advisor for general advice was limited. They said this is due in part to their belief or perception that legal section staff are far too busy; they are not routinely contactable and are only available once they have been assigned to a particular case. Note – see counter view in next section.
- There was a strong desire from some managers and investigators for a legal advisor to be physically based in each region.
- One investigator said that he has, over the years, had a lot of dealings with legal group, but more recently frustrated by constant changes of personnel.
- Some investigators thought that legal decision makers seem to be risk adverse and only willing to take on the cases with the greatest chance of success.
- Several investigators and managers acknowledged legal groups heavy workload – noting (legal group) "*are constantly under the pump*".

Example of good practice (Dynes Transport double fatality – Region 2)

- The investigation of the Dynes Transport, double fatality – *"We adopted as team approach with one member dedicated to victim liaison, leaving the rest of us (investigators) to get on with our investigative taskings. It worked well".*

Risks (Investigations)

[96] **Responses** – ***this is what I learnt***

Managers and Investigators were asked for their opinion, with examples where possible, of the current (and future) risks that may be impacting on service delivery.

- Managers identified the risk of staff burnout as their number 1 risk - followed closely by the lack of a nationally consistent approach to case management as risk number 2.
- One inspector identified that a lack of secure cabinets has resulted in files being stacked under desks, posing a specific risk to file security and privacy.
- Most investigators cited workload as a risk. Some also identified the lack of proactive and structured supervision as a significant stressor.
- Recruitment is not keeping pace with current attrition rate. It is becoming increasingly hard to attract new investigators internally into investigations because of the workload and due to the lack of a defined career path; and limited opportunities for secondment or development.
- Other Risks relating to 'service delivery failure' included:
  - not having sufficient investigators deployed at the front end of fatals
  - Poor exhibit management including chain of custody, storage, security and disposal was highlighted as a current risk. – (no drying room for wet or blood-stained clothing exhibits was raised by several interviewees')
  - Lack of interviewing training – up to L3
  - Victim management – should have dedicated victim liaison person appointed at the commencement of an investigation
  - Lack of resilience
  - Inexperience in dealing with defence counsel and need to ensure that all communications are maintained on a formal basis – so that inadvertent remarks are not later used against them in court
- Many investigators said that referral of workplace bullying complaints to investigators posed a risk as they have had no training, guidance or policy on how to conduct such investigations (see previous reference – policy paper issued on 14 May 19).

Some quotes

- *"Need to incentivise people to become investigators. People look at how busy we are and are put off straight away. Particularly when they can do other jobs in the organisation for the same money".*
- *"Good people are leaving the organisation because they are overworked and stressed".*

Continuous Improvement / Quality Assurance

[97] **Responses – *this is what I learnt***

- Investigators said that decisions were often made "on the hoof" due to the dynamic nature of investigations. Managers sometimes, but not always checked on the quality of decision making.
- Critical and often determinative decisions, with reasons, are not always documented i.e. handover of scene from NZ Police to WorkSafe
- In some offices case peer reviews are conducted by fellow investigators. It was felt that this practice was of limited value as well as consuming upwards of 2 (productivity) days of the reviewer.
- Managers said that there was no (national) quality assurance framework. Case reviews/assessments were either not being done (until end of investigation) and those that were being done during the lifecycle of an investigation did not follow any consistent procedure.
- There is strong support, as a minimum, for a team approach to be adopted for scene attendance. Further, pockets of support to specialist scene attenders to be established, particularly in the Metro regions (similar to SOCO or crime Squad).

Some quotes

- *"There is no set process for (case) quality assurance".*
- *"What quality assurance – managers are too busy".*

General - Additional issues raised

[98] **Responses – *this is what I learnt***

Training

- There was mixed commentary on the value of training. Some felt there was too much, others not enough.
- Almost all investigators sought access to more scene examination and interviewing training (with the taking of formal statements a priority).
- Some of the more experienced investigators felt that they would benefit from refresher training; particularly updates in forensic capability.
- Some investigators felt that some of the training and delivery was dated and needed a refresh.
- Some managers said that they have never been given the opportunity to participate in training needs analysis and therefore those who were setting the training agenda were missing out on a "goldmine of information concerning training needs".

Lessons Learnt

- most of the investigators said that they were not aware of a unit or mechanism within the organisation where lessons learned are stored or can be accessed. Many gave examples of reports they had completed with lessons and/ or recommendations for chance and only one recalled ever being contacted for any further advice. Further, none can recall ever seeing their learning's published and circulated internally (or externally).

Drying room

- The unavailability of drying rooms for (drying) blood stained clothing and other exhibits was highlighted as not only a health hazard but also an investigative impediment (i.e. a reluctance to collect blood-stained exhibits for analysis in circumstances where they may have been of some probative / evidential value).

Experts

- No national list of experts available.

Welfare

- Investigators said they were appreciative of having professional supervision; the quality of which depended on the extent to which both parties were willing to engage. The said that it could be improved by ensuring that following attendance at all critical incidents (or serious harm) an immediate post trauma debrief is conducted.
- One investigator who has had recent and necessary contact with professional supervisor found the process "very worthwhile" and went some way to assisting with recovery from workload pressures.

Talent and career pathways

- Mixed comments were received on talent management and career pathways. Investigative inspectors who are starting out in their careers had not thought too deeply about where they saw themselves 3 to 5 year out. At the other end of the continuum veteran investigators approaching the end of their careers had no appetite for further development. Of those in the middle some were either happy with the status quo; and the others were looking for opportunities to advance their careers. The latter group felt that the pathway for either horizontal or upward opportunities were not entirely clear to them. Because (inspectorate) interviewees were regionally based they felt that they had less career choices than Wellington based staff.

Metro v Rural differentials

- Metropolitan (City) v Rural (provincial) differences, including advantages and disadvantages, were highlighted, the distinct perception being that city investigators had more readily resources to call on and rural investigators greater distances to travel and a smaller pool of investigators.

Supervision / Span of control

- Some managers and investigators raised concerns about the wide span of control that currently exists and felt this was adversely impacting on quality of supervision. They said that is further exacerbated in rural areas where investigators are often based some distance from their managers.
- In response to a question about supervision and appraisal, one investigator said *"I have had no supervisors meeting(s); have had no recognition for what been a hard and demanding year, and when I asked to see my appraisal, I was told it was lost".*

Some quotes

- *Professional supervision – "very worthwhile"*
- *Lessons learnt - "Lessons identified go into a big black hole". "waste of time raising lessons or making recommendations"*

General Discussion – Change

What was asked - If I was the 'boss' for a day

- » What would you change as top priority? i.e. to create the desired state?

- What wouldn't you change?
- What wouldn't you change?

[99] **Responses – *this is what I learnt***

- Create a team of specialist team of 'on call' scene attenders
- Develop a "fit for purpose national case management system" – get rid of the shared (T) drive as it has limited visibility and serves no real purpose
- Purchase investigations specific software
- Free up investigators by reducing the need for so much data entry
- Establish a case prioritisation model/matrix
- Cut back on the amount of detail required in investigation reports where it is clearly obvious that no offence is disclosed and no risk of ongoing or future harm
- Co-opt Victim Support or similar type agency to assist with dealing with victims
- Appoint a dedicated Welfare officer
- Insist that every employee has an annual performance appraisal
- Set up a national list / database of experts who are available for callout or advice
- Make available portable video interview units
- Communicate lessons learned from investigations
- Establish a position for Ethnic/cultural advisor (in addition to Maori and Pacific)
- Collapse investigator and assessor positions into one i.e. dual trained and duel role
- Create a career path for investigators with some development opportunities such as short secondments to other workgroups within the organisation
- Provide improved office conditions i.e. cabinets to store files, secure storage for exhibits
- Establish positions for file briefers
- Recognise the functional and workload differences between investigators and other inspectorates and pay investigators accordingly

What wouldn't you change

- Retain roster flexibility
- Retain use of vehicles
- Retain regionally based investigators

SECTION 2 - Legal Managers and Advisors (includes prosecutors)

[100] The questionnaires and checklists that were used as a guide for the interviews of the Legal Group team are attached at Appendix B.

Roles and responsibilities

[101] **Responses – *this is what I learnt***

- Legal group managers and advisors said that they are very clear about their role, purpose and responsibilities.
- They said, although there are some slight differences between service delivery in Wellington and Auckland, core functions are broadly the same. The exceptions being that the Wellington team, in addition to litigation, tend to be more involved in legal work associated with policy advice and they participate in inter-agency workgroups. Overall the legal group said their primary functions include:
  - provision of advice to investigators (and other workgroups)
  - reviewing investigation files for evidential sufficiency
  - responding to one-off queries from frontline staff via the legal request tracker
  - litigation including prosecuting cases in court and Inquest hearings; and
  - 'other' ad hoc requests for service
- I was told there is a positive working relationship between legal group and investigators with each having a healthy respect for each other's demands and pressures.
- Investigator concerns about availability and / or immediate access to legal advice was strongly rejected by the legal group. I was told that the legal request tracker has been in place since January 2019 and this was instigated as a control mechanism to ensure that requests were logged, tracked and responded to in a seamless and timely manner. This process was initiated to avoid investigators 'cold calling' legal group seeking verbal advise without presenting all the relevant facts. It was also put in place because the unscheduled calls were distracting and they were consuming productivity time that could otherwise be expended prepping cases for pending court hearings. The new regime provides for better control, albeit some investigators may perceive those controls as limiting their access to advice.

Demand

[102] **Responses – *this is what I learnt***

- Legal group is a finite resource. They advise their 16 staff are under huge workload pressures arising from the various demands placed on them. I was told the drivers of demand include, but are not limited to:
  - Requests for advice from investigators which often are not strictly of a legal nature (i.e. seeking practice guidance); and of a nature that could be adequately addressed by investigation managers. In addition, Investigators often ring direct to legal group for advice prior to a case being assigned to a prosecutor (thus circumventing the requirement to use the legal request tracker)

- The Inadequate frequency of case reviews being undertaken by investigation managers, resulting in a disproportionate amount of 'legal' time being spent remedying flawed investigations
- This is compounded by the late referral of cases seeking legal review i.e. outside an agreed timeframe or within the 8-month policy requirement
- Fixing flaws and late referral of cases is exacerbated due to strict requirements to meet statutory timeframe for filing charging document(s)

- Legal group advise that the main impact of demands placed on them is the relentless pressure on them to meet, generally non-negotiable, court-imposed timelines; which (a) on an individual and professional level creates undue tension and stress; and (b) on organisational level can result in reputational damage due to a significant case failure. The general feeling is that an imminent case failure is a real possibility.
- Legal group advised that workload demand could be eased by:
  - Making it mandatory for investigators take 'formal (evidential) statements' from witnesses at the first opportunity, as opposed to taped (audio) interviews which often result in endless pages of, sometimes, conflicting accounts
  - Ensuring cases are referred in a timely manner (i.e. in accordance with the 8-month policy guideline)
  - Employ more lawyers or outsource more cases to the Crown

Distribution of work

[103] **Responses – *this is what I learnt***

- Legal group produce data / stats on incoming demand and as far as possible assign case distribution around dates that cases are scheduled to arrive in the office. By and large, I'm told this works well as long as cases arrive when they are due, thus enabling leave and other tasks/activities to be planned. I was also told that increasingly, cases are not arriving on target (due) dates, which is placing unnecessary pressure on the legal group. For example, if a case is submitted impromptu, late and unplanned, it invariably has to be reassigned to another, already busy lawyer.
- To reinforce this point some extreme examples were highlighted of cases being submitted for review with less than a month pending prior to expiration of the statutory 12 month time limit – in this example the lawyer concerned virtually had to work around the clock to review the case and prepare all the necessary documents for court – all avoidable had investigative timeframes been met.
- Given the deadlines and resource limitations; legal group advise that cases are prioritised, as best they can be, as a matter of necessity rather than by way a priority matrix.

Effectiveness

[104] **Responses – *this is what I learnt***

- Legal group believe that most of their work is directed at and contributes to the achievement of national goals and targets – whether that be in the areas of policy advice or general advice or in litigation.
- Legal group advised there may be scope for prosecutions to be more targeted; with perhaps an opportunity to cut back on prosecuting some offence types –machinery guard prosecutions for example. It was said that the prosecution of some offences was not having

the desired result on driving behavioural change nor is prosecution having the desired deterrence effect. It was suggested that alternatives such as education may result is a better outcome.

Meeting Timelines

- I was advised that the timeframes that legal group must adhere to are by and large dictated by either:
  i. The date when cases are referred to them for review by investigators. I'm told invariably late and outside the 8-month policy requirement; and
  ii. The timeline(s) set by court.

Interactions – Operations and Legal Section

- As previously noted, there a healthy mutual respect between investigators and legal group. But it must be said, again, that legal group are heavily reliant on the efficiency of investigators in order that they adequately meet their timelines.

Investigations

[105] **Responses – *this is what I learnt***

- A mixed response in terms of victim focus:
  - Legal group are well aware of their legal obligations under the Victims' Rights Act and Victims Code, particularly once a case is in the prosecution arena
  - Some felt that assigning a dedicated victim liaison officer at the outset of a case was a good idea; others were not as sure as investigators are not well trained or necessarily have the right skills in dealing with victims. They feel that if any changes were contemplated some clear boundaries need to be established as it is not WorkSafes responsibility to advocate for victims
  - Some believe that investigators are already too victim focused and need to step back
- Legal group are of the view that the failure of investigators to submit cases for review in a timely manner is having flow on impacts – for example:
  - Often, they have to correct flawed investigations; whereas ideally, they should be referring problems cases back to investigators to fix – but when cases are being received late, time prevents this from occurring. This causes 'other' routine work having to be placed on the backburner, resulting in downstream further delays
  - Statements needing to be reshaped into a formal statement (briefs of evidence), made worse when such statements are audio taped interviews comprising of many, often repetitive and conflicted accounts

Risks (Investigations and /or Prosecutions)

[106] **Responses – *this is what I learnt***

- The amount of oversight Investigation managers are able to apply to each case is an organisational risk. Too many cases are being referred to legal without detailed review or oversight.
- The increasing number of not guilty pleas being entered is risk as many of the investigators are not sufficiently trained to deal with complex defended hearings; and they are not experienced and lack confidence in dealing with defence solicitors / barristers.

- For complex cases (only), assign and involve a lawyer to the case much earlier on in the investigation process, particularly where it is known there may be some legal issues requiring attention (note: but this should not apply to routine cases).
- The increase in the number of not guilty hearings is inevitably going to lead to an increase in greater scrutiny of investigation processes and procedures (i.e. continuity of exhibits)
- Many investigators lack an understanding of what constitutes evidence and some do not know how to take or prepare a formal statement (for prosecution purposes).
- Some of the taped audio statements are between 50 and 150 pages long. Prosecutors have advised this practice is a risk in that some audio-taped interviews comprise sometimes conflicting accounts being given by witnesses within the same statement – they say this is a nightmare for them in terms of preparing a coherent (and admissible) formal evidential statement from the transcript i.e. reducing the 50 to 150 pages to a evidential statement. It is felt that practice is placing some cases at risk of failure due to witnesses being unable to be accurately briefed.

General Discussion – Change

What was asked - If I was the 'boss' for a day

- » What would you change as top priority? - i.e. to create the desired state?
- » What wouldn't you change?
- » What wouldn't you change?

[107] **Responses –** *this is what I was told*

- I would change the way cases are triaged and assigned for investigation (no alternative provided).
- For complex cases, I recommend a team approach should be adopted and tasks assigned using project management methodology.
- I would issue an instruction to investigators requiring all interviews are planned and they stop audio taping witness statements.

PART III

Case Assessments

- **Ryman – fatal (Civil construction – worker)**
- **Cotton Soft – injury (Manufacturing - worker)**
- **Singh Builders – fatal (Construction – other person)**
- **Quick Earth – no harm (Construction)**
- **N Brooking – fatal (Forestry worker)**

CASE ASSESSMENTS

- Ryman – fatal (Civil construction – worker)
- Cotton Soft – injury (Manufacturing - worker)
- Singh Builders – fatal (Construction – other person)
- Quick Earth – no harm (Construction)
- N Brooking – fatal (Forestry worker)

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[108] In Part III I outline my assessment of the abovementioned files which are said to be a fair representation of the type and quality of cases produced by investigators.

[109] I have assessed each of the 5 files using a colour coded rating attached at (Appendix D).

[110] Across each of the files I observed some pockets of good practice as well as some evidence of non-adherence to good practice and policy guidelines.

Scoping and planning of investigations

[111] Of the 5 files assessed, only 3 of them had investigation plans. 2 of the 3 appear to have been completed retrospectively, so in effect they are chronology of what tasks and activities were completed during the enquiry as opposed to what tasks or activities were planned to be completed. On that basis I found there to be a poor uptake in use of plans in scoping and setting the direction of an investigation. This did not come as a surprise to me, as many investigators told me during interviews, they preferred to mentally plan their investigations and build requirements as the investigation unfolded.

[112] According to what investigators told me, the main reason for this lack of uptake is that they feel there is doubling-up between the Investigation Plan, Investigation Log and notebook entries. Whilst there may be an element of truth in that view, an investigation plan nevertheless is a particularly useful tool for ensuring at the outset of an investigation that the lead investigator turns his or her mind to a range of requirements and tasks that must be considered (for example scene tasks/activities, resources, experts, cultural considerations, and witnesses etc).

How the investigations were carried out, including resourcing and availability of expertise

[113] I found that each of the 5 investigations was sufficiently resourced and experts were utilised when required.

[114] Despite some identified shortcomings, overall, I found the quality depth of investigations to be of a good standard with, in most cases, all avenues of enquiry considered and explored.

[115] The gaps I have highlighted, in my view, are due to a lack of investigative training, experience and knowledge as opposed to there being an issue with investigative policy or practice guidelines. The policy guidelines are sufficiently detailed and are fit for purpose.

[116] In all cases two or more investigators were deployed to carry out initial action. I am advised that it is not always possible to deploy two or more investigators to a scene but being able to do so is viewed as a critical success factor in that it enables and supports:

a) early intervention

b) team approach

c) tasks to be prioritised and shared

d) a good match to be found between investigator capability and task complexity

Scene Examinations

[117] More often than not WorkSafe investigators are deployed to the scene of an incident after emergency services (first responders). By that stage the scene has been frozen, boundaries set and some preliminaries enquiries made with witnesses. Where NZ Police (NZP) are in attendance the provisions the NZP and WorkSafe MOU (schedule 2 Para's 14-21 apply).

[118] However, there remain circumstances where there is still a need for the first (WorkSafe) investigator on the scene to complete his or her own an 'appreciation' (either mental or written) so that those thoughts can be factored into the requirements for the ongoing investigation (and to inform the investigation plan).

[119] The files assessed contained limited information concerning initial action taken at scenes. Some information was recorded in notebooks and some in investigation logs, but generally there was no single documented record of 'who did what' – i.e. job sheets or formal statement.

Scene Reconstructions

[120] Reconstructions are routinely used by enforcement agencies to determine what activity took place at the given time of an incident or crime.

[121] There is no (documented) evidence on any of the 5 cases suggesting that a reconstruction was carried out or even considered.

[122] I am not sure whether this is because investigators lack general experience in scene examinations per se or that scene reconstructions are not viewed as being an important component of an investigation.

Exhibit Management

[123] Despite having been told by investigators of their concerns about exhibit management, I found the manner in which exhibits were managed, from scene to exhibit store, to be of a good standard. Using information on file I was able to correlate and track the movement of exhibits from scene to the exhibit store, with the movements being appropriately documented in notebooks and on exhibit movement sheets.

[124] In some instances, there was a failure to record precisely (time, date and place) where the exhibit was located; the name of the person who located the exhibit; the name of the person who received it; and the name of the person who was responsible for finally disposing of the exhibit.

[125] As I have highlighted elsewhere in the report it would be useful if the exhibit form (and register) as well as exhibit storage rooms are regularly audited as part of internal control. I am led to believe that files are sometimes closed prior to exhibits being returned to their owners or otherwise dealt with. This results in them not only taking up valuable storage space; it also exposes WorkSafe to an avoidable risk.

[126] WorkSafe Operational Guidance: Management of Exhibits (date of issue 01/04/16) clearly sets out policy requirements for exhibit handling and storage. I sense that the policy is either not well known or well understood and perhaps a timely reminder about its contents would be useful.

Interviews

[127] On all of the 5 files contained examples of interviews (witness and duty holder) and overall the statements were of a good standard.

[128] It was clear that some of the interviewers were more experienced and more apt at following investigative interviewing best practice. This is consistent with the advice I have been given. Many of the investigators I spoke to acknowledged they lack interview experience, some adding they have not received any additional training beyond their cohort induction course.

[129] There is evidence of good use being made of written formal (evidential) statements, with many of those interviews being well planned – (including written interview plans).

[130] Some witness interviews were audio-tape recorded. Care needs to be taken to avoid such interviews from becoming too wordy, unstructured and repetitive. I saw example of one such an interview ending over 90 pages. The problems with this mode of interview were highlighted by legal group prosecutors; specifically, when endeavouring to convert this mode of statement into an admissible formal statement for court purposes.

[131] On this point there are significant advantages in taking formal statements from witness at source at the first available opportunity – as opposed to taped audio statements. For example, such statements can be produced/admitted in court, which has huge downstream time saving benefits (for investigators and prosecutors alike) should the case advance to a not guilty hearing.

[132] I noted that most duty holder interviews included multiple interviewees. I am advised this is standard practice when considering culpability/liability due to the focus generally being on the PCBU(s), as opposed to the acts or omissions of any one individual.

[133] In law enforcement the use of audio taped interviews is an outdated practice. Videotaped interviews have been in vogue, in most jurisdictions world-wide for more than 30 years. They are reliable and well tested in court. At a cost of less than $9000 per unit an opportunity exists for WorkSafe to consider the tactical placement of (either fixed or mobile) interview units across the regions. This could be supplemented by investigators receiving additional investigative interviewing training (at least L2).

Use of experts

[134] The files contained evidence of early consideration given to the utilisation of subject matter experts (SME's), with good use being made of their expertise.

[135] Managers and investigators said that expert witnesses are sourced and used on an 'as required' basis; with many such witnesses tending to be known to either the more experienced investigators or to in-house experts.

[136] It was suggested by some investigators a national database of experts should be established. I don't know whether or not such a database exits – if not it is a sensible suggestion. Otherwise if there is database, it needs to be communicated to the frontline.

Management oversight of investigations, including documentation of decisions

[137] The final Investigation Report in each case was checked and signed off by the investigators' respective manager and chief inspector. But beyond that, with two exceptions, there was a notable absence of documented evidence suggesting managerial or supervisory oversight or guidance during the course of each investigation.

[138] In cases of this type and complexity I would have expected to find strong evidence of supervisory oversight. Particularly given that some of the lead investigators were relatively new to the organisation. As a bare minimum I would have expected to see evidence of:

a) Quality assurance checks;

b) Affirmation of scope and direction of the investigation;

c) Minuted advice and guidance;

d) Minuted confirmation of completed case review(s) with suggested avenues of enquiry to be considered, explored and/or completed.

[139] It is always sound practice to ensure that a record is maintained of all determinative decisions. Such decisions ought to include investigation options considered (even if not adopted); planned actions; resource requirements; risks and welfare considerations.

[140] Auditable decision making is defined (p117 Core Investigative Doctrine 2005) as: (1) recording what has been done and why it was done; the reasons for taking particular investigative actions and what the outcome was; (2) providing an audit trail that can be followed in the event of review, scrutiny or new material coming to light.

[141] It is also said that good record keeping may be helpful when during a court hearing the spotlight is placed on the integrity of material evidence.

[142] Although none of the files assessed had decision making logs, many decisions were recorded using a combination of notebook entries and investigation plans and investigation logs. Further, there is evidence of notebooks being used to good effect to record tasks, activities and some decisions. This practice is a positive; it is to be encouraged and must be retained. But, based on some of the commentary from investigators; there may be some confusion about the purpose of the four primary record keeping instruments, namely (1) notebooks, (2) investigation plans, (3) investigation logs; and (4) decision making logs. All four have a place and purpose, but due to confusion there is a risk of duplicated effort, i.e. recording the same information in all four documents.

Victim interactions and management, including the role of third parties

[143] Only 2 of the 5 files had Victim Contact Logs. Those without logs contained very little information concerning any advice or support that was provided to victims.

[144] In one case where the victim log was, in addition to an initial phone contact call, a well written empathetic letter, as well as some informative brochures was sent to the victim's immediate family.

[145] Managers and investigators openly admitted they did not enjoy having to deal with victims as part of an investigation (See Part II relating to investigator comments concerning victims). Most felt that a dedicated victim group or liaison person, such as that offered by Victim Support would be a preferred option. An example was provided of a recent investigation where a team approach was successfully adopted and as part of the team a dedicated victim liaison officer was appointed. This approach was said to have worked extremely well.

[146] Based on what I was told by staff spoken to from Legal Group I am confident that once a case enters the prosecution arena Victims Rights Act and Victim Code considerations are met

Timeliness of investigations and the making of prosecution decisions

[147] All cases resulted in a referral to legal group, for formal legal review. 4 of the 5 cases progressed to prosecution.

[148] In all cases there were tight timeframes imposed on legal group to confirm (or negate) evidential sufficiency and file charges.

[149] Tight timeframes are putting considerable stress and demand on legal group staff.

[150] Cases are becoming increasingly complex; some involving multiple PCBU's with a recent trend for more of those prosecuted to plead not guilty. Thus, placing added strain on already heavily under pressure workgroups. Long-term this is not sustainable.

[151] When faced with a similar dilemma 10 years ago NZP introduced Criminal Justice Support Units (CJSU's) throughout the country (based on the UK model). CJSU's act as a conduit between investigators and prosecutors. Their role is to pull together all of the evidence on a file and prepare it for court. This model offers significant benefits in that for a relatively small investment, investigators and prosecutors are freed up and their time reinvested in core duties.

PART IV

N Brooking – fatal (Forestry - worker)

The issues and concerns raised

Background

[152] One of the drivers for the commissioning of this assessment was due to the dissatisfaction expressed by 9(2)(a) concerning the investigation and non-prosecution arising from the workplace death of 9(2)(a) Niko Brooking on 22 August 2016.

[153] It was on that basis that it was determined the best starting point for this assessment would be a face to face meeting with9(2)(a) . The reasons for that meeting being:

I. To outline to them the purpose of the assessment,

II. To identify their specific concerns; and

III. To gain an appreciation of a victims' perspective and their experiences interacting with WorkSafe during the course of the investigation.

[154] Accordingly, after making initial contact, I met with 9(2)(a) at the Gisborne WorkSafe office on 21 May 2019 ("meeting 1"). That meeting was immediately followed up with a further meeting on the same day at 9(2)(a) home ("meeting 2"). Present at the second meeting were their legal advisor 9(2)(a) and 9(2)(a) representing NZCTU.

Meeting 1

[155] Following introductions, I explained the purpose of the assessment, stressing that it would not entail a review or reinvestigation of the circumstances of Nikos death. They were clearly disappointed there would be no reinvestigation.

[156] I then asked 9(2)(a) to outline their specific concerns. In response they raised the following issues with me:

a) *The return of Nikos clothing*

They said that despite repeated requests to Police and WorkSafe; the clothing worn by Niko at the time of his death has not been returned to them.

b) *Victim contact by WorkSafe*

They advised that they have had limited contact with Casey (Broad) throughout the investigation and he has not provided them with information as to how the investigation was progressing. In support of this they recalled that they had met with Casey on 2 or 3 occasions (for a total of 1 ½ hours meeting time); and about 25 minutes of phone time.

[22] On 16 April 2019. Unable to meet prior to 21 May as I was out of NZ for a period of 25 days.
[23] 9(2)(a) Law, Barristers and Solicitors.
[24] representing NZCTU and family advisor.

c) *Insufficient time to prepare for Coroners hearing*

They said that they were unable to meet the time limit that was imposed on them to respond to the Coroner because WorkSafe had not provided them with the necessary papers and documents relating to the investigation. Further, based on their interpretation of the papers filed with the Coroner by WorkSafe they did not agree with conclusions reached and were seeking to have the investigation reopened.

d) *Never been advised of (Victims) rights*

They said they have never been advised of their rights as victims and throughout the investigation they lacked any knowledge of their rights; i.e. they were not provided with information about the Coroners hearing and it was not until the day before the proposed hearing that they even realised they were entitled to make submissions.

e) *Investigators lack of knowledge about the Forestry Industry*

They said that the scene investigators lacked any knowledge of the forestry industry and suggested in such circumstances there should be a specialised team deployed – a unit similar to the Specialist Crash Unit (SCU) deployed by Police at the scene of a fatal crash. They said such a team if it existed, could be deployed on an as and when required basis.

f) *Lack of investigative experience*

They believed the lead investigator, Casey Broad, was a trainee with limited investigative experience and this (the investigation relating to Nikos death) was only his second ever investigation.

g) *The non-prosecution decision*

They said that they had been led to believe the investigation would result in a prosecution and this set the tone in terms of their expectations. This, they said, was based on being told that WorkSafe lawyers were going to recommend prosecution and later they learnt that one particular lawyer did not agree with the recommendation to prosecute. 9(2)(a) when pressed on this aspect said they were advised by Casey Broad that a prosecution would be recommended and it was sometime later they saw some documents that led to the non-prosecution decision.

h) *Drug testing*

9(2)(a) highlighted the fact that as part of the post mortem Niko was drug tested, and questioned why none of his other work colleagues were similarly tested on the day.

i) *Blessing at the death site*

9(2)(a) were dissatisfied about the immediacy and planning for the blessing at the site of Nikos death.

j) *Expectations*

In concluding our meeting, 9(2)(a) explained that their expectations were two-fold. First, that the Coroners hearing has been placed on hold pending the outcome of this assessment and they were expecting a favourable result from the assessment for the Corner to take into consideration. Second, they want to know 'why' there are so many deaths and so few prosecutions arising from deaths in the forestry industry? Therefore, they expect an

outcome that will inform the pending Coroners hearing and they also want to understand why there have been so few prosecutions.

[157] I reiterated to 9(2)(a) that many of their concerns were outside the scope of my terms of reference, but nevertheless I assured them their issues were noted and taken them on board. We then proceeded to their home for the second meeting.

Meeting 2

[158] Although 9(2)(a) were present at this meeting much of the discussion was led by 9(2)(a) and 9(2)(a) . Following introductions, I outlined the scope of the assessment, (as outlined in the terms of reference). I then sought their views on expectations. This led to a general discussion about the depth of the investigation that was carried out into the circumstances of Nikos death ("the investigation"). Some of the specific issues raised and discussed were:

- That it would be helpful if the report following this assessment enabled the Coroner to conclude that the investigation was inadequate and flawed.
- That the investigation did not consider work of other Inspectors (assessors) at WorkSafe i.e. the fact that they had investigated the company (DG Glenn Ltd) on at least 5 previous occasions for various breaches. Further, they were concerned that any possible links, lessons learned or "alarm bells" arising from the investigation into Blair Palmers death 3 months earlier, were overlooked and do not appear to have been taken into account.
- That investigators lacked specific knowledge concerning work within the forestry industry.
- That the investigation did not adequately consider that Niko had not completed core modules.
- That the hauler driver had not completed requisite units enabling him to drive the hauler and his liability was never adequately considered.
- That the tailgate meeting had not been signed off by Niko and there was no risk assessment.
- That the employer's duty to control and manage risk was not discharged – evidenced by, for example, the risk matrix was inadequate as it is unclear whether the workers had any input and its was questionable whether they understood the risks and hazards. And contrary to good practice multiple people were recorded and designated as being responsible for the hazard(s).
- That there was a failure to consider the gap in the code of practice SOP relating to line retrieval.
- That there was a failure to consider why other proven options for retrieval were not considered.
- That information received via anonymous letter(s) about the companies operating practice was not considered as part of the investigation.

[159] In support of the above issues, 9(2)(a) produced a very detailed report dated 1 August 2018 entitled *Summary of Immediate failures leading to the fatal accident*.

[160] This report, she said was provided to WorkSafe in September 2018.

[161] Further, in support of the various concerns that were raised 9(2)(a) produced a letter, dated 22 September 2018, addressed to Coronial Services on behalf of NZCTU.

[162] The letter sets out 8 points for consideration of the Coroner in support of holding an inquest into the circumstances of Nikos death.

[163] The desire being that should the Coroner hold an Inquest and make a finding that would trigger S 146 (1)(b) of the HSWA; namely:

146 Limitation period for prosecutions brought by regulator

(1) Despite section 25 of the Criminal Procedure Act 2011, proceedings for an offence under this Act may be brought by the regulator.

***(b)** within 6 months after the date on which a coroner completes and signs a certificate of findings under section 94 of the Coroners Act 2006 if it appears from the certificate of findings (or the proceedings of an inquiry) that an offence has been committed under this Act.*

[164] The concerns raised in the letter to Coronial Services are consistent with the issues raised in 9(2)(a) 9(2)(a) report and the matters discussed during our meeting.

[165] Ancillary issues of a more general nature were also raised and discussed during this meeting. They included:

- A concern that investigations are too narrowly focused on immediate causes as opposed to system failures9(2)(a)
- A concern that when inspectors visit workplaces they only talk to the "bosses" and avoid talking to "workers" – resulting in a one-dimensional view of the workplace, with workers left feeling as though they have no voice with inspectors 9(2)(a)

[166] This meeting ended cordially and I again reiterated earlier advice concerning the scope of my terms of reference which precludes me from:

a) re-litigating processes or outcomes of individual case studies

b) considering whether any specific prosecutions should or should not have been commenced by WorkSafe

c) considering the correctness/quality of any legal advice provided

The investigation file

[167] The WorkSafe file that was produced following the investigation into Niko Brookings death is extensive and consists of 8 Filemaster ring-binder folders.

[168] I have read this file and assessed it across a range of best practice criteria, the same of which I have applied to my assessment of 4 other files said to be representative of investigative standards applied by WorkSafe investigators. (See Appendix C for assessment criteria). The Niko Brooking investigation as well as the 4 other cases are dealt with and commented upon as a group within Part III of this report.

[169] On 11 June 2019 I met with Mr Broad, the lead investigator. He was aware, in a general sense, of 9(2)(a) dissatisfaction, but was not aware of the existence of the 9(2)(a) report or the contents of the letter to Coronial Services.

[170] At the conclusion of our meeting he expressed a desire to respond, as far as he is able to comment, on the concerns outlined in the letter. I followed up on this with 9(2)(a) who agreed that the contents of the letter could be shared with Mr Broad.

For the purpose of this assessment the issues raised in the letter are ‘closed’ and it is now a matter for WorkSafe to determine how they wish to treat the response to those concerns

What did I learn from reading the investigation file?

[171] The file contains wide-ranging material that was gathered during the course of the investigation. That material has enabled me comment on some, but not all of the concerns that have been raised by 9(2)(a) and their advisors. In doing so I repeat that it is not within my terms of reference to re-litigate the decisions that were made during the course of the investigation; or re-consider whether or not a prosecution should have been initiated by WorkSafe.

[172] On that basis, in the table below, I have outlined each concern that was raised with me and then offered my observations based on information gleaned from the file and from talking to various people.

[173] It should be noted that I have had the advantage of talking to a number of people and reading more information that may have been available to 9(2)(a) . For example, I have had the benefit of reading not only the entire investigation file, but also the Legal Review Report which was produced by WorkSafes Legal Group in response to Mr Broads Investigation Report. For reasons of legal privilege, I am unable to reproduce commentary from that report, but needless to say it has been of some assistance to me.

Table 4: Summary of issues raised and findings

		Issue/Concern	Finding / Response
1		The return of Nikos property	- The return of deceased property is the responsibility of NZ Police. - I am advised NZ Police returned Nikos clothing to 9(2)(a) on 19 September 16. - I am advised Nikos helmet was retained by WorkSafe as an exhibit.
2		Victim contact by WorkSafe	- The file Victim Log discloses that there were 11 (documented) contacts between Casey Broad and victim(s) – between 26/08/16 and 12/12/16. - 8 contact via phone. - 3 contacts in person. - The dates of contacts precede any prosecution decision and therefore do not include Victim Impact Information (VIS) information. - Any further lack of communication may be explained due to the fact that Mr Broad was required to take several weeks off after surgery (post xmas 2016/17) and was followed up with a period of rehabilitation (ref email doc on file dated 8/03/17).
3		Insufficient time to prepare for Coroners hearing	- Other than PM information and toxicology results, the file does not disclose any information concerning any proposed Inquest hearing.
4		Advice of victim's rights	- Other than completion of Victim Log there is no information to

			confirm advice of victim rights.
E		Lack of knowledge about forestry industry	- The file discloses evidence that the initial WorkSafe response team included subject matter experts (SMEs), namely Forestry Inspector, Mr Andrew Powell. He was also consulted during the prosecution decision making process. - Forestry Inspector Mr Jennings continued to work on the investigation. - Forestry Inspector Mr Jennings was also present and assisted with the Duty Holder Interview with DG Glenn.
5		The non-prosecution decision	- The only documents on the file concerning the non-prosecution decision are the Investigation Report and The Legal Review which is a legally privileged document. - Mr Broad advises that he did not give any indication to 9(2)(a) that a prosecution would be recommended. - There are no documents on file suggesting there was a likelihood of a prosecution, in fact an email communication (of 8/03/17) between Coronial Services and Mr Broad indicates a prosecution outcome is unlikely i.e. (Broad)…. I *am not confident of a prosecution unless something glaring(sic) obvious comes up from reviewing documentation*….
6		Lack of investigative experience	- Mr Broad was relatively new to WorkSafe at the time he was assigned the lead investigator role. - Prior to commencing employment with WorkSafe, Mr Broad was employed as a constable and detective constable with New Zealand Police. - Besides attending the RNZPC for 5 months of recruit training a constable undergoes a further 2 years of training (which includes both practice and theory). A detective constable attends an intensive 4 week (pass/fail) residential CIB Induction Course –this includes in-depth law and practice. A detective constable undergoes 2 ½ years of ongoing training and assessment to attain detective designation. - On joining WorkSafe Mr Broad participated in Cohort training followed up with 6 months induction. - Although he may have lacked specific experience (but not necessarily knowledge) of the forestry industry, Mr Broad was assisted during the investigation by two experienced SME's – namely Forestry Inspectors, Mr Andrew Powell and Mr Phil Jennings.
7		Drug testing	- The toxicology report indicates that Niko Brooking was drug and alcohol tested as part of the post mortem examination. - Although not the responsibility or fault of WorkSafe, the Co-workers were not drug tested on the days of the fatality. As part of the investigation questions were asked as to why drug testing

			was not considered or carried out. - I understand the employer made the decision, on compassionate grounds, to send workers home without any tests being undertaken. - Historical results of previous drug tests were obtained as part of the investigation. - Given that no tests were conducted the probative value of any resultant analysis is an unknown
8		Blessing of the death site	- There is correspondence (emails and notebook entries) on file relating to the consideration given to the blessing the site. - There were some difficulties that led to delays. In part it appears, this was due to the issuance of the non-disturbance notice within the inner scene. - In those circumstances an opportunity was missed to engage more closely with whanau so that with mutually acceptable options could be explored and put in place. This course may have avoided any downstream concerns or criticism.
		'Other' concerns	**Finding / Response**
9		The investigation did not consider work of other Inspectors (assessors) at WorkSafe – in terms of previous DGL breaches	- The file discloses that during the course of the investigation due consideration was given to relevant previous incidents. In particular death 5 months earlier of Blair Palmer was considered. (ref. p 6 Investigation Report) - The file contains a number of documents relating to previous incidents / compliance history. (Ref Previous history of Duty Holders). - I am unable to determine what weight was placed on previous history or how that information was interpreted but that is a different issue and perhaps is then type of decision that could have been recorded in either the investigation log or decision log.
10		The investigation did not adequately consider that Niko had not completed core modules.	- The file discloses that training records of all parties including Niko and the Hauler driver were gathered as part of the investigation. - The fact that Niko did not hold standard 1269 (plan, prepare for, and carry out line shifts in cable harvesting operations) was a factor known when deciding on the case outcome. Further it was established that Niko had completed unit standard 1258 which it was said, the requirements of standard 1269 were incorporated, when he completed this unit. - The extent of the consideration given to those records is a question of degree, interpretation and opinion.
11		The hauler driver had not completed requisite units	- The file records that it was known the hauler driver 9(2)(a) r) had not completed the requisite training standard.

		enabling him to drive the hauler; and His liability was never adequately considered.	- This was discussed with 9(2)(a) r during his interview (at p 9 time – 24:33, interview on 09/09/16). - 9(2)(a) acknowledged that he had been driving the hauler for *"close to four and a half years, maybe just over…"* He also acknowledged that *"I've got two…the first two parts of getting your overall hauler ticket…."* - The file does not disclose whether any consideration was to 9(2)(a) lack of qualification in terms of his liability. - The file does however disclose that consideration was given to the part the condition of the rope played in terms of causation. This issue is discussed in correspondence produced by the legal advisor – Legal File Review - (which is privileged). The discussion relates the Draft Mainnech Report of J D Mains. This indicates that further enquires were carried out with Mr Mains, by the Chief Inspector and Forestry expert via teleconference. It appears that Mr Mains offered further information concerning the part the rope may have played, and the forestry expert rejected some of his advice on the basis that he was not considered an expert. Although this discussion is referenced in the Legal Review Report, I was unable to identify any follow-up correspondence as to what was said by the parties who participated in the teleconference. - On this particular issue, it is my view that it appears the point of difference between the query raised in 9(2)(a) report and NZCTU letter to Coroner and the investigation findings are: ○ That the investigation focused too much on the condition of the rope, rather than considering it to be a contributory factor in terms of causation. ○ That it was said because of the condition of the rope the hauler driver was distracted because he was focused on winding the rope in; ○ That this distraction may have resulted in his in ability to observe where Niko and 9(2)(a) were standing, which raises the question of this distraction as having an impact on his decision to not cease winding the rope in and / or to turn the machine off. - On the other hand, the investigation, it appears did not consider the condition of the rope to be a causative factor. - Despite being referenced in the Legal Review Report, I reiterate, for the sake of completeness, it would have been helpful if the outcome of the teleconference was documented including their reasons for coming to a different opinion than Mr Mains.
12		The tailgate meeting had not been signed off by Niko and there was no risk assessment.	- The Daily breaking out plan (Doc No 7750) was retained as an Exhibit. - The plan has been signed off by employees 9(2)(a) , but not Niko Brooking.

			- This anomaly was canvassed during the interview of the Crew 9(2)(a) , when he was interviewed on 23/08/16. At (p's 18, 19, time -29:40) ….referring to the plan it was put to 9(2)(a) by the interviewer 9(2)(a) *"you've signed it there but he's, hasn't signed ….is there any significant to that or is it just that he's just overlooked it or.."*? In response 9(2)(a) stated *"Oh I would say he's just forgotten. He would have just filled it out and just put his name in there…"* - This issue was also raised with 9(2)(a) during his interview (p 13, time – 35:46) where the question tailgate meetings were raised. 9(2)(a) said…."9(2)(a) *has a diary where it asks questions like ('how is everyone state of mind')"?* During the conversation that followed there was further reference to the tailgate meeting form as well as the breaking out plan. There was continued discussion about the daily plan and the tailgate meeting and 9(2)(a) was asked if there was any reason why Nikos signature is not there (?) In response he said*: No, I…no I didn't notice that. But one hundred percent he did fill this out".* - The fact that there is a documentary record of the daily breaking out plan tends to suggest that it did occur, corroborated by the fact that 3 of the participants (including 9(2)(a)) signed the document. Nonetheless this issue is an 'alive and contentious' one due to the fact Niko never signed the plan and we will never know the reason for that oversight. - The information on the Daily Breaking Out Plan (Doc 7750) is limited as to the proposed work plan and whether or not a risk assessment was done is indeterminable on the papers.
13		The employer's duty to control and manage risk was not discharged	- There is evidence on file that DGLs duty to control and manage risk was considered as part as part of the overall decision-making process. (ref. p 8,9 and 10 Investigation Report) - I am unable to assess the weight given to that consideration and the extent to which it was a determinative factor in the assessment of culpability.
14		There was a failure to consider the gap in the code of practice SOP relating to line retrieval	- There is evidence on file that consideration was given to the task, the risks (or lack of), and the fact there were no (ACOP) mandated controls by way of an SOP (for retrieval)- (ref. p11 Investigation Report) - There is also evidence on file that consideration was given to the use of a stawline. ref. p11 Investigation Report) - I am unable to assess the weight given to that consideration and the extent to which it was a determinative factor in the assessment of culpability.
15		There was a failure to consider why other proven options for retrieval were not considered	- See above – options were considered and in fact the investigation reported (at p 11 Investigation Report that "*the use of strawline is not specifically recommended for this type of activity in the ACOP….While it would elevate the tailrope for the*

			inhaul, the strawline would have to be retrieved and the risks of it being snagged would also occur similar to the main rope and tail rope"
16		Information received via anonymous letter(s) about the companies operating practice were not considered as part of the investigation	- There is a record on file of an anonymous letter about DGL operating practices – a handwritten letter was received on 16 September 2016. - There is no correspondence on the file to indicate was done in response to the letter.

Response to the Terms of Reference

[174] Reflecting on the terms of reference I made the following observations in relation to the Niko Brooking investigation file.

Scoping and planning of the investigation

[175] It is good practice to complete an Investigation Plan within the first 24 hours of the commencement of an investigation. The plan should set out an (as far as is possible) an estimation of taskings, responsibilities, timelines and resource requirements.

[176] An investigation plan could also include consideration of decisions made, but generally it is advisable that all determinative decisions be recorded in the lead investigators notebook and decision log.

[177] In this case an Investigation Plan was completed, but it appears to me it was done so retrospectively as opposed to within the first 24 hours. There is no decision-making log on file, but there is an Investigation Log as well as detailed notebook entries which do contain reference to decisions made.

[178] The scene was already isolated and contained when WorkSafe staff arrived. I am advised that there was a delay in WorkSafe responding which was due to a misunderstanding as to Mr Broads whereabouts. He was in fact attending a meeting at the parent companies' premises and this was initially misinterpreted as him being already on the site of the fatality, thus the delay.

How the investigation was carried out, including resourcing and availability of expertise

[179] A team approach was adopted for the initial action including the use of in-house forestry experts. There is no suggestion that resources or a lack thereof was a factor.

[180] In addition to in-house experts, the use of external experts was considered. For example, Mr Jack Main was engaged to assess mechanical equipment involved in the accident.

[181] The investigation team was also able to use material gathered by NZ Police and other first responders - including scene photographs and witness statements.

[182] Statements were taken from relevant witnesses. There is evidence that interviews of key witnesses were carefully planned.

[183] Some witnesses were interviewed by 3 parties of interest[25] over a very short space of time. This can, no doubt, lead to them, perhaps unwittingly, providing slightly different accounts about the same incident – for example the interviews of 9(2)(a) , as has been highlighted by 9(2)(a) in her report. 9(2)(a) provided interviews to Police, his employer and WorkSafe. In such circumstances it can leave witnesses vulnerable and exposes.

Management oversight of the investigations, including documentation of decisions

[25] Interviewed by Police, by employer and by WorkSafe investigators.

[184] Ideally, I would have expected to find on file, some evidence of managerial / supervisory oversight of the investigation. Such oversight could include review comments, directives or recommendations. But other than signing the file off at the conclusion of the investigation and some email communications there is limited evidence of any supervisory input. There may well have been some verbal oversight, but if that is the case, then important case conferences, reviews and directions ought to have been documented.

[185] After completing initial scene action NZ Police handed over jurisdiction to WorkSafe. The principle of 'passing the baton' applies when jurisdiction shifts[26]. To avoid any later misunderstanding in terms of who was responsible for ongoing enquiries it is desirable that any handover decisions are recorded. On this occasion the handover was not recorded.

[186] WorkSafe investigators will invariably arrive at a scene after other first responders. But consistent with what I observed on the other 4 files, there is a lack of recorded information about the examination of the scene – (see check list for best practice). I appreciate that individual inspectors have made reference in their notebooks to what they did and who they spoke to at the scene, but I think it would be useful for inspectors to get in the habit of either producing job sheets or a better still, formal statement outlining their role at the scene while it is still fresh in their minds.

[187] If this practice was followed it would avoid any confusion as to what actions or tasks were considered or completed at during a scene examination, and moreover it would provide a consolidated record of what was done; who uplifted what exhibits and who spoke to relevant witnesses.

[188] Developments and improvements in forensic testing capability as well as an increasing interest in the integrity of evidence by defence counsel means that more than ever, investigating agencies must take absolute care in recording their actions and movements within a scene.

Victim interactions and management, including the role of third parties

[189] The Contact with Victim Log indicated 11 interactions between Mr Broad and 9(2)(a) These occurred in person (3 times) and via phone (8 times). Initial contact was on 26 August 2016 and that last recorded contact was on 16 December 2016.9(2)(a) felt that there was insufficient contact.

[190] On the face of it 11 contacts appear reasonable. But this example highlights an existing gulf in expectations between what a victim expects and what investigators can realistically deliver.

Timeliness of investigations and the making of prosecution decisions

[191] The investigation commenced on 22 August 2016.

[192] Enquiries and final interviews concluded late April and early May 2017.

[193] The Investigation Report was completed 17 July 2017; then checked off by the manager 19 July 2017 and then signed off by Chief Inspector on 27 July 2017.

[194] The Legal File Review was completed on and signed off on 14 August 2017.

[195] The deadline for charges to be filed was 21 August 2017.

[196] Clearly there was considerable pressure placed on the Legal Advisor from receipt of file to completion of the Legal Review in terms of meeting the 12-month statutory time limit.

[26] Ref. p119 Core Investigative Doctrine.

Concluding comments

[197] As I have set out, I cannot provide answers to or satisfy all of the issues that have been raised with the Coroner by the NZCTU, which by and large mirror the concerns raised in 9(2)(a) 's Report. Nor can I fully respond to all of the concerns raised by 9(2)(a) . Part of the reason for this is that it is outside the scope of my terms of reference to re-litigate outcomes or consider whether any closed case should be re-opened.

[198] However, I can comfortably submit that in my opinion all reasonable avenues of enquiry were considered by the lead investigator Mr Broad, albeit some of the concerns that have been raised will need further explanation.

[199] At the time of completing this report Mr Broad advised me he was about to embark on his response to some of those issues and concerns.

[200] Ultimately, the question that will linger is not whether all avenues were considered, but whether or not all avenues were fully explored or exhausted to a standard that meets everyone's satisfaction. On this point I suspect that each of the parties will have their own views on what constitutes their interpretation of 'satisfaction' and therefore some issues will remain unresolved.

[201] In my view the most contentious outstanding issue is that relating to the condition of the rope and the impact its condition may have had may have had as a contributory factor. This, in my observation, appears to be where there is a significant point of difference in terms of its importance, as raised in 9(2)(a) s[27] report and the NZCTU letter to Coroner, versus its relevance in terms of how the investigation was resulted.

[202] Those differences are framed as follows – for the 9(2)(a) Report and NZCTU letter they submit:

- That the investigation focused too much on the condition of the rope, rather than considering it to be a contributory factor in terms of causation.
- That it was said because of the condition of the rope the hauler driver was distracted because he was focused on winding the rope in;
- That this distraction may have resulted in his in ability to observe where Niko and 9(2)(a) were standing, which raises the question of this distraction as having an impact on his decision to not cease winding the rope in and / or to turn the machine off.

[203] On the other hand, the investigation, it appears did consider the condition of the rope[28], but did not consider it to be a substantive a causative factor.

[204] In conclusion, despite being referenced in the Legal Review Report, I think it would have been helpful if the Chief Inspector or forestry expert had documented[29] the outcome of the teleconference they had with Jack Mains and outlined their reasons for coming to a different opinion than was offered Mr Mains. I believe this would have shed some light on what they were thinking and perhaps may have explained why the condition of the rope was not considered so important after all.

[27] Summary of immediate failures leading to the fatal accident (1 August 2018)
[28] Refer p 2 of Legal Review Report where the condition of the rope is discussed as well as the teleconference between the Chief Inspector, the in-house forestry expert and Mr Mains.
[29] Documented their decision by way of memo, job sheet of formal (evidential) statement.

APPENDICIES

Appendix A – Terms of Reference

Appendix B – Interview Guide – Questionnaires

Appendix C – Interview checklist (criteria)

Appendix D – Case assessment findings

APPENDIX A – ASSESSMENT TERMS OF REFERENCE

See attachment

APPENDIX B - INTERVIEW GUIDE (INVESTIGATORS)

Interview questions

Roles and responsibilities

1 What is your current role within WorkSafe? (Investigator / Supervisor / Manager/ other delete as applicable)

- Is the role and purpose clear to you (and your staff)?
- Are your responsibilities clear? (Investigator / Supervisor / Manager/ other delete as applicable)
- What is the primary role of WorkSafe Investigator (i.e. enforcement, prevention, educational – (or all – generalist)?
- Are investigators generally reactive or proactive?
- To what extent is there alignment or synergy between WorkSafe investigators, assessors, compliance officers (and Legal Section)? (check what other like workgroups exist)
- How is actionable information of interest (or intelligence) gathered and shared between the various workgroups?
- How do the various regional offices network, share information and share good practice? Are there opportunities to improve networking?

2 In terms of the role and purpose of your workgroup - What do you see as the main challenges?

3 What opportunities are there to improve role clarity?

Demand

4 Briefly describe your demand (workload) pressures? What are some of the specific demands on you or your workgroup?

5 What are the drivers of that demand?

6 What are the impacts of those pressures?

7 What opportunities exist to ease demand on you or your workgroup?

Distribution of work

8 Are case management reports generated – how often? – Who receives them; who monitors them and how is case management factored workload decision making?

9 How well is workload prioritised and distributed within your region or workgroup?

10 Is there a formal process / system for prioritisation?

11 Describe the workload within your workgroup? i.e. case holdings

12 Does your roster meet demand requirements?

13 Is there anything you would change to enable you or your workgroup to better meet demand?

Effectiveness

14 Is there clarity around current direction (strategic or tactical) of your workgroup i.e. are you focusing on the things that are aimed driving demand down and that contribute to WorkSafes (national) organisational goals, objectives and targets?

15 What do you see as the 2 or 3 most significant enablers for delivering on the national goals / targets?

16 What do you see as the 2 or 3 most significant challenges/barriers for delivering on the national goals / targets?

17 What (if anything) needs to change at the coalface to enable improved alignment with the current national operating strategy?

18 In your current role – what do you do well?

19 In your current role – what could you do better?

20 What do you think needs to change to improve your effectiveness or your workgroup?

Investigations

21 Refer attached check sheet for questions / themes re- investigations?

- *Planning* - scoping and planning of investigations
- *Execution* – The investigation process - how the investigations were carried out, including resourcing and availability of expertise
- *Management of Investigations* - management oversight of investigations, including documentation of decisions
- *Victim Focus* - victim interactions and management, including the role of third parties
- *Meeting Timelines* - timeliness of investigations and the making of prosecution decisions
- *Interactions* - between Operations and Legal teams in the making of prosecution decisions

Risks (Investigations)

22 What are the current risks?

23 What are the future risks?

General Discussion - Continuous Improvement / Quality Assurance

24 Who checks on the quality of case decision making?

25 What would you change as top priority? - i.e. describe the desired state?

26 What wouldn't you change?

27 What are the impediments to change?

Optional Discussion

28 To be determined (TBD) i.e. communication

Interview questions

Roles and responsibilities

1 What is your current role within WorkSafe? (Legal Advisor, Manager/ other delete as applicable)

- Is the role, purpose and responsibilities clear to you (and your staff)?
- As a Legal Advisor / Manager - what is the primary functions within that role?
- To what extent is there alignment or synergy between the Legal Group and investigators?
- How is actionable information of interest (or intelligence) gathered and shared between the various workgroups?

2 In terms of your role, purpose and responsibilities of your workgroup - what do you see as the main challenges?

3 In terms of your role, purpose and responsibilities of your workgroup – what are the opportunities for improvement?

Demand

4 Briefly describe your demand (workload) pressures? What are some of the specific demands on you or your workgroup?

5 What are the drivers of that demand?

6 What are the impacts of those pressures?

7 What are the opportunities that may exist to ease demand on you or your workgroup?

Distribution of work

8 Are case management/workload reports generated (for your work group) – how often? – Who receives them; who monitors them and how are they factored workload decision making when assigning fresh cases?

9 How well is workload prioritised and distributed within your workgroup?

10 Is there a formal process / system for prioritisation?

11 Describe the workload within your workgroup? i.e. case holdings – is that a manageable number?

12 Is there anything you would change to enable you or your workgroup to better meet demand?

Effectiveness

13 Is there clarity around current direction (strategic or tactical) of your workgroup i.e. are you focusing on the things that are aimed driving demand down and that contribute to WorkSafes (national) organisational goals, objectives and targets?

14 What do you see as the 2 or 3 most significant enablers for delivering on the national goals / targets?

15 What do you see as the 2 or 3 most significant challenges/barriers for delivering on the national goals / targets?

16 What do you think needs to change to improve your effectiveness or your workgroup?

Investigations

17 Refer attached check sheet for questions / themes re- investigations?

- *Victim Focus* - victim interactions and management, including the role of third parties
  - Within your role, to what extent do you consider Victims Right Act and Victims Code?
- *Meeting Timelines* - timeliness of investigations and the making of prosecution decisions
  - What are the - challenges / barriers/ opportunities
- *Interactions* - between investigators and Legal Group or individual advisors
  - Describe the relationship
  - What works well
  - What are the opportunities for improvement?

Risks (Investigations)

18 What are the current risks?

19 What are the future risks?

General Discussion - Continuous Improvement / Quality Assurance

20 Who checks on the quality of case decision making?

21 What would you change as top priority? - i.e. describe the desired state?

22 What wouldn't you change?

23 What are the impediments to change?

APPENDIX C - INTERVIEW CHECKLIST

WORKSAFE ASSESSMENT: CHECKSHEET

Assessment Themes:

a. scoping and planning of investigations
b. how the investigations were carried out, including resourcing and availability of expertise
c. management oversight of investigations, including documentation of decisions
d. victim interactions and management, including the role of third parties
e. timeliness of investigations and the making of prosecution decisions

Assessment Objectives:

- To provide a practical independent perspective on WorkSafes operational practice;
- To identify learning's; and
- To identify opportunities for improvement.

ASSESSMENT COMPONENTS	WHAT WAS LOOKED FOR
Scoping and planning investigations	**Assessment Criteria**
Investigators to provide evidence of: **Making an Appreciation:** - **Aim,** - **factors,** - **courses open,** - **choices made, and** - **Plan (approved and signed off by supervisor)** - **Mindset (open mind)**	• Written Investigation plan including: - Clear objectives - estimated tasks / timings / resource requirements /costs (if known)/ Responsibility assigned • Taskings that reflect investigation components i.e. scene, witnesses, victim, search and seizure, forensics and 'other' expert considerations, suspects (where known or appropriate), information and/or intelligence • Investigative decision making – determinative decisions based on facts • A living document – regularly updated /resulted and signed off by supervisor • The plan demonstrates self-initiative and open mind with all lines of enquiry considered and explored • Partner agency roles and responsibilities defined and understood with provision for debrief and handover
How the investigations are carried out	**Assessment Criteria**
Investigators to demonstrate evidence of: - **Execution** - **Tactics** - **Resourcing** - **Availability and use of**	• Core investigative functions carried out to the requisite standard: - Scene – arrival and initial action, reconnaissance, boundaries/cordons established, frozen and secured, examination, photographs/video, forensics, cultural considerations, mapping (use of experts) - Exhibit Management– labelled, secured, examined (as required) and indexing - Witnesses – interview plans, interviews recorded, support provided (as required)

experts	- Experts – use of external experts, opinions sought and considered and second opinion considered (as required) - Resources –are full resources routinely made available - Reconstruction – determine what activity took place at the given time - Causation / Liability - Victims – compliance with VR A and Victims Code • What information /Intelligence sources are used to inform decision making? i.e. previous breaches or deaths in same workplace • Were all reasonable avenues of enquiry considered or explored – gaps?
Management and oversight of investigations	**Assessment Criteria**
Investigators to demonstrate evidence of: - **Supervisory case review and sign-off;** - **Quality assurance;** - **Investigation conducted ethically** - **Decision making logs**	Managing Investigations • Investigation Plan checked and signed off by supervisor • Resource requirements considered (and met) • Constraints and assumptions identified • Timelines monitored • Record Keeping – Case reviews undertaken with actions noted and minuted - Decision Making Log – record of options considered and reasons for preferred option; consideration of any risks, resource considerations, tactical decisions • Case Management – helicopter view of demand, capacity and reallocation or distribution of resources (as required) • Communication – feedback internal and external (i.e. partner agencies, victims, witnesses/suspects, other stakeholders) • An ethical investigation - i.e. Conducted honestly, ethically and impartially. Has many parts; but not limited to: - due regard for the law and exercise of legal powers; - follows good practice; - even-handed in the use of discretion; - complies with code of conduct - due regard for and encourages community and stakeholder support; - due regard for people's rights including victims and offenders; - due regard for culture, cultural sensitivities, race and religious beliefs • Debrief – completed or considered (Y/N)
Victim focus	**Assessment Criteria**
Investigators to demonstrate evidence of: - **Compliance with Victim Rights Act 2002** - **Compliance with Victims Code**	• Victim contacts / completed and recorded • Updates / progress reports • Provision of victim support • Refer and code for legal and practice requirements
Timeliness	**Assessment Criteria**
Investigators to demonstrate evidence of: - **Timeliness of investigation** - **Timeliness of prosecution decision(s)**	Timeline / Timeframes • Refer timelines set in Investigation Plan – monitored, followed / met • Do they form part of QA review? • Managed appropriately to meet prosecution (decision) time frames
Interactions	**Assessment Criteria**
Assess the interactions between Operations and Legal Teams	• Formal and informal arrangements in place between operations and legal to ensure decision making timeframes / time limits can be met • Independence, clarity around role and purpose. Separation between investigative decisions and legal decisions – or 'one team approach,'?

Demand and workload	Aim: To Identify
Investigators to demonstrate evidence of: - **Demand** - **Capacity; &** - **Capability**	<u>Demand / workload pressures</u> • Identification of specific demands on individuals or workgroups that are or may be impacting on output or the quality of investigations? • Identify what are the drivers of that demand? • Identify the impacts of those pressures? • Process in place to enable case/workload prioritisation? • Establish what opportunities exist to ease demand on individuals or workgroups? • Establish if case management reports are generated – how often? – Who receives them; who monitors them and how is case management factored workload decision making and workload distribution. • Identify how is workload distributed inter-office and across regions or workgroups? • Consider whether rosters meet demand (Deployment)? <u>Identify workload (case) throughput</u> • Do targets or measure exist for throughput? • Is there a wait time for cases to be assigned – what is the threshold? What is average wait time/medium/longest etc? • What is being done to reduce that timeframe?
Alignment	**Assessment Criteria**
Investigators to demonstrate: - **they understand their contribution to organisational goals and targets**	• How well are investigators connected to organisational goals and targets • How do you know this?
People – (Investigator) management:	**Aim: To Identify**
The workforce is equipped and enabled (to reach their full potential)	- How are investigative staff enabled to perform their roles?
Talent is identified and developed	- What mechanisms are in place to identify investigative talent required now and for the future? - What is being done to develop those identified?
Staff recruitment and retention is managed	- Is staff retention an issue? If it's an issue, what is place to address it? - How is the investigator candidate pipeline being managed to ensure there is a supply to meet estimated demand?
Training	- What are the current and training requirements for investigators and their supervisors? - Are those requirements being met?
Staff engagement is encouraged and supported	- Are investigative staff engaged – how do you know this? - What initiatives are in place to support and improve engagement across the whole investigative workforce?
General Operational Practice	**Assessment Criteria**
Investigators to	• Investigators/supervisors can outline and demonstrate they understand (investigative) risks (and have mitigation plans in place that are regularly

demonstrate: they understand: - **Investigative risks** - **Continuous Improvement & Lessons Learned**	monitored) • Have an appreciation of actual (or potential) future (Investigative) risks. • Staff routinely identify and submit lessons learned through to who/where WS HQ? To enable continuous improvement and prevent same mistakes/errors recurring.

Key reference: Core Investigative Doctrine - https://www.app.college.police.uk/app-content/investigations/linked-reference-material/

NZP Manual:

https://fyi.org.nz/request/916/response/4271/attach/html/4/thomas%20daniel%20crime%20scene%20examination.pdf.html

Worksafe (NZ) investigations Policy and Practice notes

APPENDIX D - FILE ASSESSMENTS – OVERALL FINDINGS

[205] Using the criteria set out in the check sheet (at Appendix C), the Table below summarises my overall assessment of the files.

Ratings Legend

Good	Adequate	Below Standard	Red Flag	Not rated

ASSESSMENT COMPONENTS	WHAT WAS LOOKED FOR	WHAT WAS FOUND
Scoping and planning investigations	**Assessment Criteria**	**Y/N - COMMENTS (as required)**
Investigators to provide evidence of: **Making an Appreciation:** - **Aim,** - **factors,** - **courses open,** - **choices made, and** - **Plan (approved and signed off by supervisor)** - **Mindset (open mind)**	• Written Investigation plan including: - Clear objectives - estimated tasks / timings / resource requirements /costs (if known)/ Responsibility assigned • Taskings that reflect investigation components i.e. scene, witnesses, victim, search and seizure, forensics and 'other' expert considerations, suspects (where known or appropriate), information and/or intelligence • Investigative decision making – determinative decisions based on facts • The plan demonstrates self-initiative and open mind with all lines of enquiry considered and explored	*Use of Investigation Plans* - An investigation Plan is an accountability document which ought to review and signed off by a supervisor when setting the parameters at the outset of an investigation. - Of the 5 files assessed 3 of them had investigation plans. But 2 of the 3 appear to have been completed retrospectively which in effect is a chronology of what tasks or activities were completed during the enquiry as opposed to what was planned to be completed. On that basis I found the uptake and use of plans to be below standard. - The reason for lack of uptake is that investigators felt there is duplication between the Investigation Plan, Investigation Log and notebook entries. There may be an element of truth in that view, but an investigation plan is a useful tool for ensuring that at the outset of an investigation the lead investigators turns his or her mind to requirements, tasks, activities, resources, experts, potential, any cultural considerations, and witnesses etc.
How the investigations are carried out	**Assessment Criteria**	**Y/N - COMMENTS (as required)**
Investigators to demonstrate evidence of: - **Execution** - **Tactics** - **Resourcing**	• Core investigative functions carried out to the requisite standard: - Scene – arrival and initial action, reconnaissance, boundaries/cordons established, frozen and secured, examination,	*Scene* - Although in many cases WorkSafe investigators arrive at a scene after it has been frozen and boundaries set there is still a need for an investigator to complete, on arrival, an 'appreciation' (either mental and written) so that those thoughts can be factored into the investigation plan and recorded - The files assessed contained limited information concerning initial action taken at scenes. Some information was

- **Availability and use of experts**	photographs/video, forensics, cultural considerations, mapping (use of experts) - Exhibit Management– labelled, secured, examined (as required) and indexing - Witnesses – interview plans, interviews recorded, support provided (as required) - Experts – use of external experts, opinions sought and considered and second opinion considered (as required) - Resources –are full resources routinely made available - Reconstruction – determine what activity took place at the given time - Causation / Liability • What information /Intelligence sources are used to inform decision making? i.e. previous breaches or deaths in same workplace • Were all reasonable avenues of enquiry considered or explored – gaps?	recorded in notebooks and the investigation log, but no job sheets or formal statements outlining 'who did what'. *Exhibit Management scene to exhibit store* - Despite having been told by investigators of their concerns about exhibit management – (from scene to court) - I found the manner in which exhibits were managed to be of a good standard. - I was able to correlate and track the movement of exhibits from scene to the exhibit store, with the movements being appropriately documented in notebooks and on exhibit movement sheets. - In some instances, there was a failure to record precisely (time, date and place) where the exhibit was located; the name of the person who located the exhibit; the name of the person who received it; and the name of the person who was responsible for finally disposing of the exhibit. - I believe it would be useful if the exhibit form (and register) as well as the exhibit storage room is regularly audited as part of internal control. I am led to believe that files are sometimes closed prior to exhibits being returned to their owners or otherwise dealt with. This results in them taking up valuable storage space as well as unnecessarily exposing the organisation to an avoidable risk. - WorkSafe Operational Guidance: Management of Exhibits (date of issue 01/04/16) clearly sets out policy requirements for exhibit handling and storage. I sense that the policy is either not well known or understood – perhaps a timely reminder would suffice. *Interviews* - On all of the 5 files contained examples of interviews (witness and duty holder) and overall the statements were of a good standard. - It was clear that some of the interviewers were more experienced and more apt at following investigative interviewing best practice. This is consistent with the advice I have been give. Many of the investigators I spoke to freely acknowledged they lack interview experience. They said they have not received any additional training beyond cohort induction. Examples provided a variety of the 3 interview models (techniques) being used – i.e. free call, conversation and enhanced cognitive. - There is evidence of good use being made of written formal (evidential) statements, with those interviews being well planned – including written interview plans. - Some witness interviews are being audio-tape recorded. Care needs to be taken to avoid such interviews from becoming too wordy, unstructured and repetitive. I saw example of one such an interview ending over 90 pages. This will create problems when endeavouring to convert this into an evidential statement for court. - There are significant advantages in taking formal (evidential) statements from witness at the first opportunity – as opposed to taped audio statements. Nonetheless that such statements can be produced in court, which has huge downstream time saving benefits (for investigators and prosecutors) should the matter advance to a not guilty hearing. - I noted that most duty holder interviews included multiple interviewees. I am advised this is standard practice due to

		the focus generally always being on the PCBU(s), as opposed to contemplation of individual acts or omissions when considering culpability/liability. *Experts* - The files contained evidence of early consideration given to the utilisation of subject matter experts (SME's). - This is consistent with what I was told by managers and investigators when I spoke with them. They said expert witnesses are sourced and used on an as required basis. Many such witnesses tend to be known to either the more experienced investigators or to in-house experts. - It was suggested by some investigators a national database of experts should be established. I don't know whether or not such a database exits – if not it is a sensible suggestion. Otherwise if there is database, it needs to be *Scene Reconstructions* - Reconstructions are a particularly useful means of determining what activity took place at the scene at the given time of an incident. - There is no (documented) evidence on any of the files suggesting that a reconstruction was carried out. From what I observed reconstructions are not routinely considered. I am not sure whether this is because investigators lack general experience in scene examinations per se or that scene reconstructions are not viewed as being an important component of an investigation. *Intelligence* - There is little evidence of any formal information gathering, information sharing or building an intelligence picture. In the offices where assessors and investigators are co-located information arrangements are in place to share information, but this is generally on an ad hoc basis. The collection of information is by and large the product of much of the work carried out by assessors and investigators. There is huge potential for this information to be leveraged if formally fed in to a collection plan, analysed and used to inform targeted deployment decisions.
Management and oversight of investigations	**Assessment Criteria**	**Y/N - COMMENTS (as required)**
Investigators to demonstrate evidence of: - **Supervisory case review and sign-off;** - **Quality assurance;** - **Investigation conducted ethically**	Managing Investigations • Investigation Plan checked and signed off by supervisor • Resource requirements considered (and met) • Constraints and assumptions identified • Timelines monitored • Record Keeping – Case reviews undertaken with actions noted and	*Supervision and Decision-Making Log – Record Keeping* Supervision - The final Investigation Report in each case was checked and signed off by the investigators' respective manager and chief inspector. But beyond, with two exceptions, that there was a notable absence of evidence suggesting supervisory oversight or guidance during the course of each investigation - In cases of this type and complexity I would have expected to find strong evidence of supervisory oversight.

- **Decision making logs**	minuted - <u>Decision Making Log</u> – record of options considered and reasons for preferred option; consideration of any risks, resource considerations, tactical decisions • Case Management – helicopter view of demand, capacity and reallocation or distribution of resources (as required) • Communication – feedback internal and external (i.e. partner agencies, victims, witnesses/suspects, other stakeholders) • An ethical investigation - i.e. Conducted honestly, ethically and impartially. Has many parts; but not limited to: - due regard for the law and exercise of legal powers; - follows good practice; - even-handed in the use of discretion; - complies with code of conduct - due regard for and encourages community and stakeholder support; - due regard for people's rights including victims and offenders; - due regard for culture, cultural sensitivities, race and religious beliefs • Debrief – completed or considered (Y/N)	Particularly given that some of the lead investigators were relatively new to the organization. As a bare minimum I would have expected to see evidence of: • Quality assurance checks; • Affirmation of scope and direction of the investigation; • Minuted advice and guidance; • Minuted confirmation of completed case review(s) with suggested avenues of enquiry to be considered, explored and/or completed. *Decision making* - It is always sound practice to ensure that a record is maintained of all determinative decisions. Such decisions ought to include investigation options considered (even if not adopted); planned actions; resource requirements; risks and welfare considerations. - Auditable decision making is defined (p117 Core Investigative Doctrine 2005) as: (1) recording what has been done and why it was done; the reasons for taking particular investigative actions and what the outcome was; (2) providing an audit trail that can be followed in the event of review, scrutiny or new material coming to light. - It is also said that good record keeping may be helpful when during a court hearing the spotlight is placed on the integrity of material evidence. - Although none of the files assessed had decision making logs, many decisions were recorded using a combination of notebook entries and investigation plans and investigation logs. Further, there is evidence of notebooks being used to good effect to record tasks, activities and some decisions. This practice is a positive; it is to be encouraged and must be retained. But, based on some of the commentary from investigators; there may be some confusion about the purpose of the four primary record keeping instruments, namely (1) notebooks, (2) investigation plans, (3) investigation logs; and (4) decision making logs. All four have a place and purpose, but due to confusion there is a risk of duplicated effort, i.e. recording the same information in all four documents. I suggest this be readily fixed through on the job training and guidance. *Case Management* - WorkSafe does not have a defined 'end to end' case management model i.e. a national, joined up framework for managing cases from receipt of call through to final disposition. - Although WorkSafe does operates a centralised computer system it is not fit for purpose for recording and managing investigations. Has led to the use regionally based shared drives and spreadsheets for recording data and documenting investigative information. I am advised that many of the investigative the documents that are created are unable to be shared nationally. - The Napier office is piloting the use of PDF files. This, I am advised is about to the considered for national rollout. The use of PDF files should not be confused with investigations specific case management functionality. - A fit for purpose case management model and (computer) functionality would offer a number of benefits – such as:

		○ streamlining processes ○ Consideration be given to developing file briefing capability – which would cut back on the need for data entry; and would free up from desk bound activities investigators; thus, reducing case waiting times and assist in meeting prosecution timeframes. ○ Develop new and improved case functionality – including on-line case screening, case categorisation, case matrix, case reviews and improved tools/processes to enable managers and investigators to monitor and track case progress. ○ Enable processes that will link information and assist with the extraction of actionable intelligence.
		Operational Debriefs
		- Operational debriefs are one of the most efficient ways for lessons learnt to be identified, documented and used as a basis for avoiding the same mistakes being repeated. - Ideally lessons learnt from debriefs are fed into a centrally managed database as part of a continuous improvement regime. - I was advised that debriefs that debriefs are not routinely completed. - 3 or the 5 files assessed identified included recommendations for "industry learning's' and 'WorkSafe learning's'. Managers and investigators advised that there are opportunities any lessons learnt to be more widely circulated for the information and benefit of frontline staff.
Victim focus	**Assessment Criteria**	**Y/N - COMMENTS (as required)**
Investigators to demonstrate evidence of: - **Compliance with Victim Rights Act 2002** - **Compliance with Victims Code**	• Victim contacts / completed and recorded • Updates / progress reports • Provision of victim support • Refer and code for legal and practice requirements	*Victim Focus*
		- Of the 5 files assessed only 2 of them had Victim Contact Logs. Those without logs contained very little information concerning any advice or information provided to victims. - Managers and investigators openly admitted they did not enjoy having to deal with victims as part of an investigation (See Part II relating to investigator comments concerning victims). - Most felt that a dedicated victim group or liaison person, such as that offered by Victim Support would be a preferred option. - An example was provided of a recent investigation where a team approach was successfully adopted and as part of the team a dedicated victim liaison officer was appointed. This approach was said to have worked extremely well. - I am confident that once a case enters the prosecution arena Victims Rights Act and Victim Code considerations are met.

Key reference: Core Investigative Doctrine - https://www.app.college.police.uk/app-content/investigations/linked-reference-material/
NZP Manual: https://fyi.org.nz/request/916/response/4271/attach/html/4/thomas%20daniel%20crime%20scene%20examination.pdf.html Worksafe (NZ) investigations Policy and Practice notes

Ratings Legend

Good	**Evidence of:** » Criteria met and consistently meets / performs to the requisite standard » Best practice adopted, followed and met (refer check-sheet setting out what was looked for) » Role, purpose and responsibilities are clear and effort is directed at achievement of organisational goals and targets » High level of capability » Strong policy, systems, processes and practices in place » Strong on (case) reviews debriefs and lessons learnt used for future performance improvements » Staff are engaged, enabled, well-resourced and well trained to do their job and meet expectations
Adequate	**Capable and operating to potential** » Criteria and requisite standard mostly met » Delivering to expectations with examples of good practice and performance levels » Evidence of capability and consistency across all components of investigation planning, execution and ongoing management » Good organisational practices and systems in place to support effective management.
Below Standard	**Development needed / Requires Improvement** » Barely Adequate with opportunities for improvement across many of the investigation components » lack of capability or capacity with opportunities for improvement » limited evidence or case prioritisation; or matching investigator capability with case complexity » evidence of outdated case management (model) systems and processes
Poor	**limited capability** » Does not meet criteria or requisite standard with (Considerable development required to build capability » Area(s) of weakness or poor performance in terms of: - capability - adherence to best practice - development – resources / equipment now and future needs - development of people (training needs, performance, talent management) » Poor contingency management » Blind spots and/ or limited awareness around investigative risks » Agency has limited or no awareness of critical weaknesses or concerns
Unable to rate/not rated	**There is:** » Insufficient evidence or information available to make an assessment.

NOTES:

Staffing: Specialist Interventions – Relieving and secondments.

i. 1 Manager is in an acting capacity as a Chief Inspector (Hayden Mander)

ii. 1 Investigator from Central 1 (Chris Floyd) is acting as Manager for Northern 2
1 Investigator from Central 2 (Casey Broad) is acting as Manager for Central 2
1 Investigator from Southern 1 (Steve Baddock) is acting as Manager for Southern 1

iii. 1 Investigation Manager from Southern 1 (Lee-Anne Milne) has been seconded to Detailed Arrangements
1 Investigation Manger from Northern 2 (Hayden Mander) has been seconded to Chief Inspector Northern

iv. Investigator from Northern 1 (Jeff Matthews) has reduced capacity due to further education (0.2 down)
2 Investigators from Central 2 (Andrew Sabin Hope and Dipak Makan) have been seconded to Response
1 Investigator from Central 2 (Kim Severinsen) has been seconded to Regulatory Practise

v. 3 Inspectors are acting as Managers (Chris Floyd, Casey Broad, Steve Baddock)
3 Inspectors are seconded (Andrew Sabin Hope, Dipak Makan, Kim Severinsen), all from Central 2
1 Inspector on reduced hours for study leave (Jeffrey Matthews)

vi. 1 Support Officer from Southern 2 (CJ Henderson) has been seconded to a Senior Support Officer for the Chief Inspector Southern
1 Support Officer from Southern 2 has been back filled by a temp (Wendy Thomson)
1 Support Officer is working part time 0.6 (Jenny Fitzwater)

* Management vacancies are currently not being filled permanently as Operations continues to develop its Detailed Arrangements programme.