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WHITEPAPER

The Psychosocial Compliance Playbook

Being inspection-ready for the 1 July 2026 NSW Code, and why most employers aren't.

For **WHS, safety, HR and risk leaders**, with a focus on 50-500-staff organisations in construction, care & NDIS, healthcare, logistics and manufacturing.

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The position most employers are in, and don't know it

A team lead watches a worker go quiet after a near-miss on site. Something is clearly wrong. She does the responsible thing, she mentions the EAP and hands over the wallet card. He never calls it. Three months later he is on stress leave, and a claim is open. When SafeWork asks what the business did about the hazards on that site, the honest answer is: it offered a phone number. **That answer used to be enough to look like care. From 1 July 2026, in front of an inspector, it can read as something closer to an admission.**

Most Australian employers have spent the last few years doing what looked diligent, standing up an EAP, running a wellbeing day, tracking an engagement score. None of it was wrong. But almost all of it answers a question the law is about to stop asking. The new test is not *did you care*. It is: can you prove you found your psychosocial hazards and controlled them, and can your workers confirm it?

WHAT THIS DOCUMENT IS

Not a brochure. A working playbook, the duty in plain terms, the three shifts that change your exposure, and three artefacts you can use on Monday: a self-audit, a worked risk-register, and an inspection-readiness test. We would rather you used these than admired them.

The three shifts, up front

1 Your safety net is your weakest control

Your EAP and your wellbeing day are now evidence, of the lowest-order control you could have chosen. Relied on as your primary response, they can document that you saw a hazard and under-acted.

2 No one has to be harmed

The duty is risk-based, not harm-based. An inspector can act on a documentation gap alone, a missing risk assessment, no control plan, no consultation record, with no incident, no claim, no victim.

3 You've measured the wrong thing

Engagement and wellbeing scores measure sentiment. The duty requires demonstrated control of named hazards. You can hold a glowing score and zero admissible evidence of control.

1 Duty versus enforceability, get this straight first

Almost all the confusion in the market collapses two separate things into one. There is the **duty**, the legal obligation to manage psychosocial risk, live for years. And there is **enforceability**, the mechanism by which an inspector measures your compliance, sharpening on 1 July 2026. Confuse them and you either panic about a "new law" that isn't new, or shrug off a change that genuinely raises your exposure.

WHS Act, the primary duty

A PCBU must ensure, so far as is reasonably practicable, the health and safety of workers. "Health" expressly includes psychological health, not only physical safety. This is the bedrock.

WHS Regulation, the specific provisions

Psychosocial provisions entered the NSW WHS Regulation in 2022 (in force 1 October 2022), now consolidated in the WHS Regulation 2025. They create a specific duty to identify psychosocial hazards and control the risk, and direct you to the hierarchy of controls.

The Code of Practice, how to comply

The SafeWork NSW Code sets out practical guidance: the hazards to consider, the risk-management process, and what reasonable control looks like.

THE DETAIL THAT DOES A LOT OF WORK LATER

The NSW Regulation does not merely say "control the risk." It directs duty-holders to the **hierarchy of controls** and to a defined set of matters, the nature of the hazards, how they may interact, and the duration, frequency and severity of exposure. The preference for higher-order, work-design controls is written into the regulatory scheme itself. Hold that thought; it is the legal spine of Shift 1.

READ THIS TWICE, IT IS THE CRUX

From 1 July 2026 a duty-holder must comply with an approved Code **or manage the risk by another method that achieves an equivalent or higher standard** of work health and safety. The Code becomes the reference point. Depart from it and the onus effectively shifts to you to show your alternative is at least as good, not merely different, and not merely cheaper.

Section 26A is the enforceability trigger, not the source of the duty. It does not create a new offence; it changes how the existing duty is measured. **ISO 45003** is non-binding international guidance, a regulator does not enforce it; aligning with it supports demonstration of due diligence but does not satisfy the duty on its own. And under the WHS Act, **officers** carry a positive due-diligence duty that attaches to the person, not only the entity, which is why this document belongs in a board or risk-committee pack, not only in the WHS team's shared drive.

SECTION TAKEAWAY

You are not preparing for a brand-new law. You are preparing for a **brand-new standard of proof**, applied to a duty you already hold, with personal accountability for officers, and no requirement that anyone be harmed first.

2 Shift one, your safety net is your weakest control

The assumption. Almost every employer holds the same quiet belief: the EAP and the annual wellbeing day are the responsible core of "doing something" about mental health. Budget flows to them because they read as care. The expectation is that when an inspector or a court looks, they count in your favour.

The evidence that breaks it. Work health and safety has always ranked controls by how reliable they are: the hierarchy of controls. The NSW Regulation applies that hierarchy to psychosocial risk and tells you to start at the top. Counselling, resilience training and EAPs sit at the very bottom. They act on the person, never on the work. SafeWork's own guidance treats sole reliance on these lower-order measures as not enough to discharge the duty.

THE SHIFT

Your EAP and your wellbeing day are now evidence, of the weakest control you could have chosen. Relied on as your primary response to a psychosocial hazard, they do not read as diligence. **They read as proof that you identified a risk and then applied the least effective control available to you.** Your wellbeing spend can become the documentation of an under-reaction.

A control at the bottom of the hierarchy asks the worker to absorb a hazard the organisation created. It does nothing to the workload, the roster, the role confusion or the exposure to aggression that caused the harm. So when the harm recurs, and with the cause untouched, it will, the paper trail tells a clean story: the business knew enough to offer a phone number, and chose not to fix the cause.

A PRECISE WORD ABOUT EAPS

An EAP does one narrow job: confidential support for a worker who is already struggling, plus a crisis line. That is a floor, not a strategy. Bought and leaned on as your psychosocial response, it is the weakest control on the shelf, and it leaves the cause of the harm completely untouched. The error is not buying an EAP. It is letting a phone line stand in for the prevention duty, and calling that compliance.

What to do about it

- [ ] **Reclassify, don't rely.** Record any EAP and wellbeing initiatives as *supporting* controls (early intervention / treatment), never the primary response to any hazard.
- [ ] **Name a higher-order control first.** Before any training or app, ask: can we eliminate, substitute, or redesign the work? Document the answer, including why a higher-order control was or wasn't reasonably practicable.
- [ ] **Make the hierarchy visible on the page.** In your risk register, order controls top-down so anyone reading can see work design leads and individual support sits last.

- [ ] **Audit your spend against the hierarchy.** If the majority of your "mental health budget" buys lower-order controls, that ratio is itself a finding, better discovered by you than by an inspector.

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3 Shift two, no one has to be harmed for you to be found non-compliant

The assumption. Enforcement, in most leaders' heads, is a consequence of something going wrong. The felt logic is reassuring: no incident, no exposure. While the team functions and no one is hurt, compliance waits behind the things visibly on fire.

The evidence that breaks it. The psychosocial duty is a duty to manage *risk*, not to mop up harm after it happens. An inspector asks a present-tense question: have you identified the hazards and put reasonably practicable controls in place, measured against the Code? Nothing in that requires a victim. SafeWork NSW does not have to prove an injury occurred to establish a breach.

THE SHIFT

No one has to be harmed for you to be found non-compliant. The trigger is no longer an injured worker, it is the absent evidence. A missing risk assessment, no control plan, no consultation record, no review cycle: **an inspector can act on the documentation gap alone, on an ordinary visit, with nobody hurt and no claim on foot.** The exposure now sits before the harm, not after it.

You are not exposed in proportion to your incidents. You are exposed in proportion to the gap in your system, and that gap exists every single day the documentation is missing. A quiet, well-functioning team with no current psychosocial risk assessment is not low-risk in the eyes of the duty. It is undocumented.

ILLUSTRATIVE, THE VISIT NOBODY PLANNED FOR

A mid-size logistics operator has a clean twelve months: no major incidents, an engagement score trending up. An inspector visits a depot after an unrelated tip-off. They ask three night-shift workers whether anyone assessed the risks of lone work and aggression, whether they were consulted, and how they'd report a problem. The answers are vague. The inspector asks for the psychosocial risk assessment and the control plan. There isn't a current one. No one has been harmed, and an improvement notice is still entirely on the table.

What to do about it

- [ ] **Treat the documentation gap as the live risk.** Ask: if an inspector arrived unannounced this week, which links in the chain are missing? Those are your priorities, in that order.

- [ ] **Stand up the minimum defensible spine now.** A current, dated psychosocial risk assessment; a control plan with owners and dates; consultation records. These three move you out of the "nothing there" category.

- [ ] **Date everything and keep it current.** An undated or stale assessment reads almost as poorly as none. Currency is itself evidence that the system is alive.

- [ ] **Give officers a standing line of sight.** A short, regular, documented assurance to officers is both a due-diligence step and your fastest internal forcing-function.

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4 Shift three, the thing you've measured isn't the thing you must prove

The assumption. Serious organisations measure. So you have an engagement survey, maybe a wellbeing index, EAP utilisation, attendance at awareness sessions, a dashboard trending the right way. The implicit belief: this is your evidence.

The evidence that breaks it. Engagement and wellbeing scores measure one thing: *sentiment*. The duty demands something else entirely: **demonstrated control of specific, named hazards, reached through consultation and kept current through review.** A sentiment score cannot tell an inspector which hazards sit in which teams, what you did about each, why you chose that control, who owns it, or when you last reviewed it.

THE SHIFT

The thing you've spent years measuring isn't the thing you now have to prove. Engagement tells you how people feel. The duty asks what you did about named hazards, and demands consultation and review to back it. **A glowing dashboard and a defensible position are not the same thing, and after 1 July 2026 only one of them is admissible.**

Worse, sentiment data can move the wrong way against risk. EAP utilisation can climb because hazards are getting worse. Engagement can stay high in a team carrying a serious, concentrated hazard, because the people most affected have already left, or because the average drowns out the one crew at acute risk.

What your dashboard proves

"Engagement is 78% and up four points." "EAP utilisation is 9%." "320 staff attended a wellbeing webinar." All real, all worth knowing, and all describing *sentiment and activity*. None of it names a hazard, a control, an owner, a rationale or a review date.

What the duty requires you to prove

"In the intake team we identified exposure to client aggression; we redesigned the layout and added duress alarms (engineering), trained staff in de-escalation (administrative), consulted the HSR on the design, and review quarterly and after every incident." That is control, traceable end to end.

THE REFRAMING TO TAKE TO YOUR NEXT LEADERSHIP MEETING

For every wellbeing metric your organisation reports, ask one question: does this prove a hazard was controlled, or only that people feel a certain way? If it is the latter, and it almost always is, it belongs in **identify**, as a signal. The proof the duty wants lives in the risk register, the control plan, the consultation record and the review log.

5 The hazards you're actually accountable for

The Code identifies psychosocial hazards, factors in the design or management of work, the working environment, or workplace interactions, that can cause harm. They are commonly organised under six categories from the HSE framework: demands, control, support, relationships, role, and change. The categories point at the **source** of the risk, almost always how work is designed and run, not the worker's coping.

THE CLINICAL FRAME AN INSPECTOR SHARES

These hazards rarely act alone. High demands turn genuinely harmful when they combine with low control and poor support, the classic toxic combination. Both a clinician and an inspector look at the **interaction** of hazards over time, not a tick-list of each in isolation. This is why a sentiment average misses them, and why *dose*, frequency, duration, severity, is where the real risk lives.

Demands & control

Hazard	What it looks like	Illustrative sector example
High & low job demands	Workload, pace or cognitive load beyond what's achievable in the hours and resources available, or chronic under-utilisation.	Care / NDIS: support workers carrying caseloads that assume zero travel time, so every shift runs late and breaks are skipped.
Low job control	Little say over how, when or in what order work is done; rigid scripts; no discretion over pace.	Logistics: drivers held to delivery windows set by an algorithm that ignores traffic, loading delays and fatigue.
Emotional demands	Work that repeatedly requires managing one's own emotions or absorbing others' distress, emotional labour as a core, unrelieved task.	Healthcare: ward staff repeatedly delivering bad news and managing distressed families with no structured debrief.

Support & relationships

Hazard	What it looks like	Illustrative sector example
Poor support	Inadequate practical help, supervision, training or backup to do the job safely; isolation when difficulties arise.	Care / NDIS: a new worker placed with a complex, high-behaviour client on their second shift, with no on-call clinical backup.
Inadequate reward & recognition	A sustained imbalance between effort and recognition, skill and reliability that go consistently unacknowledged.	Logistics: warehouse teams who absorb every peak-season surge with no acknowledgement, feedback or adjustment.
Poor relationships & conflict	Persistent interpersonal conflict, incivility or breakdowns in working relationships, left unmanaged.	Healthcare: entrenched friction between shifts that turns every handover into a flashpoint, with no one owning resolution.
Bullying	Repeated unreasonable behaviour directed at a worker or group that creates a risk to health and safety.	Construction: "robust" site banter that has tipped into sustained targeting of an apprentice, normalised as part of the job.
Harassment (incl. sexual)	Unwelcome conduct a reasonable person would find offensive, humiliating or intimidating.	Logistics: a lone night-shift worker subjected to unwelcome conduct, with no clear, safe reporting route.
Violence & aggression	Risk of, or exposure to, aggression or violence from clients, patients or the public.	Healthcare / aged care: reception and frontline staff facing aggression from distressed patients or family as a routine event.

Role, change & environment

Hazard	What it looks like	Illustrative sector example
Role ambiguity	Unclear, inconsistent or shifting expectations about what the job is and where its boundaries sit.	Care / NDIS: after a restructure, coordinators unsure whether case management or rostering is theirs, so both are done badly.
Role conflict	Competing or incompatible demands the worker cannot reconcile.	Healthcare: clinicians told to hit throughput targets and uphold a standard of care the targets make impossible.
Poorly managed change	Restructure, technology or ownership change implemented without consultation, clarity or support.	All sectors: a restructure announced by email with no consultation, leaving teams unsure who they report to.
Remote / isolated / poor environment	Working alone or remotely, or in a physical environment (noise, heat, traumatic material) that adds psychological strain.	Construction / logistics: lone workers on remote sites or long-haul routes with limited contact and no reliable way to raise an alarm.

WHERE THIS MOST OFTEN GOES WRONG

Organisations reliably recognise the dramatic hazards, violence, bullying, and miss the quiet structural ones: role ambiguity after a restructure, chronic high demands with low control, poorly managed change. **Those are the hazards work design causes and work design can fix**, and exactly where an inspector probes.

6 The cycle the duty requires, and what an inspector asks to see

The duty is not met by a single assessment filed once. It demands a continuing cycle: **identify → assess → control → consult → review.** Consultation is not bolted on the end. It runs through every step.

Identify

Triangulate: worker and HSR consultation, psychosocial surveys, and data you already hold (claims, incidents, absenteeism and turnover by team, exit interviews, grievances, EAP utilisation as a signal). *Good looks like:* a dated register of hazards broken down by team/role.

Assess

For each hazard, weigh likelihood and severity, and critically, the frequency, duration and combination of exposure. *Good looks like:* a defensible rating per hazard that accounts for exposure and interaction and names the groups most affected.

Control

Eliminate so far as reasonably practicable; otherwise minimise via the hierarchy, starting at the top. *Good looks like:* a control plan naming the control per hazard, the hierarchy level, an owner, a due date, and the rationale.

Consult & review

The Act imposes a specific, enforceable duty to consult workers. Then review on a schedule and on events (incident, significant change, complaint, HSR request). *Good looks like:* "you said / we did" records plus recorded review dates.

THE MENTAL MODEL: A CHAIN OF CUSTODY FOR RISK

For each significant hazard, can you trace the whole chain, **we found it → we assessed it → we controlled it (and why we chose that control) → we consulted workers → we reviewed it?** An inspection is, in effect, a test of whether that chain is complete, current and documented. A break in any link is the finding.

Evidence	What it must show	What makes it fail
Documented risk assessment	The hazards present, by team/role, with a defensible rating reflecting exposure and interaction.	A generic, undated assessment that could fit any employer; no breakdown by where the risk sits.
Control plan with rationale	The control per hazard, the hierarchy level, an owner, a due date, and why that control was chosen.	A list of "wellbeing initiatives" with no link to specific hazards and no rationale for skipping higher-order controls.
Consultation records	Workers and HSRs consulted before decisions, minutes, survey actions, "you said / we did".	A comms log showing staff were informed, not consulted; surveys run but never acted on.
Review cycle	A defined cadence, recorded review dates per control, evidence controls changed, plus event-triggered reviews.	Assessed once, never revisited; no reviews after incidents or significant change.
Training records	Who was trained, on what, when, especially managers on recognising and responding to psychosocial risk.	Training treated as the control rather than as one supporting control among others.
Officer assurance	Evidence officers receive regular, documented assurance the system works.	No line of sight at officer level; the system lives entirely inside the WHS team.

Inspectors rarely open with paperwork. They start with **workers**: do people know the hazards, were they consulted, do they know how to report, did anything change when they did? Then they ask for the documents that should back up what the workers said. The gap that sinks capable organisations is the one between the system on paper and the system workers actually live.

THE TEST TO APPLY TO YOUR OWN SYSTEM

Could you hand an inspector a single, current package showing the full loop, hazards identified, risks assessed, controls chosen with rationale, workers consulted throughout, reviews completed on schedule and after events? **If any link is missing or stale, that is your priority**, because that is exactly where the chain visibly breaks.

GIVE-AWAY A

Psychosocial self-audit checklist

A working diagnostic across the six categories plus governance. Each item is a yes/no test of whether a control and the evidence for it exist today. Tick only where you could hand an inspector the artefact now; a "no" is a finding.

Demands & control

☐ Workloads assessed for whether they're achievable in the contracted hours, documented.
☐ Where high demands are unavoidable, work-design controls (not just resilience support) are in place and recorded.
☐ Fatigue from rostering, overtime or on-call is assessed and controlled.
☐ Workers have a real, documented avenue to influence how and when their work is done.
☐ A mechanism exists for frontline workers to flag an unworkable target, and evidence it's used.

Support & relationships

☐ Roles with high emotional demands have structured debrief or supervision, with attendance evidenced.
☐ Supervision and practical backup are adequate for the work's risk level, including for new and lone workers.
☐ Managers are trained to recognise and respond to psychosocial risk, with records retained.
☐ A clear, safe, trusted pathway to report bullying, harassment and conflict exists, and workers know it.
☐ Exposure to violence and aggression is controlled with work-design measures, not only post-incident support.

Role, change & environment

☐ Every role has a current, clear description; ambiguity is reviewed after any restructure.
☐ Conflicting or incompatible demands have been identified and reconciled, not left for workers to absorb.
☐ Organisational change is consulted on before decisions, with a documented process and support during transition.
☐ Lone, remote and isolated work is assessed and controlled, including a reliable way to raise an alarm.
☐ The physical environment's contribution to strain (noise, traumatic material) is assessed.

System & governance (cross-cutting)

☐ A current, dated psychosocial risk assessment exists, broken down by team/role.
☐ A control plan links each hazard to a control, a hierarchy level, an owner, a due date and a rationale.
☐ Consultation is documented throughout, not just communication after the fact.
☐ A review cycle exists, with recorded review dates and evidence of event-triggered reviews.
☐ Officers receive regular, documented assurance that the system is working.
☐ Lower-order controls (EAP, training, apps) are recorded as supporting controls, not the primary response.

Worked illustrative risk-register

What a defensible psychosocial risk-register entry looks like in practice. The columns map directly to the chain an inspector traces. A worked example of structure and reasoning, not data from any real workplace.

Hazard	Category / who's affected	Existing controls	Risk rating	Higher-order additional controls (by hierarchy)	Owner / review
High job demands, caseloads assume zero travel time; breaks routinely skipped	Demands · Community support workers (≈18), Western Sydney	EAP available; workload "check-ins" at team meetings	Likely × Major = High	**Redesign:** rebuild caseload model to include travel + admin time. **Substitution:** cap daily client count for complex cases. **Admin:** rostering rule, max 2 consecutive high-demand days; break compliance audited. **Support:** retain EAP as complement only.	Ops Manager + HSR · 3 mths, then 6-mthly; on roster change
Role ambiguity post-restructure, unclear ownership of case mgmt vs rostering	Role · Service coordinators (≈9)	New org chart circulated by email	Likely × Moderate = High	**Redesign:** issue current, signed role descriptions; reallocate rostering to a defined owner. **Admin:** manager 1:1s to confirm understanding; escalation route for grey areas. **Consult:** review roles with affected staff before finalising.	People & Culture Lead · 6 wks, then 6-mthly; on any change

Hazard	Category / who's affected	Existing controls	Risk rating	Higher-order additional controls (by hierarchy)	Owner / review
Exposure to aggression, reception/intake facing aggression from distressed clients	Relationships · Reception & intake (≈12), all sites	"Be respectful" desk sign; incident form exists	Possible × Major = High	**Engineering:** redesign reception layout + duress alarms; barrier where appropriate. **Substitution:** divert high-risk interactions to trained staff/secure channel. **Admin:** de-escalation training (recorded); clear reporting + post-incident support & structured debrief.	Site WHS Lead · Quarterly; immediately after any incident

WHY THIS FORMAT IS DEFENSIBLE

Each row shows the full chain an inspector traces, hazard, who's exposed, what's already in place, an honest rating, additional controls ordered by the hierarchy (work design first, individual support last), genuine consultation, a named owner, and a live review date with event triggers. **In every row the highest-impact additional controls are upstream work-design changes, the EAP appears only as a complement, never the headline.**

GIVE-AWAY C

"Are you inspection-ready?" diagnostic

A one-page test of the evidence an inspector expects. Score one point for each question you can answer "yes" and evidence with a current document today. Be strict: "we're working on it" scores zero.

#	Question (score 1 only if you can evidence it today)
1	**Risk assessment.** A current, dated psychosocial risk assessment broken down by team/role, not a generic template.
2	**Control plan.** Every significant hazard maps to a specific control, with a named owner and a due date.
3	**Rationale.** For each control, we recorded the hierarchy level and why we chose it (incl. why not higher).
4	**Consultation records.** We can show workers were consulted before decisions, minutes, survey actions, "you said / we did".
5	**Review cycle.** A defined cadence with recorded review dates against controls.
6	**Event-triggered reviews.** Evidence of reviews after incidents, change, complaints or HSR requests.
7	**Training records.** Managers are trained to recognise and respond to psychosocial risk, with records retained.
8	**Reporting pathway.** A clear, safe, used reporting and early-intervention route that workers actually know about.
9	**Hierarchy in practice.** Our highest-impact controls are work-design changes, not predominantly training and apps.
10	**Officer assurance.** Officers receive regular, documented assurance the system works.

0-4 · Exposed

You're relying on luck, not a system. Priority order: stand up a current risk assessment, a control plan, and consultation records, in that sequence.

5-7 · Partial

The bones exist but there are visible gaps, most often in consultation evidence, review cycles, or the rationale behind controls. Close them deliberately.

8-10 · Defensible

You can likely demonstrate a functioning, evidenced system. The work now is keeping it current so it doesn't quietly decay into a policy on a shelf.

ONE HONEST QUESTION TO FINISH ON

For your three or four highest psychosocial risks, could you, today, without preparation, produce a current document showing you found the hazard, assessed it, controlled it through work design, consulted workers, and reviewed it? **If the answer is "not quite," you now know precisely what to build, and the order to build it in.**

How Unbound Work can help

The new test rewards demonstrated control of named hazards: work redesigned, workers consulted, harm caught early and treated well. None of that comes from a phone line or a poster. It takes an operator who has actually done the clinical work, across the whole continuum.

Unbound Work is the workplace mental-health arm of Unbound Minds, a multi-site Sydney clinical psychology practice with **32+ employed psychologists**. We help WHS, HR and risk leaders turn these obligations into a defensible, documented system: psychosocial risk assessment by team and role, work-design controls ordered by the hierarchy, consultation that holds up, and a review and officer-assurance rhythm built to be read by an inspector, **evidence that survives an inspection, not engagement metrics.**

Book a no-obligation call →

Disclaimer. This document is general information, not legal or clinical advice. Regulatory references are current to mid-2026 and should be confirmed with WHS counsel for your circumstances. Illustrative vignettes, examples and risk-register entries are constructed for explanatory purposes and do not describe any actual organisation or represent the results of any Unbound Work engagement.

Regulatory currency. The psychosocial duty arises under the NSW WHS Act (primary duty of care, including psychological health) and the WHS Regulation (psychosocial provisions introduced 2022, in force 1 October 2022, now consolidated in the WHS Regulation 2025), read with the SafeWork NSW Code of Practice. Section 26A of the WHS Act makes approved Codes enforceable benchmarks from 1 July 2026, the enforceability trigger, not the source of the duty; departing from a Code requires managing the risk to an equivalent or higher standard. The duty is risk-based: a regulator is not required to prove an incident occurred to establish a contravention. ISO 45003 is non-binding international guidance. Confirm the current text of all instruments with WHS counsel before relying on this summary.