Been there.
~~Done that.~~

A report into New Zealand's repeated health and safety failures.

Business Leaders'
Health & Safety Forum

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Contents

Image credit: Business Leaders' Health and Safety Forum

Foreword

We're concerned.

Following the 2023 Business Leaders' Health and Safety Forum (Forum) inaugural *State of a Thriving Nation* report, which highlighted New Zealand's slow, costly and poor safety progress, the Forum set up an **independent Taskforce**.

The Taskforce brought together a panel of seven experienced leaders, CEOs and directors, to explore where we are going wrong, and to map out a path to improving this country's health and safety performance.

This small team, made up of highly experienced business and industry leaders, drew upon interviews and data from senior New Zealand business leaders and stakeholders to generate five tightly-focused recommendations.

This report makes uncomfortable reading.

New Zealand's ongoing failure to learn and improve safety and health at work is disgraceful.

NZ businesses and workers are not thriving. A worker is almost twice as likely to be killed at work in New Zealand than if they were working in Australia.

Our businesses also need more support from government in order to reduce the burden of unclear direction and guidance.

This is not the first time we've had an opportunity to learn and do better.

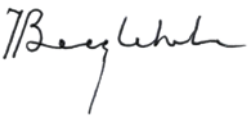
> "Those who cannot remember the past are condemned to repeat it".
>
> **George Santayana**

The New Zealand Government and business have the opportunity to finally do something different and move forward as a country. New Zealand's future must be one in which safety, health and productivity are seen as mutually reinforcing objectives for business and for Government. Without change New Zealand's performance will continue to lag, leading to a chilling effect on business performance and productivity, especially to those considering investing in our country. The Forum believes it's overdue that business and Government purposefully, relentlessly and persistently identify and action collective solutions that are proven, effective and efficient.

These changes don't need to be costly, they just need a government and system players who are willing to understand we're not doing right by our people.

When we do act, we can thrive. The Forum believes the path is clear, and that strategy, regulatory guidance, ownership and action will deliver a better result for New Zealand.

This report would not be possible without the work of the Taskforce members over the past six months. Thank you to: Andrew McLeod (CEO, Northpower); Chelydra Percy (CEO, GNS Science); Jeremy Lightfoot (Chief Executive, Department of Corrections); Mike Bennetts (former CEO, Z Energy); Stacey Shortall (Partner, MinterEllisonRuddWatts) and Susan Huria (Chair, Leaderbrand and associated entities).



Taskforce Director
Toby Beaglehole

Forum CEO
Francois Barton

1. Executive summary

In the six years since it was launched, the Government's 2018-2028 Health and Safety Strategy (the 2018-2028 Strategy) has seen no action plan or implementation.

This stalled progress, combined with an absence of regulatory clarity and a lack of accountability through inadequate coordination and action across government agencies and industry, is unacceptable.

The Forum's March 2024 survey of its CEO members concluded that 90% wanted the Government to prioritise improvements to New Zealand's health and safety performance.[1] To add to this, the Taskforce's interviews of 30 senior business leaders and stakeholders from December 2023 – March 2024 found widespread frustration with safety performance and the absence of central guidance.

All of us know the cost of New Zealand's workplace harm is significant, and avoidable. The Forum objectively quantified the cost at $4.4 billion for 2022.[2] Lifting our standards to that of Australia would save New Zealand $1 billion per annum. The quantifiable financial argument for safety improvements is irrefutable.

New Zealand's lagging performance is also not a recent trend – our workplace fatality rates have barely shifted in the last decade whilst comparators like Australia and the UK have continued to improve their performance. Our failure to learn is stark – the 2013 Independent Taskforce's report on Workplace Health and Safety could have been written today.

We need intervention to redress this shameful performance, keep workers safer, and reduce avoidable confusion for employers.

Too much bureaucracy becomes counter-productive and makes things worse, as we see in the abundance of road cones across traffic management in New Zealand. But with clarity from the regulator, and an engaged and collaborative approach, New Zealand businesses can be set up for success and have the capacity and capability to deliver genuine leading practices.

We need the commitment and resilience to implement what we've seen work overseas. The path to reforming and improving the health and safety of New Zealand workplaces lies with a robust, sustained and coordinated commitment across government and business to implement what is proven, tested and easily replicated from elsewhere.

It became clear through our work that New Zealand has been here and done this before, and apparently learned little from it.

The Taskforce was set the job of reviewing the reasons for New Zealand's chronically flatlining health and safety performance. Our analysis identified three key barriers the Taskforce believes are holding us back as a country:

1. There remains no credible national strategy to align, coordinate and focus New Zealand's finite resources to drive sustained reductions in harm, nor is there any organisation or group taking proactive and accountable "oversight" for our national performance.
2. There is a lack of regulatory clarity for too many business about what's expected of them, resulting in an unhelpful and ineffective combination of businesses either duplicating "performative safety" efforts or taking no actions at all.
3. The incentives and sanctions for health and safety performance are confused, variable and inconsistent, to achieve sustained and focused motivation and implementation by businesses to meet their responsibilities to keep workers safe, healthy and productive.

1 Business Leaders' Health & Safety Forum, "Have Your Say Survey", March 2024.

2 *State of a Thriving Nation* Report – inaugural report.

This Taskforce report makes **five key recommendations** under these three key areas, which cannot be ignored if we're to change the health and safety trajectory we're on as a country. They will also ensure those doing the important mahi in our country are better protected by clearer guidance and strategy to support and direct the businesses they work for.

1.1 A refreshed strategy that is implemented

The 2018-2028 Strategy has not been enacted, nor have the required action plans been put in place. For the 2018-2028 Strategy to be effective, there needs to be strong and purposeful ownership, ongoing measurement, governance oversight and clear allocation of accountabilities.

The Taskforce recommendation is to:

1. **Rewrite and relaunch** the 2018-2028 Strategy, including both implementing comprehensive governance and a three-year action plan to capture and ensure progress, including the two recommendations below.

Image credit: Business Leaders' Health and Safety Forum

1.2 Focused regulation to deliver gains to employers and workers

Some regulations have only been partially implemented and lack codes of practice or safe work instruments. Businesses are getting little, if any, insight from the regulator about what "good" – let alone "best" practice looks like. Deliberate focus is needed on describing and implementing core regulations and regulatory instruments to deliver clear and concise guidance and expectations.

Regulatory change is too slow and doesn't keep pace with actual practice. This impedes businesses' ability to implement safe practices efficiently as the lag can be years long. A streamlined and swift regulatory process is needed to speed up simpler and crisper implementation. The issue is not the quantum of resource, it is where it is allocated. The Ministry of Business, Innovation and Employment (MBIE) needs to increase policy resourcing to enable timely regulatory oversight and implementation.

Enforcement is sporadic and offers little by way of cautionary lessons, instructive examples or useful case law. Businesses are receiving inconsistent signals on what behaviour will be permitted and what behaviour will be sanctioned. Poor safety performance often goes unaddressed, and boundaries are unclear or inconsistently enforced.

The Taskforce recommendation is to:

2. **Review and implement** priority regulatory changes to ensure the most appropriate mix of regulations, codes and guidance to clearly specify businesses' accountabilities and expectations.
3. **Apply** the rules clearly and fairly and oversee them expertly to ensure poor or negligent business practices are consistently held to account, and leading performance is incentivised.

1.3 Embed ownership and accountability

There is an absence of ownership of New Zealand's health and safety performance. Central coordination across the relevant agencies is inadequate. MBIE, Accident Compensation Corporation (ACC) and WorkSafe NZ's actions and accountabilities are not integrated or well coordinated. This means opportunities are being left on the table, and known barriers are going unaddressed.

There are critical system levers, including enforcement and guidance, and opportunities, such as collaboration with industry and sharing data, that remain underutilised. Industry will engage to develop codes of practice and play more of a role – which is made possible when Government agencies are actively playing their role too.

The Taskforce recommendation is to:

4. **Establish** an independent oversight function of the 2018-2028 Strategy, incorporating a small group of industry leaders and workers to ensure progress and momentum for improving New Zealand's health and safety performance.
5. **Establish and maintain** a coherent, credible and current body of government and industry data and insights to inform and focus WorkSafe NZ and business health and safety efforts.

We believe this work can be initiated and executed within six months. Remedying poor performance is not complicated; neither is it resolved by a once-over-lightly approach. It will require a system reset with deliberate interventions as outlined in this report. This will ensure we have a fit-for-purpose system of oversight, guidance and ownership that is commensurate with a first-world economy and delivers the health and safety we all expect at work.

2. Introduction

The Business Leaders' Health and Safety Forum is an independent coalition of business and government leaders committed to improving the performance of workplace health and safety in New Zealand.

The Forum was launched in 2010 by Prime Minister John Key with just under 100 members, and has now grown to more than 400 members who are CEOs, managing directors or country heads of New Zealand organisations.

Our vision is leaders building cultures that enable people and businesses to thrive.

That vision cannot be realised if New Zealand's health and safety performance, strategy, and accountabilities are not being strongly led and well coordinated.

2.1 Taskforce formation and approach

The Health and Safety Systems Taskforce was established by the Forum in November 2023, with the following scope:

To review the reasons for flatlining performance, with a focus on the critical guiderails provided by regulations and regulatory posture.

This included understanding the legislative framework (i.e. Health and Safety at Work Act 2015 (HSWA), regulations and guidance), regulatory implementation (i.e. mainly WorkSafe NZ's performance), and strategic and system alignment (i.e. national action plan, system targets and accountability, effective oversight, connection across other functions such as immigration, employment practices and infrastructure).

To make recommendations to increase the effectiveness of the regulations, the enforcement thereof and the performance of the wider health and safety system.

By bringing together highly experienced business and industry leaders from a variety of backgrounds and disciplines, the Taskforce was charged with exploring the issues facing health and safety performance from a variety of angles.

To supplement Taskforce knowledge, and allow deeper lines of enquiry, the Forum Chief Executive and Taskforce chair conducted interviews with over 30 stakeholder representatives, focused on CEO and leadership team input. These included government agencies, large and medium-sized corporates, and various not-for-profit organisations and industry bodies. We specifically sought to understand the impacts of regulation and policy on contractors and sub-contractors, and to explore how central policy decisions played out at the front line.

Finally, the Forum itself added Taskforce-specific questions to its annual survey of members, for which 130 responses were received that has further informed the findings, recommendations and conclusions in this report.

This combination of Taskforce oversight, targeted interviews and a broad industry survey has been supplemented by the existing economic analysis from the Forum's inaugural ***State of a Thriving Nation*** report, regulatory review, detailed case studies and analysis of overseas[3] and New Zealand health and safety reviews. This, supplemented by the considerable knowledge and expertise the Taskforce brought to the table, has generated a tightly-focused set of recommendations that will deliver better outcomes for workers and employers alike.

The Taskforce focused on two areas of concern: implementation of the health and safety legislative framework, where stalled regulations are already causing widespread frustration; and the effectiveness of the 2018-2028 Strategy, where documented intent is not being matched with any action.

During the Taskforce's work, however, two more facts became apparent. First, there was no stakeholder arguing that the country's health and safety performance was going well. Secondly, we have been here before with previous reviews, yet apparently done little to apply those learnings.

The Business Leaders' Health and Safety Forum, and this Taskforce, acknowledge and thank those who gave generously of their time and insights in support of better health and safety outcomes for New Zealand workers and employers.

3 Including the NSW Auditor-General's Report on the Effectiveness of SafeWork NSW, February 2024.

3. Findings

3.1 Failure to learn

The 2013 Independent Taskforce's report on Workplace Health and Safety could have been written today. The 2013 report identified that:

1. New Zealand poorly implemented the Health and Safety in Employment Act 1992 with insufficient follow through to develop appropriate regulations, Approved Codes of Practice (ACoPs) and guidance.
2. The primary regulator (then Department of Labour) had not been resourced to provide sufficient guidance for those wanting to do the right thing or sanctioning those who do not.
3. There was poor alignment and coordination across agencies tasked with injury prevention.

The Forum Taskforce likewise observes that today:

1. New Zealand has poorly implemented HSWA 2015 with insufficient follow through to develop appropriate regulations, ACoPs and guidance.
2. The primary regulator (now WorkSafe NZ) has been better resourced, but has still failed to provide sufficient guidance for those wanting to do the right thing and sanction for those who do not.
3. While the legislatively required 2018-2028 Strategy for health and safety at work exists, an implementation plan and measurement of delivery and progress with key measures like fatalities remain absent.

Image credit: Business Leaders' Health and Safety Forum

3.1.1 How are we still here?

New Zealand has a history of poorly implemented health and safety reform. Changing that is our opportunity. We have tools available that we have not used, and overseas examples, particularly in Australia and the UK, that we have not heeded.

Since the 1970s, both Australia and UK have developed and improved their national approach to health and safety, underpinned by some core principles and mechanisms (widely referred to as the Robens Model).[4] In 1992, New Zealand adopted the Robens Model as our national approach to health and safety via the Health and Safety in Employment Act. That adoption signified the potential for improvements to health, safety and productivity for employers and workers alike.

However, MBIE has proven to be insufficiently muscular, openly acknowledging that progress has been inadequate in its 2023 Briefing to the Incoming Minister (BIM): *"an outdated and incomplete regulatory system"* which *"is creating uncertainties and inefficiencies for businesses and the regulator".*

For a regulatory function, which is critical to the safety of New Zealand's workforce, this simply isn't good enough.

> "MBIE's policy function has been grossly under resourced, resulting in it taking so long to achieve so little, as there are simply too few people working on key elements. There needs to be more curiosity about what works – we've seen nothing on the policy agenda to review post HSWA implementation to understand what has worked and what hasn't."
>
> **Senior health and safety researcher and leading safety and governance expert**

New Zealand's health and safety performance has consistently and persistently lagged behind the UK and Australia, from whom we modelled our health and safety approach (*State of a Thriving Nation* provides more detail on comparative performance). Lifting performance is not just about competing with other countries, it's about New Zealand applying a proven model in service of healthier work and a more productive workforce.

4 Safety and Health at Work, Report of the Committee 1970-72, Chairman, Lord Robens.

3.1.2 Pike River was a painful opportunity to learn

Pike River was a painful moment of truth for New Zealand, a wakeup call resulting from a tragic, systemic failure by all parties. The Independent Taskforce on Health and Safety established that our high rates of harm were in large part the result of never properly implementing the key components of the Robens Model, which delivered sustained improvements in the UK and Australia.

Those insights were accepted by the government of the day and directly informed their health and safety reforms between 2013-16, to ensure those key components were implemented fully.

> "This reform includes an overhaul of the law to provide clear, consistent guidelines and information for business, additional funding to strengthen enforcement and education with a focus on high-risk areas, and better coordination between government agencies."
>
> **Minister of Labour, Hon Simon Bridges 2013**

While some of those components have been implemented, many have not. The Taskforce's evaluation is as follows:

Area	2013 Taskforce Report recommendation	Status today
Legislation	Rationalisation of the plethora of highly prescriptive, sector-specific occupational safety and health legislation.	**Partially implemented** There remain a wide range of sector-specific Acts, regulations and enforcement bodies.
Guidance	Under a Robens Model, core principles should be set out in legislation, supported by more detailed regulation, ACoPs and guidance.	**Not implemented** While a high-level or "light" framework has been applied, the absence of guidance leads to business confusion.
Accountability	Establish a new workplace health and safety agency with a clear identity and brand, and statutorily defined functions. It should be constituted on a tripartite basis, including an independent chair and members reflecting the interests of workers, unions, employers and iwi. The new agency should have primary responsibility for workplace harm prevention, including strategy and implementation.	**Partially implemented** Board doesn't reflect recommended structure. Responsibility for strategy and implementation is unclear/ineffective.
High quality data	Robust, comprehensive and integrated workplace injury and disease data collection, monitoring and reporting system, an effective data collection and management system ensures the timely identification of signals and trends.	**Partially implemented** Data remains a weak point in safety management, being largely reactive and backward looking.

3.2 The Forum's analysis

3.2.1 *State of a Thriving Nation*

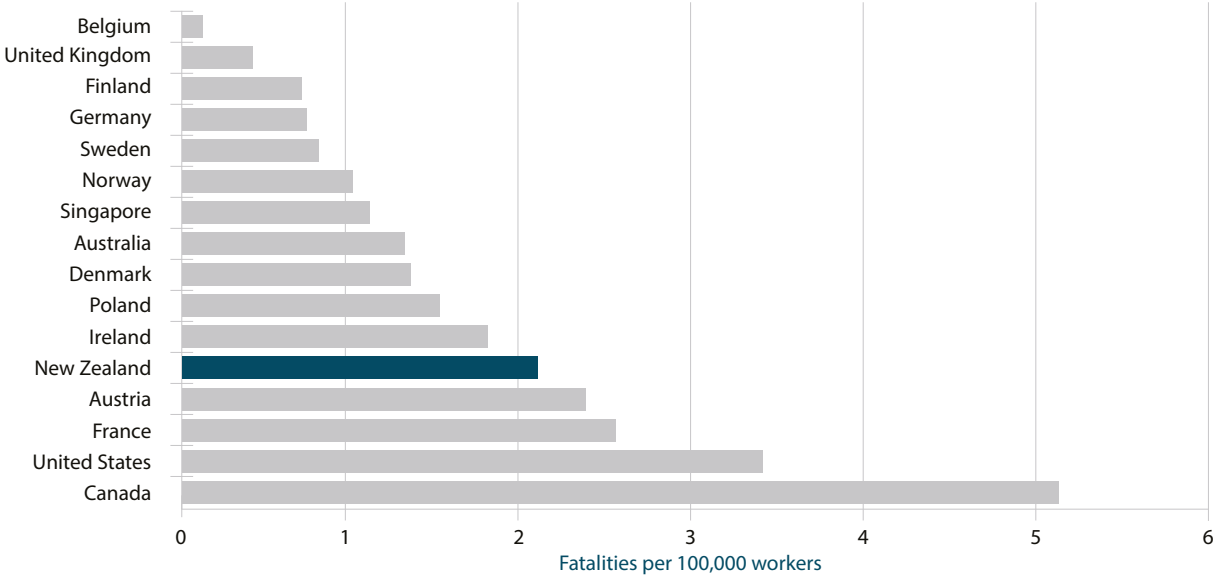
The Business Leaders' Health and Safety Forum's inaugural *State of a Thriving Nation* report in 2023 provided clear and objective evidence that New Zealand's historical health and safety performance continues to flatline, while the UK and Australia continue to improve.

The cost of New Zealand's failure to implement properly the internationally demonstrated and officially acknowledged components of a coherent national approach to health and safety at work is conservatively $4.4 billion. If we were able to replicate Australia's per capita performance, that cost would be reduced to $3.4 billion. These economic costs do not include the many indirect costs to lost productivity, social impacts and burden on our health system.

The Forum itself will continue to run the *State of a Thriving Nation* report annually, as a way of reflecting on and measuring progress.

Figure 1

Workplace fatality rate: International comparison (2021 or latest)



Source: Forum's *State of Thriving Nation* report, August 2023

Graph Data Source: ILO, WorkSafe Australia, WorkSafe NZ, Sense Partners

3.2.2 Sentiments from the Forum's 400+ CEOs

When the Forum surveyed business leaders in March 2024, 90% of respondents wanted the Government to prioritise improvements to New Zealand's health and safety performance.[5] This is consistent with the overwhelming feedback from interviewees that deliberate action is required to improve our safety performance.

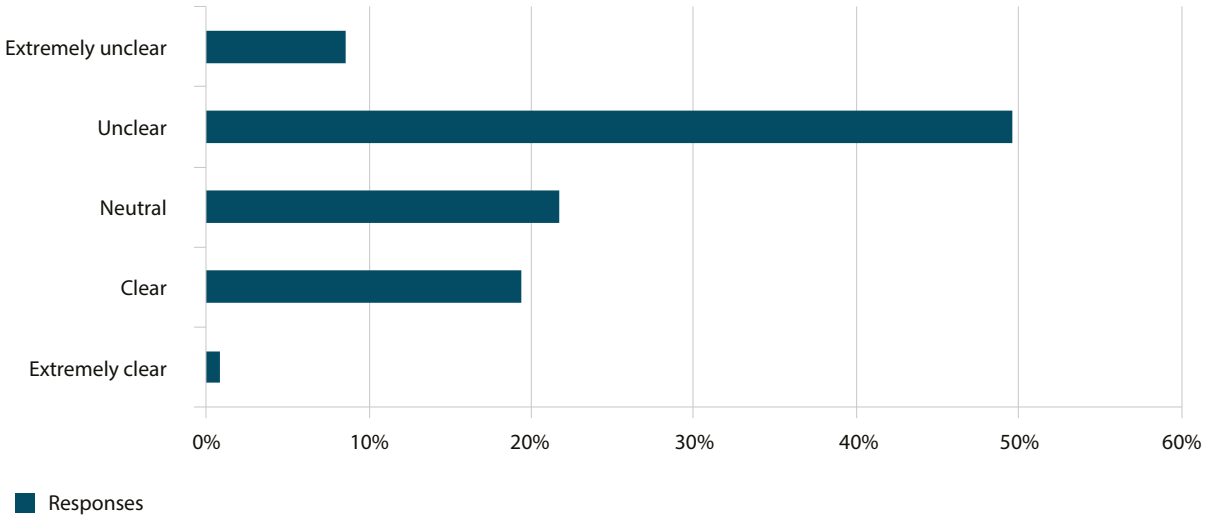
Close to 60% of members were also unclear or extremely unclear about New Zealand's national plan of action around health and safety.


Image credit: Business Leaders' Health and Safety Forum

Figure 2

How clear are you on New Zealand's national plan of action and priorities for improving health and safety?

Answered: **129**



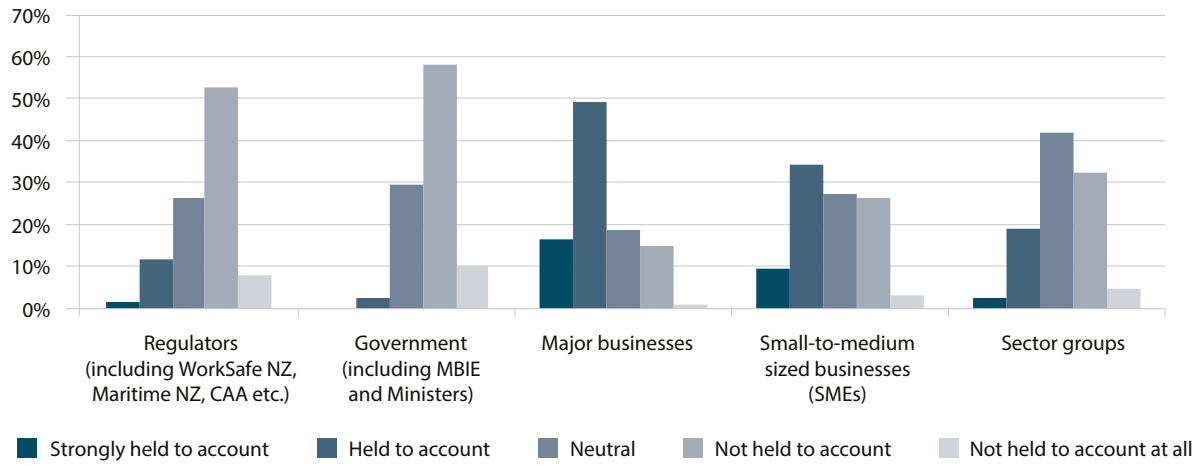
Source: Forum CEO member survey, March 2024

5 Business Leaders' Health & Safety Forum, "Have Your Say Survey", March 2024.

Figure 3

Forum CEO survey: How well are the following organisations and wider ecosystem being held to account for health and safety performance in New Zealand?

Answered: **129**



Source: Forum CEO member survey, March 2024

Members were also asked to rate how well regulators, government and the wider ecosystem were being held to account. Government, closely followed by regulators, rated the highest as not being held to account.

At the same time, the Forum asked non-member industry colleagues their thoughts. Their 130 responses showed almost identical results.

This Taskforce report therefore calls for coordinated public and private sector effort, in service of simple and clear regulation focused where it's needed, a strategy that is owned and implemented, and deliberate central oversight to make sure and to be accountable for that work getting done.

3.3 A national strategy – not implemented or effective

Under the Health and Safety at Work Act 2015, the Minister is required to publish a national strategy that outlines the Government's overall plan for the direction for improving the health and safety for workers in New Zealand. This can be amended and updated at any time.

The current strategy is *The Health and Safety at Work Strategy 2018-28*. Australia has a similar requirement, and its current national strategy is the *Australian Work Health and Safety (WHS) Strategy 2023-2033*. The UK's primary regulator, the Health and Safety Executive UK (HSE UK), outlines their national direction through – *Protecting People and Places – HSE Strategy 2022-2032*.

While each of these strategies share some common elements – *vision* particularly, there are specific and significant differences in how the Australian and UK strategies translate their vision and direction to more forward-looking actions outlining what and how that happens. In short, the Australian and UK strategies are clearer and more coherent in their respective:

- Vision – a deliberate statement of purpose and intent
- Clarity and targets – specificity around good performance metrics
- Collaboration – ensuring government and business are working together
- Ownership and accountability – defining who is delivering what outcomes
- Credibility – an integrated whole that creates confidence and clarity.

While New Zealand's strategy for health and safety at work exists, an **implementation plan and measurement of delivery and progress with key measures like fatalities remain absent.**

3.3.1 Comparative implementation – New Zealand, Australia and the UK

Strategic elements	New Zealand	Australia	United Kingdom
Vision	✓	✓	✓
Clarity and targets	?	✓	✓
Collaboration	✓	✓	✓
Ownership and accountability	✗	✓	✓
Credibility	✗	✓	✓

✓ = **Strong** ? = **Weak** ✗ = **Absent**

3.3.2 Gaps and deficiencies

The 2018-2028 Strategy falls short in comparison in critical terms relating to vague articulation of what it wants to achieve, and no targets for change. Whilst clear that actions will be required by many, it is effectively silent on where the ownership and accountabilities sit for those actions to occur.

> "Safety is the outcome of many components – including systems, infrastructure investment, definition of competence, training commitment and more. What's not clear in New Zealand is who is looking at the whole? This needs to be a joint exercise with industry and government."
>
> **Chief Executive, multimodal public transport provider**

3.3.3 Implementation and action

The 2018-2028 Strategy outlined commitments to develop a detailed action plan and to establish some form of oversight group (for 2019). Neither of these actions appear to have occurred. At the same time, New Zealand's rates of harm have continued to flatline.

The absence of an action plan and clear accountability for implementation of the 2018-2028 Strategy is glaring. The strategy was supposed to deliver an action plan in 2019, to be refreshed every two to three years, and annual dashboards added from 2020 onwards. That these haven't happened doesn't make the 2018-2028 Strategy a bad strategy – it makes it a "wish" or a strategy without a plan.

Further, there has been no accountability for the absence of that action plan, nor any group or mechanism established to drive the intended outcomes.

3.3.4 Accountabilities not exercised

MBIE is the formal owner of the 2018-2028 Strategy. In the strategy, accountabilities or "roles to play" are allocated for large and vaguely defined groups ("government, business, workers, sectors"), and the nature of those roles are devoid of detail.

This absence of detail might be excusable if the execution of the strategy filled in the gaps. But it has not, and we are now six years into the nominal delivery period.

Effectively, the strategy pitches workplace safety as something that everyone has an equal obligation to enact and an equal ability to have an impact. That is not the case. Government agencies, and particularly regulators, have levers that no-one else can pull to improve health and safety outcomes at work.

Further, there are a wide array of regulators and regulations applying to health and safety, including 13 Acts outside HSWA 2015. The full list is tabulated at *Appendix one* and covers 17 sets of regulations under those other Acts, as well as the 14 sets of regulations relating to HSWA 2015 along with their approved codes of practice, safe work instruments and other relevant regulatory instruments. This complicated framework needs to be rationalised to make it manageable for regulators and understandable for business.

3.4 Regulation – poorly implemented and unresponsive

Regulation provides parameters, boundaries and guidelines within which business can safely operate. Excessive regulation can impede business operations, and inadequate regulation creates uncertainty and excessive cost as employers are forced to repeatedly fill the gaps. Our assessment is that New Zealand has long suffered from unclear regulation for health and safety.

> "The Regulatory context, the allocation of resources and the resulting focus provides a signal to business around what matters and what good looks like. In the absence of regulatory clarity in New Zealand currently, that signal is missing."
>
> **Chief Executive of a New Zealand-based multinational major hazard operation**

In the 2013 Independent Taskforce Report, the authors noted: *"The performance-based Robens Model for health and safety legislation, which underlies the existing legislation, is sound. The framework provides a flexible architecture for achieving and maintaining high standards of health and safety performance without choking industry and innovation through high compliance costs."*

The tools are there, however too many agencies are failing to use the tools available to them appropriately. Those tools can work – Maritime NZ have made progress and demonstrated influence, by having a range of voices at the table, and bringing together worker perspectives, company data and regulator data to build a complete picture. Regrettably, this is the exception not the rule.

In an effective regulatory environment, all activities of regulatory authorities should:

- be clearly focused on the underlying regulatory objectives
- represent the course of action(s) that is likely to achieve these objectives in the most effective and efficient manner
- be integrated and aligned, that is, they work towards common purposes and objectives, and they are flexible and innovative, in order to achieve the best regulatory outcome in the particular circumstances of each case.

MBIE provides specific guidance on how New Zealand's regulatory system is designed to operate, noting health and safety as one of 17 regulatory systems that MBIE administers. It's hard to say how well that administration is going because the last assessment of the system's fitness for purpose was carried out in August 2017 – by MBIE itself.

What we do know is that health and safety regulation is languishing. Plant and structure regulations have been circulating since 2019. Hazardous substances regulations are queued up behind them. Both sets of regulations are sorely needed by businesses and will deliver much needed clarity about safe work practices.

The result is that we find ourselves in a situation where:

- some regulations have only been partially implemented, and lack codes of practice, guidance or safe work instruments to help interpret regulatory expectations
- regulatory change is too slow and doesn't keep pace with progress and actual practice. This impedes businesses' ability to implement safe practices efficiently as the lag can be years long, with the result that some required regulations have not been implemented at all
- there is an absence of demonstrable oversight of the framework of regulations and guidance, to ensure gaps are filled, guidance is accurate and up-to-date, good safety behaviour is defined and poor safety behaviour is addressed.

> One industry partner put it to us plainly "there's fairly generic macro-regulation then hundreds of pieces of legacy regulation that are the daily reality for operators, like the 1962 spray painting regulations."
>
> **Employment policy expert**
> **Business Association**

These concerns are also clear in MBIE's Briefing for the Incoming Minister (BIM) in which the Ministry acknowledged the health and safety legislative system is *"an outdated and incomplete regulatory system"* which *"is creating uncertainties and inefficiencies for businesses and the regulator, in areas of risk that significantly contribute to ongoing work-related harm."*

Furthermore, the Ministry stated *"The HSW Act is performance based – it specifies an outcome (ensuring the health and safety of workers and others affected by the conduct of the work) but not how a business must achieve this. This is the role of regulations, which provide more certainty on how the business can comply with the primary duty of the Act in their specific situations. The lack of regulations for some circumstances, and the continued reliance on outdated regulations (some dating from the 1970s), is creating unnecessary costs to businesses and the regulator".*[6]

> "Who sets the standard? WorkSafe NZ seem to be struggling with their role and who sets the standard, leading to misconception and misunderstanding."
>
> **Senior health and safety executives from energy, construction and telco sectors**

The net result of this regulatory context is confusion, inefficient, costly duplication and harmful (and sometimes tragic) gaps around what it is businesses need to do to keep people at work safe and healthy.

In an area where absolute clarity of strategy, intent, execution and practice is critical, we lurch between an absence of definition, and overprescription – a case in point and working example is road cones.

> "We know following Pike River that performance-based regulation works for [the] big end of town but not for SMEs who need clear guidance on what good looks like."
>
> **Senior health and safety researcher and leading safety and governance expert**

6 Ministry of Business, Innovation and Employment, Briefing to the Incoming Minister for Workplace Relations and Safety, November 2023.

Traffic management example

The 'sea of cones' around roadworks. It's something we're all familiar with and which has, together with the escalating costs of traffic management, featured in the headlines a lot over the last year or two. We hear about cones and speed limits in place where no work appears to be going on, much to the frustration of motorists. Workers turning the stop/go signs – sometimes wearily, sometimes cheerily – clad in hi-vis vests that are the same colour as the cones, allowing them to blend in nicely.

These workers bear the brunt of the frustration of drivers, who are unaware of the reasons behind these controls. Abuse and assaults of road workers has become a significant concern.

How did we get here?

For many years temporary traffic management (TTM) has been based on a code of practice (CoPTTM) issued by the New Zealand Transport Agency (NZTA). The core of this document (sections A to H) is 567 pages long. Sections I and J add hundreds more. It is a highly detailed and prescriptive document.

Contractors need to have their traffic management plans approved by Road Controlling Authorities (RCAs) before work starts. RCAs are, essentially, NZTA or local councils depending on who is responsible for the particular road, with councils often imposing their own additional requirements. While TTM specialists design the plans, the road workers who implement them may be moving reasonably frequently between different locations subject to different RCAs and so different interpretations.

One of the stated intentions of CoPTTM was *"to improve the standard of TTM in New Zealand through consistency of application."* Given that every piece of road, every intersection and every project is different, this was a significant challenge, as acknowledged by another stated aim, *"to manage the increasing incidence and variety of activities that are being undertaken on the road"*. This led to ever-increasing requirements specifying what to do in each conceivable situation, from what signage to use, what speed limits to set and how far apart cones should be, to what colour and reflectivity was required on hi-vis. 567 pages later, we had a 'guide' that was impenetrable to all but the most dedicated specialist.

Auditors would check implementation, often with more of a focus on compliance with the code than achieving an outcome of safer workers or road users.

In attempting to provide exact guidance for every possible situation, it becomes necessary to establish a baseline that covers a majority of cases. This inevitably means that the baseline is more than is strictly necessary for smaller, lower risk situations, or simply unachievable in others. The outcome is a 'health and safety gone mad' approach where blanket rules make little sense. A company may require their workers to wear hard hats at all times. This is easy to enforce but seems unnecessary when there are no overhead hazards on a particular site. In some instances, blanket rules make things less safe – a requirement to wear gloves to prevent cuts can reduce dexterity and increase the chance of making a mistake that may be a much higher risk than the cut.

When rules seem nonsensical, people either ignore them when they can, or get frustrated when they have no choice but to comply. There were often good reasons why road cones and speed limits were in place (e.g. to protect damage to newly finished road surface). Drivers didn't know this, though, and got frustrated. Some informational signage explaining what is happening may have alleviated some of this, but CoPTTM limited what signs were allowed.

In the end, as noted TTM involved a very prescriptive approach that attempted to cover every situation, resulting in a process so convoluted hardly anybody could use it. There were hundreds of pages to manage a single principal hazard – traffic and the potential for vehicle impact. This was overseen by a number of different RCAs with varying requirements and processes that changed according to who was responsible for the road. The workers having to implement the plans had to slavishly follow what was written down, even if it seemed not to be the best way of doing things in that location at that time.

What did that mean?

This system intended to provide strong safeguards. More road cones doesn't equate to more "safety". For a short job, it could take longer to set up the traffic management than it did to complete the work – significantly increasing both time and cost of the maintenance, but also exposing the workers to traffic for longer and increasing the risk. Costs increased dramatically. Restrictions on allowable working time meant that traffic restrictions were in place for far longer.

As Cos Bruyn, MD of Fulton Hogan noted in an article, *"…injuries to our employees working in the road corridor and exposed to public traffic are not reducing."* The TTM system was missing the mark.

Companies were responsible for their teams working in the road corridor, but had no leeway or flexibility to approach management of the hazard in the way they thought best.

All of which added up to the sea of cones, the negative coverage and a dissatisfaction that spilled over into abuse and violence, possibly creating greater risks than it solved.

What to do?

Much of the above is in the past tense. CoPTTM is in the process of being replaced by a new guide – the New Zealand Guide to Temporary Traffic Management, currently being trialled. This takes a more risk-based approach. It guides the user through a risk management process to understand the particulars of the situation and provides categories of control types to consider using. It's supported by a library of more detailed user guidance. And it comes in at less than 100 pages. Still a lot, but much easier to navigate and use.

Lessons

In complex environments, there are too many factors to try to control everything. Each time something new comes up it gets thrown onto the pile of rules that gets bigger and bigger. Too much bureaucracy becomes counter-productive and makes things worse. Far better to clearly articulate the outcomes you are looking for and provide the tools to make that achievable in ways that are suitable for the local circumstances.

Lack of clarity through sheer volume is only made worse by numerous and differing agencies responsible for oversight. System players need to work together to develop a clear vision of what is required. They also need to provide usable and flexible guidance on how to implement that and a sensible and proportionate regime for oversight and maintaining standards. Then we might have safer workers, less costly traffic management and happier road users – winning on all fronts.

Case study developed by Craig Marriott (Craig Marriott Consulting).

Image credit: Unsplash, Eduardo Soares

3.5 Ownership – absence of central coordination, ownership and application

If the 2018-2028 Strategy tripped as it left the starting blocks, it is perhaps no surprise that the system has failed to respond to the vision and direction that it articulates.

3.5.1 Absence of ownership

The absence of national level ownership by Ministers and the relevant government agencies for ongoing health and safety improvements is a fundamental flaw in New Zealand's approach.

Too often, "the system" is blamed, effectively attributing failure to an unspecified, underfined, intersection of responsible parties, none of whom can be individually held accountable.

> "Despite what's happened over the last decade or more, we are still not addressing complex issues with systems thinking. We don't even agree on what the system looks like, let alone how we influence it, or whose job it is."
>
> **Senior health and safety researcher and leading safety and governance expert**

We see an example of this in New Zealand's response to the ongoing fatalities and serious harm caused by quad bikes. The official data tells us that in the last 13 years there have been almost 700 serious harm notifications – running at an average of 55 per year. In May 2019, WorkSafe NZ issued a strong recommendation that a crush protection device be installed by quad bike operators.

Then in late 2023, quad bike fatalities made a more sustained appearance in the headlines with the grim news of "Four Deaths in Four Weeks" impacting the communities of Marokopa, Eketahuna, Stratford and Ohauaiti. This capped a two-year period with 19 reported quad bike deaths.

The calls for change have been led by Safer Farms, a membership-based sectoral safety organisation. It seems the obligation to address poor performance in this area, as in many others, will fall on membership-based sectoral safety organisations.

The existence and growth of such membership-based safety advocates is a genuinely positive improvement. But these groups require demonstrable and coordinated support from other players bringing their unique capabilities to the challenge, such as strong leadership and effective and clear guidance from the regulator, and adequate, sustainable funding.

Ownership of strategy is about clearly articulating what the future looks like and why it is important. Without that ownership, these groups' collective effectiveness is inhibited and risks becoming a stopgap, filling the vacuum at the centre of the 2018-2028 Strategy.

3.5.2 Inadequate central coordination

Our system of health and safety also suffers from inadequate central coordination, central leadership and orchestration. MBIE, ACC and WorkSafe NZ's roles are not integrated in support of delivering improved health and safety outcomes.

For the most part, those we interviewed saw a lack of leadership and ownership of the system, and a tendency for agencies to point to overlapping responsibilities as a justification for adopting a passive posture. Accordingly there was little collaboration between central agencies, rather the absence of coordination has led to delays, hold-ups, or no progress at all. In a survey of business leaders conducted by the Forum, just 23% of respondents agreed or strongly agreed that "there is clarity about the role and responsibilities of the major system players in health and safety in New Zealand (business, regulator, government)".[7]

In a similar vein, just 14.4% of respondents considered regulators were held to account[8] versus 65% of major businesses being held to account. Comments included "we are in a health, safety and wellbeing desert". WorkSafe NZ was described as only telling industry what is being done wrong, without providing information, advice or assistance. The one bright spot that recurs in feedback is the positive remarks about how the regulation around Major Hazard Facilities (MHFs) is clear on focus, communication and capability. As illustrated by the Methanex example described on page 26, an approach that seeks wide involvement in risk management, mitigation and awareness is particularly effective at these complex facilities.

In the words of one interviewee: "A structured health and safety system would be able to respond because roles and responsibilities would be clear. Collecting and analysing international evidence and domestic evidence would be automatic. While WorkSafe NZ can say that 'those who create the risk have to manage it', we also need to be clear on whose job it is to clarify and share what constitutes an effective and acceptable intervention. What does it say about New Zealand's approach to health and safety, to ongoing fatalities from known risks, that we don't have a team committed to assessing and ensuring implementation of our national solutions?"

The message from this feedback is clear – a country like New Zealand still requires active and deliberate coordination to distil and instil appropriate good practice and execution.

7 Forum Survey March 2024, Question 5.

8 "Held to Account" or "Strongly Held to Account", Forum Survey March 2024. Question 4.

3.5.3 Levers and opportunities have not been exercised

System levers (e.g. regulations, guidance, inspection, investigation and enforcement) and opportunities (collaboration with industry, including data) have not been well exercised.

In effect, our interviews with senior leaders across different sectors clearly signalled that we are not making effective use of either the carrot or the stick. Both are required to deliver sustained improvement. Our system neither deliberately nor consistently encourages the outliers of excellence or penalises the outliers of poor behaviour.

> "The absence of regulation where industry requires it can result in performance divergence between larger and smaller businesses. Larger players adopt their own standards and smaller employers are left to do as they see fit… with all too predictable consequences."
>
> **Chief Executive, Energy sector association**

Enforcement in New Zealand is sporadic and offers little by way of cautionary lessons, helpful examples or instructive case law. The progress of the Whakaari White Island prosecutions has ultimately raised as many questions as it has answered, and interviewees were generally frustrated by the absence of useful case law arising from this highly significant case.

Lawyers we interviewed who act for employers confessed puzzlement at serious harm events that WorkSafe NZ has chosen to allow the employer to remedy internally, despite obvious failings and regulatory breaches. Businesses are getting very little insight from the regulator about what good practice, let alone best practice, looks like. Perceived inconsistency as to what WorkSafe NZ prosecutes, and what it does not, carries the risk of undermining the credibility of the core regulator.

Too often, New Zealand's culture of "she'll be right" is on show in our approach to health, safety and wellbeing. An approach that overly relies on workers innovating on the spot with the tools at hand is clearly not one that is deliberately applying levers to deliver reliable safety outcomes. As one interviewee put it: "Number eight wire mentality is the worst way to go – find the safest way of doing things and go back to first principles. You need a 'just culture' to ensure the safe behaviour". A just culture and a culture of ad hoc response are unhappy bedfellows – WorkSafe NZ has the levers to make it clear which approach is desired.

> "I vividly recall WorkSafe NZ's first Chief Executive, Gordon MacDonald, saying that the role of the regulator was to both 'shine the light' and 'hold the feet to the fire'. I think we need WorkSafe NZ to rediscover that clarity and confidence in its roles and execution."
>
> **Francois Barton, CEO Forum**

3.5.4 Major Hazard Facilities – a positive lesson

There are examples in New Zealand, however, where we have got the key building blocks in place and have achieved performance as good as our Australian and UK peers. In the area of high hazards (low probability, high consequence – such as underground mining, tunnelling or storage of hazardous substances), MBIE has ensured appropriate regulations. WorkSafe NZ has also provided appropriate and competent advice, as well as specialist regulatory capability, to ensure assurance and oversight.

In response, business performance in these risk areas stands in positive and stark contrast to other industries.

One interviewee who leads the New Zealand operation as part of a global firm noted that their New Zealand business has become the centre of excellence for their worldwide operations regarding "safety case" development since the 2013-2016 reforms. This "safety case" concept involves demonstrating to a third party that you are safe to operate, and it originates from the UK, where the use of safety cases is widespread.

Image credit: Business Leaders' Health and Safety Forum

Methanex example

Walking from the visitor car park to reception at the Methanex plant at Motonui in Taranaki, you could easily mistake it for a visitor centre at a scenic reserve. But behind the trees is a sprawling factory manufacturing methanol. This, along with Methanex's three other New Zealand sites, has been designated an upper tier major hazard facility (MHF).

Sites that can hold above a certain amount of identified hazardous substances are designated as MHFs under the regulations of the same name. According to WorkSafe NZ's website, MHFs "are facilities that store and process very large quantities of hazardous substances. These facilities have the potential to generate catastrophic events which could cause harm to people, the environment and the wider economy." In short, they are the places that can explode, burn or release toxic material that can have major impacts. As a result, businesses need to be extra careful about how they manage them.

MHFs are separated into lower and upper tier based on material inventory. The requirements are largely the same, with the main difference being that upper tier facilities need a safety case approved by WorkSafe NZ. This literally makes the case that the plant is safe to operate – hence 'safety case.' This has the same basic components as any other risk assessment – identify the hazards, define controls, implement them and make sure they work – but in much more depth. Comparing a normal risk assessment to a safety case is like comparing a family car to a Formula 1 car. They're fundamentally the same, but one takes a lot more specialist knowledge and skill and you wouldn't want to attempt it without some serious training.

Methanex operates production facilities in five other countries and works on a collaborative basis between the different facilities. The New Zealand team's safety case approach has been adopted for use globally. So, what contributes to a successful outcome like that? Stuart McCall, Managing Director of Methanex New Zealand, highlights some areas:

"The high hazard space has better regulatory clarity. It feels more scientific than general operational health and safety. The SFAIRP (so far as is reasonably practicable) element helps with determining where you should invest and creates good conversations."

Regulatory clarity helps, but still needs engagement by the regulator and the duty holder to be successful. McCall again:

"The first five years of safety cases were very collaborative – recommendations and mutual assistance. An engaged regulator and active duty holder ensure success. There is a role for helping businesses before enforcement is necessary. Regulatory intervention and investigation should be the last stop and we need supportive processes behind and before that. Engage when things are going well and raise standards. Have the learning conversation first."

Methanex is not an isolated example of success in this area. Australia is a few years ahead of New Zealand in the implementation of MHF management, but when Z Energy was acquired by Australian owners Ampol, there were plenty of positive noises about major hazard management by Z. Julian Hughes, Z General Manager of Supply, says: "They recognised the quality of our systems and approaches, particularly our management of safety critical elements, and we're now working together to share good practices and learn from each other."

Hughes concurs with McCall about the role of WorkSafe NZ: "They have helped us through the process by being both clear and firm about expectations, but in a practical and supportive manner. We just completed an inspection, and their feedback was helpfully very specific and identified items for next steps, but also gave positive recognition for progress made."

Key success factors

The MHF regime covers a wide range of industries and hazards, with over 100 designated facilities around the country from explosives manufacture, through chemical processing to LPG storage. All provide different hazards and require different controls. Recognising this, the regulations provide a framework for organisations to work with, rather than being prescriptive about what they have to do. This enables the businesses to design systems that are practical for them.

These were based on the Australian regulations, so New Zealand can't claim much credit for their design, but WorkSafe NZ has supported this by:

- Providing a dedicated high hazards team, with consistency in inspectors allowing a relationship to be built with duty holders.
- Staffing that team with technical specialists who have a good understanding of the engineering and processes under review.
- Developing clear, usable guidance that focuses on the most important areas.

Methanex, Z Energy and others under the regime have responded to this with investment and focus on these significant hazards. They also found other benefits such as knowledge of their processes, a clearer understanding of risks and priorities and a general rigour in application that benefits other areas of business.

Businesses can't rely on accident metrics with major hazards as events simply don't happen very often. This focuses the mind on prevention and building the capacity to contain equipment failures or procedural errors when they do happen. A safety case is a positive demonstration of safety for future operations, rather than a backward-looking approach trying to investigate and fix what went wrong last time. This is a more fertile environment for learning.

Lessons

Clarity around which risks are the most important drives investment in time, effort and money into the right places. The risk focus of HSWA is intended to support this but, too often, health and safety focuses on what is most visible and not what is most important. There are many examples around the world of disastrous consequences when the invisible high-risk hazard was forgotten about. The MHF regime provides a good template for how to narrow focus onto the highest risk areas for best return on effort.

Building that clarity around a practical framework, rather than a prescriptive approach, enables businesses to be both nuanced and innovative in their approach. Again, HSWA is designed as such a framework, which sometimes gets forgotten when supporting regulations start getting into more detail about specifics. A 'one size fits none' approach doesn't help anybody.

Engaged and collaborative regulators and duty holders create an early intervention environment where learning and improvement is the order of the day. Quality written guidance helps enormously with this.

The biggest lesson of all, though, is that when New Zealand businesses are set up for success in a practical system, with clarity, guidance and buy-in from all parties, they have the capacity and capability to deliver genuinely leading practices that stand up to international scrutiny.

This case study demonstrates that judiciously applied guidance and collaborative interaction between regulator and business in a way that acknowledges the employers' deep understanding of risk achieves sustained and real performance improvements in health and safety. It shows that results are delivered when the core components of good regulatory practice are properly implemented. The challenge in front of us is to continue that implementation across all parts of the regulatory system.

Case study developed by Craig Marriott (Craig Marriott Consulting).

4. Conclusions

4.1 Strategy needs to be refreshed and implemented

The New Zealand Government's approach to the 2018-2028 Strategy is ineffective and needs refreshing with purpose, intent and commitment. Implementation of the 2018-2028 Strategy requires ownership, accountability and insight. That requires confirmation either that MBIE is going to refresh the strategy and create and drive an action plan, or that some other form of oversight will be put in place.

The ironic effect of stalled progress is that the 2018-2028 Strategy document still has validity today, despite being released over six years ago. That means we collectively have a solid base to rewrite and issue a refreshed version, which pays attention to the lessons of inaction and poor safety performance that has been experienced over that six-year period.

The refreshed version of the 2018-2028 Strategy needs to be more deliberate in describing governance, ownership, and prioritising actions and opportunities for employer and worker insight and involvement.

Image credit: Business Leaders' Health and Safety Forum

4.2 Focused regulation will deliver gains to employers and workers

Deliberate focus is needed on core regulations and regulatory instruments that will deliver clear and concise guidance and expectations.

A more effective, streamlined and timely regulatory development and review process is needed to speed up implementation. The ongoing delays and incomplete regulations including plant and structure and hazardous substances regulations, is profoundly unsatisfactory and erodes industry confidence.

Where there is an absence of regulatory clarity, employers are forced to substitute with ad hoc policy decisions about common risks. Nowhere is this more apparent than in traffic management, and the regularly derided plague of road cones that line our roads.

While HSWA 2015 is fit for purpose, the supporting regulatory framework is not. Action is needed, promptly, in service of improved productivity, allowing effective regulation to support business to better manage risk.

The three areas for improvement are:

1. Removal of duplicated or out-of-date regulations, with replacement only where needed or unable to be satisfied by guidance.
2. Introduction of principles-based regulations necessary for business clarity and worker safety, including long-stalled plant and structure and hazardous substances regulations.
3. Better use of guidance, to create the swim lanes within which employers and workers can get on with managing risk.

Unsurprisingly, statutory obligations and requirements relating to health and safety are contained in a wide range of statutes beyond HSWA. Consequently, there are more than ten regulators involved in monitoring and enforcing matters relating to health and safety (as well as developing policy for the same). This includes organisations for which health and safety is not a core area of their operations (such as the Ministry of Education). Therefore, depending upon the scope of any reform of legislation relating to health and safety, a range of different Ministers and Ministries/ Departments may be involved in the policy design and decision-making. That breadth of application could have consequences for the complexity of any reform process, unless a tight focus in maintained.

4.3 Ownership needs coordination and action

There is inadequate coordination and action across central agencies and industry in support of safer work performance. Whilst the Act is in place and largely fit for purpose, the regulations, codes of practice, and guidance such as safe work instruments are either absent, obsolete or lack clarity. Business therefore lacks the clarity and certainty, and even where business develops or wants to develop good practice guidance, there may not be any element in the legislative framework to tie it to.

Accountabilities of government agencies are unclear, and levers aren't always being applied even where accountabilities are clear. There are not effective systemic responses where business and government agencies come together, confident in and delivering on their accountabilities, to find collective solutions.

4.3.1 Industry will contribute

Our feedback is clear that industry wants to play its role in contributing to clearer, effective and practical standards and promoting better implementation in workplaces and across supply chains – but this equally relies on government agencies more actively playing their role too. What does not work is having a partially-implemented Robens' based regulatory approach, then assuming that employers and industry will somehow fill in the gaps.

MBIE and WorkSafe NZ need to articulate a structure for health and safety that provides business with a clear commitment and pathway to bring certainty to what good practice looks like. There must be both a clearly defined requirement, and an unwavering commitment by the regulator to achieve the outcome. This will deliver clarity both about what good practice looks like, and a mechanism for good practice to be promoted. Relying on membership-based and peak industry bodies to simply sort it out without guidance is insufficient.

Current regulatory map

Primary legislation	Number of relevant secondary/ regulatory instruments	Responsible regulator
Education and Training Act 2020	4	Ministry of Education NB: Identified by the Government as one of the priority sectors for 'regulation sector review'.
Electricity Act 1992	81	WorkSafe NZ Electrical Regulatory Authorities Council
Gas Act 1992	27	WorkSafe NZ
Hazardous Substances and New Organisms Act 1996	4	Environmental Protection Authority
Health and Safety at Work Act 2015	60	WorkSafe NZ Mines Rescue Trust Board (aka New Zealand Mines Rescue Service, i.e. in respect of Health and Safety at Work (Mining Operations and Quarrying Operations) Regulations 2016). Civil Aviation Authority New Zealand (see Gazette Notice 2016-go958). Maritime New Zealand (see Gazette Notice 2016-go957).
Maritime Security Act 2004	3	Maritime New Zealand
Railways Act 2005	1	Waka Kotahi | New Zealand Transport Agency

A fully regulatory list with opportunities for change is detailed in Appendix One.

5. Recommendations

Noting the Minister of Workplace Relations and Safety's stated intent to introduce health and safety reform, action is needed now. We need a clear and effective regulatory framework, implementation of a national strategy and clear accountabilities. Supported by strong, shared data, and a deliberate, time-bound plan for implementation, such reform will deliver long-term lasting improvements to health, safety and wellbeing for New Zealand.

The Taskforce view is that strong leadership and oversight with an orchestrating regulatory role will unlock the potential of business to establish clear, safe and workable codes of practice and guidelines, as has been the experience in other countries.

5.1 Rewrite and relaunch the national strategy

The Taskforce is calling for the 2018-2028 Strategy to be revitalised and implemented, and for the action planning process already laid out to be initiated and followed through. This will deliver progress that can be measured and monitored.

5.1.1 **Rewrite and relaunch** both strategy and action plans

Rewrite the 2018-2028 Strategy and relaunch it to include a three-year action plan to capture and ensure delivery of the elements below. This means delivering an updated strategy by the end of 2024 for the 2025-2028 period. The strategy must include an action plan as currently specified, with that action plan being overseen by an independent group (see 5.3.1 on page 33).

Action planning should be explicit, time-bound and measured, including health and safety improvement targets supported and informed by relevant data.

Effectively the strategy should also incorporate all the remaining recommendations. This is in support of lifting New Zealand's performance towards that of other comparable countries, by applying lessons learned and no longer accepting average as good enough.

5.2 Focus and update regulations and guidance

Rather than more regulations, the pragmatic implementation of the tools available under the regulatory hierarchy is required. The rules then need to be applied to ensure that poor practices are remedied and excellence is identified and shared.

5.2.1 **Determine** the most appropriate mix of regulations, codes and guidance

Review and agree the priority changes required to ensure the most appropriate mix of regulations, codes and guidance to eliminate duplication and specify business' accountabilities and expectations.

Regulations like plant and structure and hazardous substances need to be finalised, and more broadly codes of practice and other guidance material need to be developed and shared.

> "The Regulator needs to identify non-negotiables and work with industry on good practice."
>
> **Chief Executive, Energy sector association**

5.2.2 **Apply** the rules to address poor performance and share leading performance

Apply the rules clearly and fairly to deliver a level playing field for New Zealand business where poor or negligent business practices are consistently held to account, and leading performance is incentivised. This requires WorkSafe NZ to play a more active role in consistently applying regulatory standards and delivering clear and consistent messaging, guidance and enforcement where necessary.

5.3 Embed ownership

The failure to implement the 2018-2028 Strategy is the starkest example of a lack of health and safety ownership for New Zealand. That lack of ownership is a key impediment to the success of health and safety reform and requires swift redress.

5.3.1 **Establish** independent governance group

Implementing the 2018-2028 Strategy requires a governance group enabled to set targets, create collaboration and hold the players to account for improvements. This independent oversight function comprising a small group of industry, worker and relevant crown agency leaders would ensure progress and momentum for improving New Zealand's health and safety performance. This is part think-tank and part hold-to-account, focused on implementation of robust strategy, sound action planning and clearly defined milestones.

This group would also help remove any grey areas around accountability for delivery, or overlapping obligations, with a focus on speed of execution and efficiency of implementation.

> "Where's the collective view of the serious injuries in New Zealand? ACC looks at general compensation costs and lower-level soft tissue injuries. WorkSafe NZ looks at fatalities. But what about the high potential injuries or events? What do they tell us, and what we can learn from those high potential events? We need that data collected, analysed and shared back to us."
>
> **Senior health and safety executives from energy, construction and telco sectors**

5.3.2 **Establish and maintain** a coherent, credible and current body of government and industry data and insights to inform and focus WorkSafe NZ and business health and safety efforts

Ensure government and industry data and insights are effectively applied and utilised to focus WorkSafe NZ and business efforts in the areas of highest risk and swiftest resolution. This requires collaboration between government and industry and recognises that to be useful, data must be shared, accurate, reliable and repeatable.

As well as using data to determine the sectors and activities that experience the highest risk, further root-cause analysis is needed, taking a risk-based approach to addressing underlying behaviours and perverse incentives, and a willingness to invest in whole of sector solutions.

Investment in solutions does not necessarily mean additional investment cost, it means a coordinated response by government and industry, and a methodical and considered approach to problem resolution. This approach depends on robust data analysis on the widest possible reliable dataset, and contemplation of related factors like contract specification, procurement practices and procedural efficiency.

6. Appendices

6.1 Appendix one: List of regulators/regulations

Current regulatory map with opportunities for change

Primary legislation	Number of relevant secondary/regulatory instruments (Regulations/standards/notices/codes of practice/instruments)	Responsible regulator[9]	Opportunity for change
Civil Aviation Act 1990	3	Civil Aviation Authority of New Zealand Aviation Security Service	
Education and Training Act 2020	4	Ministry of Education NB: Identified by the Government as one of the priority sectors for 'regulation sector review'.	Health and safety at ECEs and Playgroups is regulated by the *Ministry of Education* under ECE Regulations 2008 yet health and safety at limited attendance childcare centres is regulated by *WorkSafe NZ* under Health and Safety at Work (Health and Safety at Work (General Risk and Workplace Management) Regulations 2016).
Electricity Act 1992	81	WorkSafe NZ Electrical Regulatory Authorities Council	ECP 34 is challenging because of how it is drafted, and it has some internal inconsistencies: • The standards are highly technical and cannot be straightforwardly interpreted without technical expertise. • The EESS is inter-jurisdictional (with Australia) yet does not have direct force in New Zealand but is partially incorporated via regulations.
Gas Act 1992	27	WorkSafe NZ	Standards cannot be straightforwardly interpreted without technical electricity expertise, and access is paywalled.
Hazardous Substances and New Organisms Act 1996	4	Environmental Protection Authority	Great complexity given city and district council roles in non-workplaces, WorkSafe NZ's role in workplaces, and requirements under other Acts (e.g. Resource Management Act and local council bylaws).
Health and Disability Services (Safety) Act 2001	2	Ministry of Health	
Health and Safety at Work Act 2015	60	WorkSafe NZ Mines Rescue Trust Board (aka New Zealand Mines Rescue Service, i.e. in respect of Health and Safety at Work (Mining Operations and Quarrying Operations) Regulations 2016) Civil Aviation Authority New Zealand (see Gazette Notice 2016-go958) Maritime New Zealand (see Gazette Notice 2016-go957)	The Health and Safety at Work (Hazardous Substances) Regulations 2017 cross-refer to out-of-date iterations of EPA notices and could be confusing in complying with requirements: • Possible overlaps with Railways Act 2005 and Railways Regulations 2019 that could benefit from clarification or consolidation. • Challenges applying regulations for large-scale compressed tanks regulated under regulations and the Hazardous Substances (Compressed Gasses) Regulations 2004.

9 Where an Act or instrument contemplates multiple regulators, we have included only those whose functions are relevant to the enforcement of workplace health and safety obligations. Thank you to MinterEllisonRuddWatts for their assistance with this regulatory mapping.

Primary legislation	Number of relevant secondary/regulatory instruments (Regulations/standards/notices/codes of practice/instruments)	Responsible regulator[9]	Opportunity for change
Health Practitioners Competence Assurance Act 2003		Health and Disability Commissioner	
Maritime Security Act 2004	3	Maritime NZ	Maritime NZ's Briefing to the Incoming Minister of Transport 2023 noted: "[its] legislation: does not anticipate or enable new technologies; provides inadequate tools to manage maritime incidents, poor quality vessels or maritime security risks; and creates considerable confusion around the differing roles of national and local regulation" and noted that "New rules and small scale 'tweaking' to legislation and regulations have sometimes been made without any new resourcing to deliver them effectively. Systems have not always kept up with the changing environment they are regulating."
Mines Rescue Act 2013	4	WorkSafe NZ Mines Rescue Trust Board (aka New Zealand Mines Rescue Service)	
Outer Space and High-altitude Activities Act 2017	2	Civil Aviation Authority New Zealand WorkSafe NZ	
Plumbers, Gasfitters, and Drainlayers Act 2006		The Plumbers, Gasfitters, and Drainlayers Board WorkSafe NZ	
Prostitution Reform Act 2003		Ministry of Health	
Racing Industry Act 2020	3	New Zealand Thoroughbred Racing Incorporated Harness Racing New Zealand Incorporated New Zealand Greyhound Racing Association Incorporated.	
Railways Act 2005	1	Waka Kotahi | New Zealand Transport Agency	• Scope for consolidation with Amusement Devices Regulations 1978. • Overlap with Health and Safety in Employment (Pressure Equipment, Cranes, and Passenger Ropeways) Regulations 1999 (e.g. in respect of funicular vehicles) that could be clarified/consolidated.

6.2 Appendix two: Taskforce members

Toby Beaglehole

Chief Executive, Royal NZ College of General Practitioners
Forum Director (Taskforce Chair)

Toby has been on the Board of the Forum since 2019, and is a Trustee for Construction Health & Safety New Zealand. Recently appointed as Chief Executive of the Royal NZ College of General Practitioners, he has held previous CEO roles over the last decade in vocational education and the oil and gas sector, demonstrating his belief in great training leading to better wellbeing outcomes.

Chelydra Percy

CEO, GNS Science

Chelydra Percy was appointed as Chief Executive of GNS Science in May 2023. Prior to joining GNS Science she held CEO and leadership roles at a range of organisations. Chelydra strongly believes that great health and safety must be at the heart of every responsible business.

Andrew McLeod

CEO, Northpower

Andrew is the Chief Executive of Northpower, the 1,500 strong team managing electricity and fibre networks across the Whangarei and Kaipara districts, and professional energy construction and maintenance services across the North Island.

Mike Bennetts

Former CEO, Z Energy

Mike has been a CEO and Director in the global energy sector, more recently as the founding CEO of Z Energy Limited from 2010 to 2023. Since April 2023, Mike works as a mentor and executive coach through Taumata Advisory Limited.

Stacey Shortall

Partner, MinterEllisonRuddWatts
Founding Trustee, WhoDidYouHelpToday charitable trust

Stacey is an internationally recognised lawyer with over 25 years of experience in significant litigation and regulatory matters including health & safety issues. Having also spearheaded community projects designed to create social change, Stacey is a Member of the New Zealand Order of Merit and has twice been a semi-finalist for Kiwibank New Zealander of the Year.

Jeremy Lightfoot

Chief Executive, Department of Corrections/Ara Poutama Aotearoa

Appointed as Chief Executive in February 2020, Jeremy leads a workforce of 10,000 people who manage around 10,000 people in prison and 30,000 people serving sentences or orders in the community. Jeremy has extensive public sector, commercial and contract management experience both in New Zealand and the UK, with a strong focus on Public Private Partnerships and Public Finance Initiatives.

Susan Huria, ONZM

Ngāi Tahu, Ngāi Tuahuriri
Chair of LeaderBrand and associated entities

Susan is the Chair of Leaderbrand, and is Chair of Gisborne Covered Production. She is a director of the Royal College of General Practitioners, Chair of the Remuneration Committee and an Audit Committee member. She is also a director of Trust Investments Management Limited, Ospri and of Accessible Properties, the property arm of IHC.

6.3 Appendix three: Taskforce scope

The Taskforce was established with the following scope to:

- Understand the legislative framework (i.e. Health and Safety at Work Act 2014, Regulations and Guidance).
- Consider regulatory implementation (i.e. mainly WorkSafe NZ's performance).
- Evaluate strategic and system alignment (i.e. national action plan, system targets and accountability, effective oversight, connection across other functions such as immigration, employment practices and infrastructure etc.).
- Make recommendations to increase the effectiveness of the regulations, the enforcement thereof and the performance of the wider health and safety system.

6.4 Appendix four: Interviews and survey summary

Expert interviews

We conducted over 30 expert interviews with almost 50 interviewees, including chairs, CEOs, and senior executives from private and public sector organisations and academics across a range of sectors including:

- Construction and infrastructure
- Forestry
- Public transport
- Telecommunications
- Manufacturing
- High hazard facilities
- Legal services
- Health and safety services
- Public Sector
- Industry association.

Survey data

On behalf of the Taskforce, the Forum conducted two surveys in March 2024:

1. A Forum CEO survey which 133 CEOs and their teams took part in. Among other questions it also asked the four key Taskforce-related questions below.
2. An industry survey which 130 people responded to, with the same four Taskforce-related questions. From this industry survey, respondents were from a range of sectors, namely:
    - Agriculture 10.43%
    - Charity or Not for Profit 3.48%
    - Construction 24.35%
    - Distribution/Wholesale 5.22%
    - Education 5.22%
    - Energy/Utilities 6.09%
    - Forestry 7.83%
    - Government/Public Sector 22.61%
    - Healthcare 4.35%
    - Legal 0.87%.
    - Medical/Health 2.61%
    - Manufacturing 14.78%
    - Retail 3.48%
    - Services/Consulting 15.65%
    - Transport 14.78%

Survey questions

1. **There is clarity about the role and responsibilities of the major system players in health and safety in New Zealand (business, regulator, government).**
   Rate this question (Strongly agree, Agree, Neutral, Disagree, Strongly disagree).
2. **How well are the following organisations and wider ecosystem being held to account for health and safety performance in New Zealand?**
   Rate this question (Strongly held to account, Held to account, Neutral, Not held to account, Not held to account at all) across:
    - **a.** Regulators
    - **b.** Government
    - **c.** Major businesses
    - **d.** SMEs
    - **e.** Sector groups.
3. **How clear are you on New Zealand's national plan of action and priorities for improving health and safety?**
   Rate this question (Extremely clear, Clear, Neutral, Unclear, Extremely unclear).
4. **How strongly do you want the Government to prioritise improvements to New Zealand's health and safety performance?**
   Rate this question (Strong prioritise, Prioritise, Neutral, Doesn't need to be prioritised, Not prioritised at all).

Business Leaders'
Health & Safety Forum

Contact us **info@forum.org.nz** or find out more at: **www.forum.org.nz**