



NEW ZEALAND COUNCIL OF TRADE UNIONS
Te Kauae Kaimahi

**Submission of the
New Zealand Council of Trade Unions
Te Kauae Kaimahi**

to the

**Independent Taskforce on Workplace
Health and Safety**

on the

Review of the Health and Safety System

**P O Box 6645
Wellington
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Summary of recommendations

The CTU recommends:

- A. Strengthening the powers and protections for Health and Safety Representatives in regulation.
- B. All businesses should be encouraged to have health and safety representatives regardless of size i.e.: the 30 employee quantification should be reviewed.
- C. Higher penalties imposed for breaches of the HSE Act. Currently penalties are set at such a small amount that businesses can indulge in 'gaming' the system. A system of civil fines such as infringement fees should be implemented as an effective prevention tool.
- D. A presumption of safety included in the New Zealand legislation. Amend the economic factors legislated for under section 2A of the HSE Act so that cost is not the 'catch all' at paragraph 2A(1)(e). The Australian model law has the catch-all phrase that provides that unless the cost is "grossly disproportionate" all practicable steps to ensure safety are required to be taken. The "grossly disproportionate" test is recommended for the New Zealand context.
- E. Introduce a new obligation to the Act that requires the promulgation of regulations where they will manifestly improve safety. This would provide a limit to the regulator's discretion thereby curbing the effect of political or business influences not to regulate.
- F. Create a new Independent Crown Entity with a tripartite governance structure, as a specialist agency focused on the development, administration and enforcement of the HSE Act and workplace enforcement of the Hazardous Substances and New Organisms Act 1996. This entity would be responsible for policy and strategic direction.
- G. Include promulgation of regulations and standards in the role of the new Crown Entity.
- H. Create regional Health and Safety Centres. These centres would be independent and government funded, and report to the new Crown Entity. The regionally based centres would employ Safety Advisors. The Safety Advisors would be available to advise and mediate on health and safety issues in any workplace.
- I. Provide for a further two-day senior representative training course (at level four)for Health and Safety Representatives. This course would enable representatives to issue Improvement Notices.

- J. The introduction of a criminal offence of corporate manslaughter into New Zealand law similar to the UK Corporate Manslaughter and Corporate Homicide Act 2007, clarifying the criminal liabilities of companies including large organisations where serious failures in the management of health and safety result in a fatality.
- K. That 'hazard' remain the basis to the Health and Safety in Employment Act 1992 (HSE Act.)The general approach to identify hazards and the steps to eliminate, isolate or minimise those hazards works to promote the prevention of harm. This is unlike the concept of 'risk' which effectively increases the likelihood of harm by assessing an 'acceptable level of risk' rather than applying the precautionary approach.
- L. The HSE Act should prevail over other Acts in terms of occupational health monitoring. Hazardous substances need to be independently monitored at worksites.
- M. There are many more recommendations made throughout this submission. This document needs to be considered in its entirety.

Thank you to the 1,204 Health and Safety Representatives who participated in the CTU Survey.

The information gathered has been used to inform this submission.

The results are attached at Appendix Two and many quotes from the survey illustrate this submission.

1. Introduction

- 1.1. This submission is made on behalf of the 37 unions affiliated to the New Zealand Council of Trade Unions Te Kauae Kaimahi (CTU). With 350,000 members, the CTU is one of the largest democratic organisations in New Zealand.
- 1.2. The CTU acknowledges Te Tiriti o Waitangi as the founding document of Aotearoa New Zealand and formally acknowledges this through Te Rūnanga o Ngā Kaimahi Māori o Aotearoa (Te Rūnanga) the Māori arm of Te Kauae Kaimahi (CTU) which represents approximately 60,000 Māori workers.
- 1.3. The CTU has a long-standing interest and significant expertise in occupational safety and health. This reflects the high importance which union members have consistently assigned to health and safety protection at work reflected in surveys of membership views and the priority given to health and safety by unions over many years. Ensuring effective protection for workers has formed a core part of unions' work. It is fundamental that employees and their unions work collectively on this issue and that unions are able to participate in the determination and implementation of health and safety standards. The CTU strongly believes that the Government has a responsibility to provide an effective occupational safety and health statutory framework at national, industry and enterprise levels.
- 1.4. . Unions are a key player in improving health and safety, able to reach a wide range of workers across a wide range of sectors. In addition to being a leading accredited provider of training for elected health and safety representatives, the CTU (along with some affiliates) has a significant bank of resources and training programmes that have a health and safety component which are available for use by affiliates. Some examples include: workplace bullying, harassment, stress in the workplace, Accident Compensation, delegates as health and safety educators.

- 1.5. The CTU welcomes the opportunity to make this submission and believes that this Review provides a very significant opportunity to fundamentally improve the health and safety of New Zealand workers. Every accident has a cause that could potentially have been eliminated. Every accident has consequences, and in some cases they are extremely severe – including resulting in the death of a person (or of people) and drastic and has damaging effects on others including family, workmates and the community. The workplace death and accident rates in our country are simply unacceptable and we sincerely hope that this review can be part of a renewed effort to drastically reduce them.
- 1.6. This submission begins with an overview of health and safety regulation in New Zealand, including our obligations in international law. It goes on to discuss the principles on which the Health and Safety in Employment Act 1992 (HSE Act) is based and identifies key areas in which the CTU believes the Act should be strengthened. We answer all questions posed by the Taskforce's Issues Paper.

2. Regulatory Framework

- 2.1. Prior to 1992, the regulation of health and safety in New Zealand, along with many other Commonwealth countries, had adopted a somewhat narrowly focussed approach based originally on the British Factories Act. Legislation was often ad hoc and based on regulation around specific hazards, activities and workplaces. As a result specific industries had detailed and prescriptive regulations, while others had no protection at all. Administration of the law was also very fragmented with aspects of OSH regulation being included in 31 Acts supported by 100 regulations and Codes of Practice and administered by five government departments.
- 2.2. Most countries revised their approach to the regulation of health and safety from the 1970s onwards. The legislative policy model on which these changes were based had their origins in Scandinavian legislation and practice but are more commonly associated with the recommendations of the 1972 Robens Commission of Inquiry in the UK. As an academic expert

on the Health and Safety in Employment Act 1992, John Hughes has noted, the key features of the Robens model were a single set of performance standards across the range of industries, occupations and processes, a self-regulatory approach placed jointly on employers and workers (focusing on workplace health and safety committees) with tripartite governance (employers, unions and government) underpinning health and safety policy.¹ Hughes also noted that the Robens model, in the words of one academic, was developed in, and reflects, an environment of “a relatively strong trade union movement, a highly regulated labour market, relatively low unemployment levels, a predominance of ‘standard employment’ and relatively well-resourced regulatory agencies”. It is the CTU view that these elements are essential to underpinning the model and without them there are serious holes in the system especially in an environment where the workforce is more fractured and there are more precarious and transient employment arrangements.

2.3. This Robens approach was adopted across a wide range of countries in the 1970s and 1980s. In 1985 in New Zealand, a tripartite Advisory Council on Occupational Safety and Health (ACOSH) instigated public discussion on occupational safety and health reforms. In 1988, it made six recommendations for a new statutory framework. These were:

- The present toll of injury and disease can be reduced by appropriate prevention measures. These can be applied at all levels from the workplace to the Government.
- A preventative strategy needs to focus on underlying work systems and not solely on making workers and employers aware of risks. Accidents and disease do not generally occur because of ‘apathy’ or carelessness but often through unsafe systems of work and processes.
- For economic and social reasons, a basic level of safety needs to be imposed by law on all enterprises.

¹ Hughes John *The Policy Considerations which prompted the enactment of the Health and Safety in Employment Act 1992 and the subsequent mining regulations in 1996 and 1999 Background Paper to Royal Commission of Inquiry into Pike River Tragedy* EPMU0003/8-9.

- Lax enforcement of the law undermines the position of employers who responsibly abide by minimum legal standards. The law should be adequately, uniformly and equitably enforced through a system of inspection and the imposition of penalties for contravention.
- Because occupational safety and health is an issue affecting employers, workers and government, the establishment of policy and the determination of the basic standards of safety and health secured by law should involve a statutory tripartite process at a national level. In addition, it is through these tripartite structures that any conflicts which may arise between employers and unions over health and safety issues, can be resolved.
- Although the provision of a safe and healthy workplace is a management responsibility, workers need to be involved collectively in applying and maintaining safe and healthy conditions and practices in the workplace.

2.4. The CTU believes the six recommendations remain fundamentally sound, but much needs to be done including the provision for specific requirement in legislation, and the model of implementation needs to change to meet the new realities of the workplace.

2.5. The work of ACOSH was positively regarded by the Law Commission² and Hughes has noted that:³

The key feature of the ACOSH proposal was a new piece of legislation which would apply to all work activities and replace existing legislation by setting out basic principles similar to the Health and Safety at Work Act 1974 (UK). It was envisaged that the legislation would address issues such as the respective duties of employers, employees, designers, manufacturers, importers and suppliers by setting out broad performance standards. Underpinning these broadly stated general duties, regulations

² New Zealand Law Commission Personal Injury: Prevention and Recovery (Report on the Accident Compensation Scheme) (NZLC R4, Wellington, 1988) n 10, 28.

³ Hughes John *The Policy Considerations which prompted the enactment of the Health and Safety in Employment Act 1992 and the subsequent mining regulations in 1996 and 1999* EPMU0003/8-9

under the Act would deal with particular hazards or circumstances and prescribe desired standards for performance. Codes of practice would then set out the recommended practices in technical detail in order to achieve the standard of performance prescribed in the regulations.

The advantages of this legislative approach were seen as being, among other things, coherence, accessibility, uniformity of standards, and universal coverage.

2.6. While the CTU generally support the legislative intent it believes elements of it are weak and are not working. In particular the Act focuses on performance regulation and is insufficiently strong on requirements for specific prescription. There are numerous contexts in which prescription is either essential to ensure health and safety, or is efficient in that it simplifies understanding of requirements for both employers and workers. For example, as the Royal Commission of Inquiry on the Pike River Coal Mine Tragedy ('the Royal Commission') has identified, a much higher degree of prescriptive regulation is needed in high hazard industries. The test in the Act of all practicable steps also needs to be clearer in regards to the priority given to the cost of hazard management. The Pike River Royal Commission has recommended that the "cost test", should also play no part in the mandatory provisions of regulations⁴. The reference to all practicable steps in the Object of the [HSE] Act in s5(d)(i) should be reviewed to ensure it does not obstruct specific prescription and regulation.

2.7. ACOSH also recommended the establishment of a Tripartite Commission (unions, employers, and government) accountable to a Minister and responsible for developing and implementing policies to ensure a safe and healthy work environment. An authority was envisaged as acting as the administrative and operational arm of the commission with support from an institute providing technical and scientific research. It was suggested that this division of function would ensure that objectives were not confused, that no one party would "capture" policy advice, that functions would be

⁴ *Report of the Royal Commission on the Pike River Coal Mine Tragedy*, Recommendation 2.

devolved to a local level and that the commission was “accountable” to all of the interested parties.

2.8. While the Workplace Health and Safety Council has an element of this, it has nowhere near the powers or functions envisaged and its effectiveness is therefore minimal. In the political environment of the time, the ACOSH recommendations were not adopted in several important respects. Gunningham and Neal note in their report to the Royal Commission :⁵

“The HSE Act was a product of this deregulatory environment and in its initial version was stripped of some of the key measures recommended by Robens, not least tripartism, worker participation and an independent executive.”

Consideration of the Underlying Principles

2.9. The CTU is concerned that the “all practicable steps” test has been interpreted in a manner that weighs the expected cost and probability of damage against the expected cost of preventing it and gives too much weight to cost when determining if an employer had taken “all practicable steps” under the Act in s2A(1). When listing the matters that an employer must have regard to, the practicable steps section of the Act culminates in the calculation of cost of each step at s2A(1)(e). This approach does not do enough to promote the protection of worker health and safety as the determining factor.

2.10. Cost may be a consideration to some extent (and is covered by the term “practicable”) but it should not be highlighted in the Act as a form of mitigation against taking actions which could be costly but are important and reasonably achievable.

2.11. The HSE Act also creates very limited criminal liability (which promotes moral responsibility) on top of this basic test.

⁵ Gunningham Neil & Neal David *Review of the Department of Labour’s interactions with Pike River Coal Limited* 4 July 2011 DOL0100010001/18 at para 46

2.12. The CTU recommends that the legislation remain within the criminal jurisdiction as this area of law reflects the elements of moral obligation including concepts of denouncement, deterrent and responsibility, and later in this submission we recommend the strengthening of penalties and liabilities .

2.13. Moral obligation is a fundamental element of workplace health and safety which overrides a purely economic assessment of what is reasonable or practicable in order to ensure the health and safety of workers. Increased emphasis on moral responsibility will impact on the safety culture of the country – an important change if our record is to be improved. As the then Minister of Labour, Kate Wilkinson, stated in welcoming the beginning of the consultation process for this review. “People have a **right** to know that when they leave for work in the morning, they will be coming home safe and well at the end of the day” (our emphasis).

The moral obligation not to endanger the safety, health or lives of others is amplified in this context by the objective situation that workers are not in complete control of the environment which is capable of putting their health and safety, at risk. This is recognised in the HSE Act by placing the primary responsibility and duties for health and safety on the employer or person in control of the working environment . In this context responsibility cannot be reduced to a calculation of whether the economic consequences of an injury or damage to a worker’s health or loss of life exceed the cost of preventing it occurring.

In your opinion, what is the cause of the majority of incidents causing injury or illness in your workplace?

“Profit and more profit – There is no reason or incentive for companies to comply to H&S – Whistle blowers are ridiculed and eventually leave the company”*

*the quotes in boxes in this submission are a sample of comments collected from the CTU survey.

2.14. The CTU recommends that identifying 'hazards' remains the basis to the HSE Act. We support the general approach to identify hazards and take the steps to eliminate, isolate or minimise those hazards to promote the prevention of harm and believe it is the right approach if the settings are right to make it work. The concept of 'hazard' allows the precautionary principle to operate in situations like workplace safety when there is a level of uncertainty and change. If the Act were completely risk-based for example, the precautionary principle would be largely dispensed with and would have the overall effect of increasing the risk of harm.

2.15. The CTU supports the addition to the legislation of a requirement for a 'competent person', similar to Australia, where a competent person should be employed to assess hazards. Both workers and management should be trained in such skills.

2.16. In addition, guidance could be provided regarding hazard identification which could improve compliance. There is no such guidance at present.

ILO Convention 155

2.17. In addition to domestic law, New Zealand has international obligations in the regulation of health and safety in employment through International Labour Organisation (ILO) Convention 155. This convention, ratified in New Zealand in June 2007, establishes a number of principles for national policies on occupational safety and health, together with provisions for how these should be operationalised at national, industry and enterprise level. Some of the most important principles included in ILO Convention 155 include the following:

- Ensuring that Governments have a national policy on occupational safety, occupational health and the working environment developed in consultation with worker and employer representatives
- Having adequate systems in place for inspection and enforcement, together with adequate penalties for breaches

- The right of workers to refuse to undertake unsafe work
- Ensuring that systems at the workplace provide for safe work, prevent unsafe exposure to hazards (including biological and chemical hazards)
- Ensuring that workers and their representatives are consulted about workplace health and safety and are fully informed about any hazards at their place of work.

2.18. The CTU has raised issues with the ILO Committee of Experts about the extent to which New Zealand fully meets its obligations under the convention. These are dealt with in the relevant sections of this submission.

The Health and Safety in Employment Act 1992 – principles and issues

2.19. The stated object of the Health and Safety in Employment Act 1992 (HSE Act) is to prevent harm to employees at work. The intention of the Act is to facilitate this by promoting excellence in health and safety management by employers, defining hazards and harm, imposing a requirement to take all practicable steps to ensure health and safety, providing for the involvement of employees in health and safety management and establishing a range of enforcement methods in relation to a failure to comply with the legislation.

2.20. There is a wide range of principles underpinning the Act. Without describing these in detail, we note the following provisions which are of concern to the CTU in the effective operation of the Act:

2.21. Employers have a general duty to take all practicable steps to provide for, and maintain, a safe working environment and to ensure that employees are not exposed to hazards. In particular, employers must systematically identify existing and new hazards and, if significant, take steps to eliminate them, isolate them or minimise the likelihood that they will cause or be a source of harm to employees.

2.22. Under Part 2A employers also have a general duty to ensure that employees have a reasonable opportunity to participate effectively in ongoing processes for the improvement of work-place health and safety. Employers must have an employee representative “system” in place for doing this in workplaces with 30 or more employees, or in smaller workplaces if employees request this. Two days paid leave a year are provided for under the HSE Act for health and safety representatives to attend approved health and safety courses.

2.23. Part Three of the Act covers standards-setting, and makes provision for publishing Approved Codes of Practice and promulgating regulations. While Approved Codes of Practice are designed to identify “preferred” work practices or arrangements, regulations impose enforceable duties in respect of workplaces, work processes, activities, or substances. Those duties may be imposed not only on employers and workers, but may also be on suppliers and manufacturers.

2.24. An improved purpose for ACOPs would be to provide technical guidance to meet standards.

2.25. The Act also makes provision for the appointment of Health and Safety Inspectors to help employers and employees improve safety at workplaces by providing information and education and to ensure compliance with the provisions of the Act. Inspectors may issue improvement or prohibition notices to ensure compliance and may also issue infringement notices.

2.26. The Act creates two types of offence. The first, under section 49 of the Act is where a person acts or fails to act knowing that it is likely to cause death or serious harm. If convicted, this can result in a fine of up to \$500,000 or two years in prison. The second type of offence under section 50 states that when a person commits an offence that results from a failure to comply with the provision of the Act, a penalty of up to \$250,000 can be imposed. The 2002 amendments introduced the ability for inspectors to issue Infringement notices and impose infringement fees as an alternative to prosecutions but this option has not been used.

2.27. The concerns that the CTU has in relation to these provisions, and suggested measures to strengthen the Act, are set out below and throughout this submission.

All practicable steps

2.28. The primary obligation in the Act of All Practical Steps is insufficiently defined and has therefore been weakened in practice.

2.29. A presumption of safety should be included in the New Zealand legislation. In the Australian model law⁶ when defining “reasonably practicable” (the counterpart to the HSE Act’s all practicable steps), the availability of means to ensure health and safety is separated from the cost of those means, and the cost is explicitly subordinated to other considerations. So Section 18 of the model law is as follows:

18 What is reasonably practicable in ensuring health and safety

In this Act, reasonably practicable, in relation to a duty to ensure health and safety, means that: that which is, or was, at a particular time, reasonably able to be done in relation to ensuring health and safety, taking into account and weighing up all relevant matters including:

- (a) the likelihood of the hazard or the risk concerned occurring; and
- (b) the degree of harm that might result from the hazard or the risk; and
- (c) what the person concerned knows, or ought reasonably to know, about:
 - (i) the hazard or the risk; and
 - (ii) ways of eliminating or minimising the risk; and
 - (d) the availability and suitability of ways to eliminate or minimise the risk; and

⁶ Model Work Health and Safety Bill, 23 June 2011, available at <http://www.safeworkaustralia.gov.au>.

(e) after assessing the extent of the risk and the available ways of eliminating or minimising the risk, the cost associated with available ways of eliminating or minimising the risk, including whether the cost is grossly disproportionate to the risk.

2.30. This separation of duty from costs is not included in the New Zealand Act. Compare s2A of the HSE Act, sections 18(d) and (e) to 2A(e) of the Australian regime, and it is clear that in the NZ Act, cost is built into the test in a manner which gives it too much weight. In Australia cost is to be considered only “after assessing the extent of the risk and the available ways of eliminating or minimising the risk”, and then can be considered only when “the cost is grossly disproportionate to the risk”. In discussing the cost element of the Australian test, the CTU is not recommending that risk assessment be included the New Zealand legislation.

2.31. The Safe Work Australia’s Guide to the Work Health and Safety Act⁷ describes the test: “Costs may only be considered after assessing the extent of the risk and the available ways of eliminating or minimising the risk. Ordinarily cost will not be the key factor in determining what it is reasonably practicable for a duty holder to do unless it can be shown to be “grossly disproportionate” to the risk. If the risk is particularly severe a PCBU [Person Conducting a Business or Undertaking] will need to demonstrate that costly safety measures are not reasonably practicable due to their expense and that other less costly measures could also effectively eliminate or minimise the risk.”

2.32. We recommend separation of the consideration of the means for all practicable tests from consideration of cost, and replacing the consideration of cost with a ‘grossly disproportionate’ test similar to the Australian model law for s2A of the HSE Act. This would make clear that there is a requirement to go beyond solely economic considerations and would recognise that there is a moral obligation

⁷ *Guide to the Work Health and Safety Act*, Safe Work Australia, October 2012, p.5.

2.33. . Bluff and Johnstone (2004)⁸ describe, the “grossly disproportionate” test as having arisen from court decisions interpreting “reasonably practical” and other similar formulations of “all practical steps” in Australian jurisdictions (p.15). They quote (p.39) the recommendation of the Maxwell Occupational Health and Safety Act Review in Victoria, Australia of 2004 that the legislation should say that “once the severity and likelihood of the risk have been assessed, the relevant safety measure should be implemented unless the cost of doing so would be grossly disproportionate to the risk as assessed”. This “reinforces a precautionary approach by requiring that the requisite preventive measure(s) to be taken unless there is a stark imbalance between the cost and the risk”.

DOL and Investigation of Vehicle Accidents

2.34. Clarity is needed in the investigation of all work-related accidents – including for example those in motor vehicle which are currently investigated by the Transport agencies. It is unclear that the provisions of the Health and Safety Act are fully investigated in these inquiries where the focus appears to be on the technical aspects of the crash rather than the steps taken at the workplace to make the driving safe. This includes accidents that occur when workers are travelling to and from work. There should not be a sharp dividing line between work and outside-work accidents in such cases, as the reality of the nature of work can blur the lines. Workers who drive exhausted, for example, two hours to and from work, for a 12-hour shift, and have an accident are not afforded enough protection.

2.35. Victor Ripia was killed on 25 July this year in a truck accident in the Kaingaroa Forest. His death was investigated by the Serious Crash Unit of the New Zealand Police who have been unable to find the cause of the accident and have referred his death to the coroner. On CTU inquiry the police are unable to tell the CTU if any of the circumstances of his employment have been investigated. His widow has not been contacted.

⁸ Liz Bluff, and Richard Johnstone. *The Relationship Between “Reasonably Practicable” and Risk Management Regulation*. Working Paper: National Research Centre for Occupational Health and Safety Regulation, ANU, Canberra, Australia, September 2004. Available at <http://hdl.handle.net/1885/42687>.

Victor was employed by a small company that owned one truck and contracted it to transport wood from the forest to the mill on dangerous forest roads. His widow has many stories of situations where driving conditions were in Victor's view, dangerous. He was paid \$18 per hour and not paid for the hours he put in that were not on-the-road (he regularly worked on the truck, bought his own safety gear including gloves, and got up very early to get ready for long drives to pick up loads and worked long hours). The RT radio in his truck was not working and he had been given a cell phone as a replacement – it would not work on forest roads and was illegal for use when driving. He was in a convoy on the day he died – the first of three trucks. When the two trucks behind him arrived ahead of him, there was no system to notice he had not turned up – it was three hours before he was looked for. He was lying down a bank, crushed by his load. Victor's widow has not been paid his final pay or holiday pay despite requests and it appears likely he did not have an employment agreement.

2.36. Two car accidents each killing 4 workers associated with the Moeangi Station have occurred this year as workers returned home from work. The first included a 16 and 13 year old boy. The DOL did not investigate either. It is unclear what the investigations covered by the Police. Clearly alcohol was involved in at least one. Regardless, these are workplace accidents and should be investigated in accordance with the Act.

2.37. All agencies that investigate workplace accidents (aviation, maritime etc) need to be consistent in the approach regarding workplace obligations.

The Failure to Regulate

2.38. It was originally intended that adoption of a less prescriptive legislative approach to health and safety would be underpinned by robust systems for the management of specific hazards, including publishing codes of practice and promulgating regulations under Part Three of the Act.

2.39. When the Act was passed in 1992, there was an understanding between Department of Labour officials and the social partners (CTU and the NZ Employers Federation) that standards in existing instruments (such as Acts, regulations and Codes of Practice) would be “rolled over” and applied under the new Act. At the same time, a tripartite standards-setting process would review existing standards and develop and promulgate new regulations and codes of practice. In practice this never occurred and, in the mid 1990s the then Minister of Labour, Hon Doug Kidd, announced that this was no longer government policy. This caused considerable concern among unionists and health and safety experts for a range of reasons. As John Hughes has emphasised :⁹

“...regulations and approved codes of practice are vital to provide the appropriate level of detail for performance-based standards, yet appear not to be prioritised, possibly due to budgetary constraints and lack of technical support available to the Department of Labour.”

2.40. These concerns appeared to be recognised by the Government in 2009 when then Minister of Labour, Kate Wilkinson, acknowledged in the foreword to the Department of Labour’s published enforcement policy for the HSE Act, that business representatives had signalled their concerns that uncertainty about complying with the law might actually compromise health and safety.¹⁰ In the same year the National Occupational Safety and Health Advisory Committee (NOHSAC) to the Minister reported:

“In New Zealand codes of practice are developed relatively rarely, notwithstanding the perceived need for such instruments. In New Zealand, of the 29 approved codes of practice listed on the Department of Labour’s website, only four were issued in the last five years, and 17 are more than ten years old.”

2.41. Consequently, the codes of practice that are available are sometimes inconsistent with current industry practice. The Department of Labour has

⁹ Hughes John *The Policy Considerations which prompted the enactment of the Health and Safety in Employment Act 1992 and the subsequent mining regulations in 1996 and 1999* EPMU0003/15

¹⁰ *Keeping Work Safe* Department of Labour 2009 <http://www.dol.govt.nz/PDFs/keeping-work-safe.pdf>

no formal system for prioritising the review of Approved Codes of Practice. Many codes of practice contain references to outdated standards, legislation and definitions. Sixteen years after the introduction of the HSE Act, stakeholders, such as employers, unions and OSH practitioners remain concerned about a lack of support and guidance for workplaces from governmental agencies.

2.42. It has been suggested that the Department of Labour, for both reasons of government policy and because they are “time-consuming and onerous”, has deliberately chosen not to develop Approved Codes of Practice. The consequence of this is that:

...not only some duty holders (particularly small- and medium-sized enterprises) but also inspectors themselves lacked, and to a significant extent still lack, sufficient guidance in discharging their respective responsibilities.¹¹

2.43. The DoL is reluctant to regulate as evidenced by the fact that the Department of Labour has not introduced a single Approved Code of Practice since 1998-99.¹²

2.44. A requirement needs to be introduced to the Act that provides for the mandatory promulgation of regulations and/ or Approved Codes of Practice where they will manifestly improve safety. This would limit the regulator’s discretion, and ensure better accountability for this work.

2.45. Alongside strengthening the requirement for regulation the process for standard setting needs to be more robust. There are many industries in which the hazards, and the control measures, are so well known that a strong case exists for more prescriptive regulation. This includes the case where hazards are associated with high-consequence/ low-probability events but also where standards are known to improve safety even when accidents maybe less severe (e.g. falls from ladders, working at heights).

¹¹ Gunningham Neil & Neal David Review of the Department of Labour’s interactions with Pike River Coal Limited 4 July 2011 DOL0100010001/18 at para 46

¹² Dave Murphy, Department of Labour oral evidence to the Commission of Inquiry into the Pike River Mining Tragedy.

In his report to the Department of Labour on Pike River, Professor Michael Quinlan noted that there was an argument in favour of more prescriptive regulation in those circumstances, along with mandatory reporting/notification requirements with regard to hazardous events and potentially hazardous events or deviations from safe practices. He argued that:

“Where control measures are clearly known in relation to hazard a requirement that they should be applied is unambiguous and assists management in terms of compliance”.¹³

2.46. This position is also argued by Bluff and Gunningham, who note that the specification of standards is particularly important where there is a high degree of risk, control measures that are applicable in all circumstances and where risks have acute and significant consequences. Furthermore, they note that there are a number of advantages associated with specification standards, including the clear identification of preventative measures to be taken by employers, administrative simplicity and ease of enforcement and the creation of a level playing field in highly competitive industries.¹⁴

Standard Setting

2.47. The CTU is concerned about the lax approach that has been taken by the former Department of Labour to standards setting. Reports from experts to the Department of Labour confirm that there is a substantial deficit in the development of appropriate health and safety standards in the form of regulations and Approved Codes of Practice (ACOPs) under the HSE Act.

2.48. Regulations and Approved Codes of Practice are rarely developed and many are out of date. Many industries have no organised voice for workers and standards are being developed by the industry themselves without necessary scrutiny (e.g the forestry ACOPs). The lack of resources and

¹³ Quinlan Michael, *Survey Report Reviewing Evidence from High Hazard Incidents and Matters Related to Regulation in Underground Mining* DOL4000010002 at para 224

¹⁴ Bluff, E. and Gunningham, N (2003) “Principle, Process, Performance or What? New Approaches to OHS Standards Setting”, Working Paper 9, ANU National Research Centre for OHS Regulation.

the significant gap in guidance material designed to promote compliance with the Act is an issue on which the ILO Committee of Experts commented. There is a general lack of effort to include a worker voice with some of the most dangerous industries (e.g. agriculture, forestry, fishing, construction) being almost completely de-unionised, meaning extra effort needs to be made for worker voice to be heard.

2.49. A consequence of this gap is that some employer groups have, with the tacit approval of the Department of Labour, developed their own codes of practice and guidelines. For example, codes and guidelines in the coal mining industry developed by MinEx, the national Health and Safety Council for the New Zealand minerals industry. While the board of MinEx includes union representation, there is no question that employer and industry interests are dominant. In most other cases there is no union involvement at all. This is not an acceptable model. As Gunningham and Neal caution:

In your opinion, what is the cause of the majority of incidents causing injury or illness in your workplace?

“Fatigue with having to meet deadlines and not being allowed to work overtime to meet those deadlines. Not taking micro breaks from computers because of those deadlines.”

“there is a risk of conflict of interest between industry’s concern to minimise costs (which might result in the creation of low standards or no standards at all) and the public (and worker) interest in improved occupational safety and health outcomes. Such codes might, for example, result in the lowest common denominator approaches and a de facto lowering of the general duty standard of care”.¹⁵

2.50. Standard setting is resource intensive at the front end but saves money longer term. There is an urgent need for a properly resourced process for standard setting to ensure all participants are adequately supported to be fully engaged in the process. The CTU believes standard setting should be the role of the new Crown Entity as described below and in each case should involve two distinct stages:

¹⁵ Gunningham Neil & Neal David *Review of the Department of Labour’s interactions with Pike River Coal Limited* 4 July 2011 DOL0100010001/18.

- The technical stage of establishing a link between a hazard and its consequent health effects. This process involves risk assessment and is properly the province of technical experts.
- The evaluation of the social impact of these health effects. Absolute safety is never guaranteed and the process of determining minimum acceptable levels of safety should include representatives of the workers exposed to the risks (including through a process agreed with the CTU as to how competent worker participation in standard setting will be supported in non-unionised industries).

2.51. The process of determining acceptable minimum standards of safety should be undertaken at a national level. It should be recognised that standard setting is a social process and not solely the prerogative of technical experts to determine acceptable levels of risk.

2.52. The CTU strongly believes that this standard-setting function should be undertaken by fully-funded independent specialist groups that include representation from appropriate industry (employer and union) representatives. This is an essential part of the Robens model and such a process is reflected in similar legislation in comparable countries such as the UK, Australia and South Africa. The standard-setting process itself should be managed by occupational safety and health professionals and be one step removed from the Government to ensure there is no political interference. These groups would report to the new Crown Entity.

2.53. An immediate priority should be a systematic and concentrated repair effort to fill the regulatory void resulting from two decades of neglecting to create and update New Zealand's workplace health and safety regulations and ACOPs. These instruments are necessary and fundamental to the administration and enforcement of the HSE Act 1992 and the workplace enforcement of the Hazardous Substances and New Organisms Act 1996. The process can be shortened by basing regulations and ACOPs on the best practice among comparable instruments from other countries, modifying them for local conditions as necessary. The repair effort should

be sufficiently funded and the required expertise made available to bring our regulatory instruments up to standard, and then commitment made to the ongoing funding and effort required to maintain, update and where necessary expand them on a continuing basis. The funding should include the costs of tripartite involvement in this process. Leadership of the effort should be one of the highest priorities of the new specialist Crown Entity.

2.54. Such an approach would be consistent with the requirements of International Labour Convention 155 which was ratified by New Zealand in 2007, and with the current terms of reference of the WHSC.

2.55. There is already considerable data and analysis through the work of the WHSC and NOHSAC reports which have identified areas that would benefit from more prescriptive regulations.

3. Regulator Role and Responsibilities

3.1. The Pike River tragedy, and evidence that has been presented to the Royal Commission, have shaken the already low level of confidence that workers throughout New Zealand have in the Department of Labour as the agency responsible for administering the HSE Act. It has been argued by many that the department has forfeited its right to continue in that role. Concern has also been expressed that the specialist capacity of the department has been so diminished over the years that it does not have the skills and knowledge to ensure that the potential of the HSE Act, as an instrument for the protection of the health and safety of workers, is able to be realised. This is not to say that the Department does not have staff dedicated to the improvement of Health and Safety, far from it, but the years of retrenchment and restructuring and the philosophical shift from a regulatory to an advisory role have neutered its effectiveness. On this basis, and in order to build confidence in institutional arrangements, a new and independent body is required.

3.2. It is of concern that the establishment of the new Ministry of Business, Innovation and Employment (MBIE) includes all functions of the current Department of Labour. New Zealand's specialist occupational safety and

health function has been subsumed in a government agency which has as its primary focus the promotion of business and economic growth. Cabinet papers recommending the establishment of the new Ministry make it clear that its primary objective is the establishment of:

“.... a new business-facing department to take more effective leadership of New Zealand’s microeconomic policy agenda and the development of practical decisions to achieve productivity improvement and competitive, internationally-focused businesses and industries.”¹⁶

3.3. The past side-lining of occupational safety and health provides no assurance that a commitment to enforcement of the current legislation would be any stronger under the new regime. The workplace health and safety function is barely visible in the large and complex ministry. Indeed, the CTU has major concerns that workplace health and safety will be seen as a barrier to achieving the goals of the Government’s Business Growth Agenda, despite its listing among the targets of that agenda. The CTU has therefore given consideration to other institutional arrangements for the public management function of regulating occupational safety and health.

3.4. In considering these options the CTU is not intending to question the integrity of well-intentioned specialist and other staff in the former Department of Labour. It can be reasonably inferred that the key decisions relating to the Act and its administration have been made at a political level. However, with regard to MBIE, the CTU is firmly of the view that the regulator function should be carved out and established as an independent agency. The very real risks of regulatory capture have been warned against by Gunningham and Sinclair:

“...the location of an OHS inspectorate in a government agency whose primary responsibility is the economic success and productivity of the very industry it purports to regulate is a prescription for disaster”.¹⁷

¹⁶ http://www.ssc.govt.nz/sites/all/files/mbie-1778145_0.pdf.

¹⁷ Gunningham N and Sinclair D, *Factors Impinging on the Effectiveness of the Mines Inspectorate* The Australian National University 2007 EPMU0011/14.

- 3.5. An obvious alternative to including health and safety in MBIE is that a new Crown Entity with a tripartite governance structure be created as a specialist agency focused solely on the development, administration and enforcement of the HSE Act 1992 and the workplace enforcement of the Hazardous Substances and New Organisms Act 1996. It would also be responsible for policy and strategic direction. This is a model that has operated successfully in the UK, through the Health and Safety Executive since 1975.
- 3.6. We recommend the establishment of such a specialist agency. We do not support the agency being a Crown Agent. Considering examples such as ACC and the Tertiary Education Commission, such agencies risk still being very dominated by the responsible Minister, and there would be little public confidence in its independence. In our view the agency should be an Independent Crown Entity (similar to the Transport Accident Investigation Commission) to ensure greater independence for its governance, which is particularly important for a tripartite board. The social partners should appoint their representatives to the Board with a requirement that appointments are made on the basis of expertise.
- 3.7. Such a model would be consistent with recommendations of the 1988 ACOSH Report, as well as the models of similar statutory occupational safety and health authorities in “Robens countries” i.e. UK, Canada, Australia. It would also ensure that an important regulatory function – the protection of the health and safety of workers in their employment – is not unduly influenced by the new role of MBIE in building competitiveness.
- 3.8. It would provide greater flexibility to enter into co-regulatory or skill/resource sharing partnerships with, for example, Australian regulatory authorities. The potential for standards-setting processes that operate on a trans-Tasman basis is an area of policy which the CTU believes has considerable merit and which we would like to see explored further.
- 3.9. There is a requirement for tripartite engagement under ILO Convention 155. In the UK the similar body, the Health and Safety Commission, was

merged into the Health and Safety Executive on 1 April 2008 and became the governing body of the Executive. Given that the whole workplace health and safety system must involve both social partners, it makes sense for the governance of its regulator to be tripartite. It increases the sense of ownership of all those involved – Government, employers and workers.

3.10. We note and agree with the comment of the Royal Commission that “As Robens concluded 40 years ago, advisory committees have little influence; an executive board is required if there is to be effective participation in decision-making.”¹⁸

3.11. Support for the worker participation system, including the Health and Safety Representatives, should be provided by the regulator as an essential part of its role in ensuring that the regulatory framework is working effectively. This support has been noticeably absent from the Department of Labour. The CTU proposes a reform of this in this submission.

3.12. The Royal Commission notes that New Zealand’s ratio of 0.8 Health and Safety Inspectors per 10,000 employees is almost half that of Tasmania (1.5 per 10,000). The Royal Commission states that “Western Australia was the lowest of the Australian jurisdictions, but still had a ratio of inspectors to employees almost 20% higher than New Zealand’s.”¹⁹ And, “New Zealand also has the second lowest government expenditure on health and safety regulation per employee (at a little over two-thirds of the Australian average)”²⁰

3.13. We note and support the announcement of additional funding to increase the number of inspectors but note that even if the target of 20% more Health and Safety Inspectors is reached we will only be equal to the least well-resourced Australian state. At least until our injury and fatality rates fall to well below OECD averages, the number of inspectors should be significantly above average in order to restore credibility that the regulator

¹⁸ *Report of the Royal Commission on the Pike River Coal Mine Tragedy*, Chapter 24 para 27.

¹⁹ *Report of the Royal Commission on the Pike River Coal Mine Tragedy*, Chapter 18 figure 18.3 and para 13. These figures exclude mining inspectors.

²⁰ *Ibid.*, Chapter 18 para 14.

has the capacity to do the job required of it for an effective national health and safety system. The Royal Commissions report has found that rates of serious harm rose as numbers of inspections fell between 1992 and 1997.²¹

3.14. Inspectors' training and pay rates need to be increased to reflect the high level of competency and capability required and the international demand for these roles (particularly in mining). The inspector's role needs to have more focus on prosecution and penalties. Currently all prosecutions have to be taken within six months which is inadequate and means that inspectors are pressured to work within the time limit. The CTU recommends that this timeframe be extended to two years.

3.15. The advice and education roles of the Department should be separated from the inspection role. One approach to this would be to give ACC the responsibility to provide advice and education. This would need to be an absolute responsibility defined in statute and, unlike the present situation, not qualified by any requirement to reduce ACC levies. ACC would be required to follow the strategies and policies of the Health and Safety Crown Entity, which would have statutorily defined roles including policy, monitoring, enforcement, developing regulations and ACOPs, and promoting and enforcing them.

“...The moment an incident occurs [...] rules are used to discipline those involved.”

3.16. The Royal Commission's report has noted that “Until comparatively recently, accidents were routinely attributed to frontline operator error, and contributory causes were not considered, including the actions of those at management and governance level. The broader context, or setting, in which the operator acted was essentially ignored. If, by contrast, the question ‘why’ is asked – why did the operator act as they did? – a whole range of contributory factors may emerge. Perhaps the machine operator's training was deficient, fatigue clouded their judgement, the machine guard

²¹ *Report of the Royal Commission on the Pike River Coal Mine Tragedy*, Vol 2, p.272

inhibited production or overriding guards was commonplace in the factory.”²²

3.17.

3.18. The CTU also believes that the investigation regime should contribute significantly more to policy and practice development. Currently investigations continue to determine prosecution but rarely go into root cause information and little is made of accident reports to compare practice, gather cross industry information or develop policy. This is a waste and leaves an incomplete picture on how industries are managing hazards. Investigations should have three roles: To determine what happened and any liability or improvements needed at the enterprise level; to add to knowledge about industry practice and hazards; to develop responses that avoid further accidents in the industry.

3.19. The CTU believes workers should have access to an anonymous telephone service to which they could report safety issues to the regulator while keeping their identity private from their employer. This mechanism is important to mitigate fear of reprisal associated with “whistleblower” actions.

3.20. The CTU supports the Rail and Maritime Union’s submission with regard to the fragmented regulator.²³

Funding

3.21. In addition to direct funding from the crown the Crown Entity should have the power to raise its own funds in order to carry out its functions. This would avoid the situation we have seen for several years of inadequate and reducing funding hamstringing good health and safety regulatory enforcement and development by the regulator.

²² Report of the Royal Commission on the Pike River Coal Mine Tragedy

²³ Sections 11.1 and 11.2, Submission of the Rail and Maritime Union to the Independent Taskforce on Workplace Health and Safety, November 2012.

3.22. The CTU has considered the cost implications of increasing the regulator's capacity to both undertake the work programme necessary to address the deficiencies in the HSE Act and its current administration and to ensure more effective enforcement. Although there is a strong case to be made for an increased government budget appropriation through Vote: Labour, there is also the option of increasing the revenue available for this purpose through an increase in the existing HSE Levy, currently collected through ACC. The rate of this levy has not been increased since 1999. Appendix One provides background information on the levy describing the history of the levy and its current use.

3.23. We submit that the Crown Entity should have the power to raise sufficient funds to cover its costs in at least two ways. In addition to having the power to set the HSE levy at appropriate levels it should also have the power to charge individual employers for services, for enforcement actions, and for any actions necessary following enforcement. Consideration should also be given to fines and penalties being paid into its funds rather than the Consolidated Fund.

3.24. We note that this is consistent with the Royal Commission's recommendation that: "In principle, the levies should be spent on health and safety administration and be fully allocated to the regulator. The new Crown agent should be able to transfer funds between years as needed."²⁴

3.25. We anticipate that the HSE levy will need to be increased to ensure that standards of health and safety management in New Zealand workplaces are improved. There is evidence to support the proposition that there are tangible benefits in doing this. For example, research evidence from the USA shows that the coalmining fatality rate is closely related to funding of the regulatory agency:

"Research on US coal mines shows that the fatality rate is inversely related to the size of the federal budget allocation to the regulator – the larger the budget, the smaller the fatality rate. Moreover this is

²⁴ *Report of the Royal Commission on the Pike River Coal Mine Tragedy*, Chapter 25 para 36.

independent of the nature of the legislation being enforced. In short, a well-resourced regulator is the key to reducing fatalities.”²⁵

4. Work Arrangements and Structure of Work

4.1. It is widely agreed by academics and researchers working in the area that changes in the nature and structure of the labour market have had a major impact on the operation of health and safety representatives. The combined effect of the changes to employment and occupational safety and health laws in New Zealand in the 1990s resulted in:

- The widespread weakening of employee participation in occupational safety and health
- A lessening of employee knowledge and awareness of health and safety issues
- A weakening of union representation and bargaining on health and safety issues
- An increasing unwillingness of workers to report OHS problems caused by insecurity of work
- A separation though outsourcing (contracting) of those best placed to ensure workplace safety (the receiving employer) and those providing the labour (contractors/employees of contractors).
- Increased difficulties with employee health and safety induction, training and participation as casualisation and short-term appointments increased.

In your opinion, what is the cause of the majority of incidents causing injury or illness in your workplace?

“Subtly [we are] being pushed by managers and supervisors to hurry on tasks and break downs to minimise downtime. Staff are constantly rushing instead of planning jobs for themselves. We work 24/7 shifts therefore more care is needed at night.”

²⁵ Hopkins A and Wilkinson P *Safety Case Regulation for the Mining Industry* Working Paper 37 National Research Centre for Occupational Safety and Health, Australian National University 2005 in Gunningham and Sinclair supra Note 26.

- Increased pressures through a combination of low pay, increased work hours including multiple job holding, and pay related to production, creating encouragement for increased unsafe practices and increased likelihood of accidents as a result of fatigue.

4.2. John Hughes has noted:

“Health and safety representation was envisaged by Robens as depending on strong union organisation within large enterprises, yet union density in the private sector effectively collapsed in New Zealand after the introduction of the Employment Contracts Act 1991 and this too has been seen to have led to a lack of support and guidance for workplaces.”²⁶

In your opinion, what is the cause of the majority of incidents causing injury or illness in your workplace?

“under staffing - overworked staff who struggle to get annual leave and 4 days off per fortnight, lack of adequate protective equipment, lack of sleep due to lack of staff and having to work 7 or 8 sleep overs in a fortnight. We constantly struggle to get adequate supplies of protective equipment and are now 'rationed' so we don't use too much as it is costly!”

4.3. Although little research evidence is available in New Zealand of the impact on workplace health and safety of the Employment Contracts Act, there is a general acknowledgement that it had an adverse effect on conditions of work for most employees. The 1990s saw a dramatic growth in precarious employment - shift work and night work, self-employment, part-time jobs, multiple job-holding, home-work, and casual and temporary employment (increasingly through labour-hire companies).

4.4. An international review of 93 research studies covering 11 countries, in a range of industries and employing a number of methodologies, has shown that the growth of these types of work arrangements have had an adverse effect on workers' health and safety. Of the 93 studies, 76 found that

²⁶ Hughes Ibid.

precarious employment was associated with a measurable deterioration in occupational safety and health.²⁷

- 4.5. The experience in New Zealand accords with the broad findings common to those studies. Precarious employment is often associated with economic pressures or changes to payment and reward systems that endanger health. These include competitive tendering and consequent “corner-cutting” by subcontractors, the outsourcing of dangerous tasks, payment by results and low pay, work intensification and overload, long hours of work, and the limited resources that some businesses devote to workplace health and safety.

In your opinion, what is the cause of the majority of incidents causing injury or illness in your workplace?

“Trying to complete a job in the cheapest way possible, particularly contractors tendering, building safety into the job will increase the price submitted. [There is a] lack of commitment to identify and control hazards.”

“...contractors [are] taking short cuts (not following permit to work) People are charged with the responsibility to follow the permit to work but they just fill it in as a paper exercise.”

- 4.6. Secondly, precarious employment can be associated with dangerous forms of work (dis)-organisation. For example, it is common for temporary or labour hire workers to be inadequately trained, especially where the workforce is young and inexperienced or where there is a high level of labour turnover. Similarly, outsourcing and labour hire contracting means the introduction of “strangers” to the workplace, disruption of informal flows of safety knowledge and communication and an increase in complexity and ambiguity in rules and procedures. Downsizing can result in a loss of knowledge with the loss of older and more experienced workers

In your opinion, what is the cause of the majority of incidents causing injury or illness in your workplace?

“Employers increasing the workload on individual employees by not employing the correct number of people to do a job safely. Rushing and lack of proper training are the leading causes [of injury] in my opinion. These are generally the result of management cost cutting measures.”

²⁷ Quinlan M, Mayhew C & Bohle P *The Global expansion of precarious employment, work disorganisation, and consequences for occupational health: a review of recent research* International Journal of Health Services, Vol 31 Number 2 – 2001 pp 335-414.

and resulting multi-tasking may result in additional risks if workers are not suitably retrained. Precarious workers are often in a weak position to raise or complain about OHS issues, particularly in a non-union environment. Canadian studies have shown the much higher rate of accidents for workers new to a job – a position precarious workers are in repeatedly: “unadjusted claim rates for workers in their first month of a job were four to six times higher than those with more than one year on the job.”²⁸ Australian research has shown that “agency workers are especially vulnerable to injury early in their placement, and insufficient attention is given to accommodating unfamiliarity to counter workers’ vulnerability in new workplaces”²⁹. The 90 day rule is a particularly aggravating feature in this regard – it makes it very difficult for a new worker in a new job in a competitive job market to question, let alone challenge, any unsafe practices.

4.7. Third, the OHS regulatory framework is designed and implemented to predominantly deal with permanent employees in large workplaces. On multi-employer work-sites complex webs of legal and management responsibility and control increase risk. To compound this, changes to labour legislation weakened minimum standards and union input.

4.8. We provide three case studies:

1. Kenny Callow

Ken was killed in the Wharerata forest – one of three forestry deaths in that forest in the last 18 months. Each of the three deceased worked for separate contracting companies. The forest owners benefitted from Ken’s work, but offered no reciprocal employment protections as they had contracted that out to his direct employer. Ken appears to have made a terrible mistake while at work one day resulting in his death. Under production pressure, he appears to have abandoned the felling of a tree on which he had begun work due to discovering

²⁸ FC Breslin and P Smith. *Trial by Fire: a Multivariate Examination of the Relation Between Job Tenure and Work Injuries*. Occupational and Environmental Medicine 63, no. 1 (January 2006): 27–32. Also: “Newness” and the Risk of Occupational Injury. Issue Briefing, Institute for Work & Health, May 2009. Available at <http://www.iwh.on.ca/briefings/newness>.

²⁹ Elsa Underhill, *Temporary Agency Workers and the Contribution of Workplace Unfamiliarity to Workplace Injuries*. In AIRAANZ 2007 : Diverging Employment Relations Patterns in Australia and New Zealand, Conference Proceedings, 11. Association of Industrial Relations Academics of Australia and New Zealand Conference. Auckland N.Z.: University of Auckland, 2007. <http://hdl.handle.net/10536/DRO/DU:30008220>.

it was rotten and of no value. He moved on to the next tree leaving a hazard close by which collapsed on him taking his life. The DOL inspector found Ken was “the architect of this own demise”. The inspector does not appear to have taken into account whether the terms and conditions of Ken’s employment may have impacted on his decision to leave a hazard in place. A forest owner in the region described the three deaths as “unfortunate”. Ken’s mother articulated in a beautiful letter to the *Gisborne Herald*, just how unfortunate she felt it was:

In response to the article in Monday night’s paper on forestry safety, we were outraged at Mr Drummond’s comment regarding the loss of three lives in the Wharerata forest as being “most unfortunate”.

Yes, Mr Drummond, it is unfortunate that we have lost a son and two young boys do not now have a father — and that there are two other families in Gisborne still grieving for a loved one taken in yet more forestry accidents.

Lend a thought to those forestry workers who are out there in the burning heat or freezing snow with minimal appropriate clothing. To wear bulky cold-weather gear can slow you down if you have to move fast to get out of the way of a rolling log. Our son did this on a daily basis, often wearing shorts in the snow.

When you are tucked up in your cosy warm bed, Mr Drummond, spare a thought for the boys who are out there from 4am to 5pm often six days a week.

As a mother it agonised me to see our son come in at the end of the day that exhausted he could not eat a meal but just fell into bed.

There is huge pressure put on our forestry workers by contractors and forest owners for those men to get the wood out. Often they skip meal breaks to reach a deadline.

All of this you may not know Mr Drummond, as you have your OSH policies — but in reality, this is how you get your quotas.

These men and women risk their lives to earn a living, yet no one gives a thought to how those logs arrive at the wharf.

Spare a thought for the families, Mr Drummond. If it had been a member of your family, would it still have been “unfortunate”?

Unfortunate is not the word our family would use!

Ken’s mother also speaks of his hypothermia symptoms in the winter and shaking from dehydration in the summer following a day of work. Of him seeking other duties to reduce the physical stress but of these being difficult to provide within a small contracting company. It is the view of the CTU that Ken’s employment conditions were a major contributor in his accident.

2. Charanpreet Dhaliwal

Young security guard Charanpreet Dhaliwal was employed on a Fulton Hogan building site, owned and operated by Fulton Hogan. His employer was a very small security company, CNE Security, contracted by Fulton Hogan to provide security.

Charanpreet came to NZ from India to study computers. His family invested everything to give him and them this opportunity. He attended a PTE computer course in Auckland and following completion was hoping to get work here in the industry.

Charanpreet did a bit of security work for the World Cup. On 18 November last year, he called the owner of CNE, whom he had heard about from friends, to see if they had any work. The employer said he didn't but he should come in the next day for an interview.

Shortly afterwards, a guard due to work that night, rang the employer asking for the night off for his birthday. The employer rang Charanpreet back and offered him a trial that night on the Fulton Hogan Building site in Henderson. He accepted. There was no discussion about an employment agreement and possibly no intention to pay him for the evening's work.

They arranged to meet at the isolated site at 10.30pm that night. He was told to bring a torch!

That night at 10.30 the boss, the birthday boy (who had himself, only worked one shift for the company) and Charanpreet turned up. Charanpreet had bought a small torch. The birthday boy showed him around the site for 10 minutes, gave him the keys and left him to it. The site had been burgled before, leading to Fulton Hogan getting security. Charanpreet was not given any warning of this, not told any safety information. By four in the morning he was dead. Murdered.

The Sikh community in Auckland raised money to get his body home to his mother. Fulton Hogan gave a donation of \$4,000 towards the \$8,000 costs and no one made an ACC claim for funeral expenses.

The CTU has received his first and last pay cheque – \$50.25 It didn't come with a payslip, and there is no employment agreement for Charanpreet. His mother who is dependent on him will get no ACC. He had no earnings, so no earnings related compensation is payable. He had no legally recognised dependents so no lump sum is available either. A very cheap death all round.

Fulton Hogan has refused to address either the issue of some compensation for Charanpreet's family, nor engage in a discussion about responsible contracting and how this type of situation might be avoided in the future. CNE

is being prosecuted but the company that benefitted from his labour (Fulton Hogan) and was in the best position to secure his safety is able to walk away from all responsibility with even the Department of Labour (now MBIE) suggesting it had taken “all practicable steps” in terms of Charanpreet’s safety that evening. Charanpreet was 21.

3. Joseph Dunbar

Joseph was 17 and killed on his first day of work in the Pike River mine. He was working for major Australian drilling company Valley Longwall. He was to be engaged as a contractor, making him a contractor to a contractor to Pike River. There is no genuine reason as to why this would be the type of employment relationship that Joseph should endure. He was not a contractor in the sense that he worked for many companies, he was to work regularly and full time for VLI, there were no opportunities for any tax advantages. It was simply a ruse to avoid the reciprocity of an employment agreement, and the fundamental rights to freedom of association, collective bargaining, as well as the statutory minimums in the New Zealand law that apply to employees (holidays, sick leave, minimum wage). Ben Rockhouse was similarly employed by VLI and was paid in cash in the pub without any tax or ACC levies being deducted despite his request for formalisation.

VLI was prosecuted for its failings in Pike. This included the operation of an extremely dangerous drill without meeting the most basic safety requirements. The drilling process was methane creating and electrical. It was considered so dangerous that a registered electrician was required to check it each week. It had its own methane monitor, calibrated to check when levels of methane rose above 1.25% (explosion rate is 5%). This was also to be checked weekly. VLI contracted these jobs to Pike River who did not complete the checks. VLI failed to ensure they were carried out.

On the day of the explosion, the drill was checked as Pike considered the methane monitor was triggering early. It was found to be faulty and in need of replacement. This was not done that day and VLI continued to leave three staff in the mine including Joseph. In court, VLI pleaded guilty and on 27 October 2012 was fined on \$46,000 with the judge finding a moderate breach. To media, the company said: “Although the company believed it been ‘innovative’ in its safety standards, it could not say ‘hand on heart’ it had done all it could to keep its people safe and had decided to plead guilty”. In sentencing, Judge Farish said Valley Longwall took very few steps to ensure it met the required safety standards but she took into account its unblemished safety record, its guilty plea and its genuine remorse for the deaths, as well as the reparation it paid to the families of the three men.

The judge refused VLI Drilling's plea for a discharge without conviction, saying

its culpability was moderate rather than low.

It had claimed that would damage its international reputation and could have "significant fiscal ramifications", which were disproportionate to its offending. However on 31 October 2012 (four days later) VLI won a Hunter manufacturing award for Excellence in safety – and in a sign of its contempt for these families – accepted it.

The judge said "VLI took very few steps to ensure there was a safe working environment."

She decided that the only connection to the explosion was that it was the catalyst to investigations into what could have been done better at the mine, leading to the charges. There seems to have been no consideration of the benefits of having a working methane monitor. Instead the judge said the breaches had the "potential" for serious harm.

She accepted the company had not departed from industry standards in how it ran the rig but said it was a large international company that had not enforced its fundamental requirement to protect the safety of employees.

It is unclear if Joseph knew the drill had a malfunctioning methane monitor or if he knew how to get out of the mine in an explosion. He had never had the chance to exit the mine before. The chances that this boy could have raised any health and safety issues, joined a union, recognised any dangers or asserted himself in any way were denied by the nature of his employment.

Another dead miner, Stuart Mudge had previously worked for VLI. His step father provided evidence to the Royal Commission of his experience with the company. He worked five months as a driller's assistant before moving to work directly for Pike. He was employed as a contractor and would invoice the company for payment, but often had to chase his payments including being paid by credit card from time to time, which is consistent with Ben Rockhouse's experience. He received none of the benefits of employees (it appears Australian miners were fully employed by VLI and had these benefits). Stu told his parents stories of walking into the mine with methane bubbling up through the puddles. At one point the drill malfunctioned and Stu was suffocated unconscious in the mine, from the gas. He was carried out on a drift runner. Despite feeling sick he went to work the next day to avoid losing an attendance bonus. He was told by friends to go to the Department of Labour about these concerns but was concerned he would lose his job. He was 31 when he died in the Pike River mine.

- 4.9. The status and rights of workers who are vulnerable, insecure, or regarded as contractors for service, needs major reform. The relationship between the absence of such rights and poor standards of workplace health and

safety are clear. They have also been highlighted in the Pike River Mine tragedy. This could include

- legal mechanisms that look through triangular employment relationships and/or confer additional rights for those on contracts for service.
- Broadening duties beyond employers to an arrangement such as the Australian one of a “Person Conducting a Business or Undertaking” (PCBU) in which the full degree of responsibility is not only for the health and safety of employees but also for contractors and subcontractors (and all the way down a subcontracting chain), franchisees and the people they employ, as well as to ensure that the upstream supply of equipment and materials used (including aspects such as design) and downstream use of the products of the business are safe for their users.
- Duty to ensure proper induction and training in both general and site-specific aspects of health and safety are provided to all workers (regardless of their contractual status) before they commence work, proper safety equipment is provided, and supervision for health and safety purposes of workers in their first year³⁰ by a person competent to do so.
- Representation of all workers on site by all health and safety representatives (not simply to those employed by their employer)
- Inspection regime to include consideration of employment arrangements and the contribution they make to any accidents (including scrutiny of employment agreements, payments, hours, rights etc)

4.10. Any change to duty-holder responsibilities to include receiving employers, should strengthen all duty-holder responsibilities and should not exclude any level of management or employer from liability.

³⁰ Breslin and Smith (op cit) provide evidence from Canada that injury rates in the first year of work are between two-thirds higher and four times higher than that of longer serving workers when other factors such as age, industry and occupation are adjusted for.

4.11. We make further proposals below, including Health and Safety Centres, which are also aimed at improving the position of such workers.

5. Worker Participation and Engagement

5.1. The concept of tripartism and employee participation is fundamental to the Robens/ACOSH model and is a vital part of the regulatory framework. There is overwhelming evidence collected internationally from multiple studies that worker participation drastically reduces the incidence of occupational injuries and illness. As Gunningham and Associates note:

Workers have the most direct interest in OHS of any party; their lives and limbs are at risk when things go wrong. Moreover, the hazards at work need to be identified and evaluated, and workers experience and knowledge is crucially important in successfully completing both of these tasks. Worker participation also has a number of other benefits.³¹

5.2. In 1992, the Government declined to include any provisions relating to elected health and safety representatives or enforceable employee involvement in health and safety policies and processes. Its view was that health and safety should be managed by the employer, to the exclusion of employees or their representatives if the employer thought fit.

5.3. It was not until the 2002 amendments to the HSE Act 1992 that rights for employee participation were included in New Zealand legislation. The arguments in favour were rehearsed by Cabinet at the time of the 2002 amendments to the HSE Act, when it was noted that evidence from both Australian and New Zealand research showed that employee participation was associated with good health and safety practice and compliance with workplace health and safety legislation. Moreover, in response to the Discussion Paper issued for the purposes of public consultation on the proposed legislation, 54% of respondents supported the suggestion that health and safety representatives should be elected. Despite this, both Treasury and the Ministry of Economic Development argued against the

³¹ Gunningham and Associates *Report to the Department of Labour* (DOL0010020402/15).

proposals on the grounds that they would increase compliance costs on business.

5.4. The provisions included in the New Zealand Act are minimal by international standards. They provide for:

- A new general legal duty on all employers to ensure that all employees have the opportunity to be effectively involved in health and safety processes.
- The right for workers to elect health and safety representatives in their workplace with statutory or agreed roles as part of worker participation arrangements. Health and safety representatives have a right to two days training leave annually, and the employer has an obligation to actively arrange this leave including regarding the power to serve hazard notices on employers.³² Inspectors to monitor these provisions have penalties available for non compliance.
- A statutory right to refuse dangerous work (reflecting a common law right and which is arguably an obligation under the section 19 duty on all workers to take all practicable steps to protect their own health and safety and the health and safety of others).

In your opinion, what is the cause of the majority of incidents causing injury or illness in your workplace?

“Most accidents I have been involved with are management’s refusal to listen to the serious requests of staff and reps. We have a H&S policy & procedure which are token and a commitment which is really only “risk minimisation” or “butt covering” rather than a real concern for safety.”

5.5. International research also, however, demonstrates that representation alone is not sufficient. It is critical that employee health and safety representatives are informed and knowledgeable, and are provided with sufficient time off to undertake their functions effectively. The CTU has some concerns about the operation of the Part 2A employee participation provisions of the HSE Act. These are detailed below.

³² Note: Regarding the right to leave, however, whilst the leave has been extensively used and some employers have exceeded the two days per year, whether or not representatives attend training courses and which training courses is more often than not determined by the employer.

Systems for Effective Employee Representation

- 5.6. It is a concern that some workplaces do not have effective and democratic systems in place for the election of health and safety representatives. This has been the result of a lack of enforcement of Part 2A by the Department of Labour, and continuing command and control approach to all aspects of workplace operations by a many employers.
- 5.7. We acknowledge that in some workplaces there is a lack of interest or reluctance among employees to take an active role. We believe that our proposals for strengthening the representative role, along with steps to improve understanding of the importance of workplace health and safety and the culture that surrounds it will help to encourage more worker participation.
- 5.8. The Department of Labour took no steps to promote, or undertake training in relation to, Part 2A of the Act after it came into effect in 2003. There is widespread non-compliance with the requirement of the Act for health and safety representatives to be elected in all workplaces with 30 employees or more. This is particularly also true in SMEs where union coverage is often weaker. Even amongst some of the bigger employers agreed employee participation systems as required by section 19C of the Act have not been developed and many of them are not reviewed regularly as required.
- 5.9. Further, despite requests from the CTU, the DOL has only very recently acknowledged the importance of employee participation as an effective means of driving compliance with the HSE Act and making places of work safer and healthier.³³ While a practice note was issued in March 2010 stating that enforcing employee participation mechanisms would be accorded priority in inspections and that inspectors would work closely with trained health and safety representatives in places of work, the CTU has seen little evidence of this being implemented. The department should be active in its enforcement of Part 2A as an essential contributor to

³³ *Keeping Work Safe* Department of Labour 2009 <http://www.dol.govt.nz/PDFs/keeping-work-safe.pdf>.

workplace health and safety, ensuring that compliance is a mandated requirement, as it is in the UK.³⁴

5.10. Non-compliance with Part 2A reflects the opposition of many employers to employee participation, individually or collectively, in health and safety processes required by the Act. Sometimes this manifests itself in anti-union sentiment. In other cases lip-service is paid to the requirements of the Act and essential information is withheld from health and safety representatives and employees. Employees in supervisory or management positions are shoulder-tapped by management to become health and safety representatives. The CTU experience is that health and safety committees are often stacked with managers, or dominated by them. Or two committees are formed – one of workers and the other of managers – often if this is case, the worker committee is made to feel inferior and are not sufficiently valued for their contribution to health and safety. In some instances, a national committee is formed in large companies (with for example 9,000 employees) and this is supposed to be the main body for employee engagement and participation.

5.11. This is problematic for a range of reasons.

5.12. An ideological objection to worker participation has very real consequences for health and safety outcomes. As a highly experienced health and safety expert has observed:

“The notion of a tripartite approach to health and safety envisaged in Robens and ACOSH, has tended to be the exception rather than the norm, partly due to reduced union membership in some sectors and, in

In your opinion, what is the cause of the majority of incidents causing injury or illness in your workplace?

“Our work environment is cramped and we have many people working in limited space which causes injuries. Shortage of staff creates more pressure issues to complete the mountain of work. Management make the staff feel like they are clumsy fools when we report an injury so some do not get reported and as a result continuous repetitive movement creates a worst problem.”

³⁴ <http://www.hse.govt.uk/foi/internalops/ogprocedures/rep.htm>.

others, an antipathy towards employee involvement. The tripartite approach is important as the model envisages an approach in which all of the key stakeholders participate in setting and monitoring safety standards. Without the involvement of employee reps there can be a lack of buy-in and commitment to the resulting product in the same way that the absence of involvement of the regulator can result in standards which are unenforced. And it should not be forgotten that ILO conventions, such as 155, to which New Zealand is a signatory, mandate such an approach”.³⁵

5.13. As we have commented above, there is not only a practical reason for effective worker participation, but there is also a moral obligation in that it is the workers whose health and safety is at stake. Without an effective worker voice health and safety standards and practices go largely unmonitored.

5.14. There is also a need to focus on “representativeness” and the role of Health and Safety Representatives, and to regulate workplaces in this respect. The Act intends that representatives are elected by workmates rather than appointed by managers. However the results of our survey of health and safety representatives show that more than 40% of representatives were appointed by management.³⁶ The current legislation is insufficient and the development of a proposed Code of Practice (as anticipated in section 19B(3) and provided for in section 20(1)(ad) of the HSE Act) was frustrated in 2006 by employers because they demanded that representatives be appointed contrary to the definition in section 2 of the Act which says a representative is an employee elected by other employees to represent them in health and safety matter. This resulted in the Code of Practice not being progressed by the Department of Labour.

5.15. The CTU recommends that

³⁵ John Hughes Supra.

³⁶ The Results of the NZ Council of Trade Unions Survey of Health and Safety Representatives 2012 (Appendix Two)

- Health and safety representatives and committees should be required for all workplaces with at least ten employees. We support the Royal Commission's call for all underground coal mines to have documented worker participation systems³⁷ and propose that this requirement is extended to all high hazard industries.
- All workplaces should be encouraged to have health and safety representatives regardless of size ie: the more than 30 employee quantification should be reviewed. There should be a special focus on small to medium enterprises to ensure that health and safety representatives are present.
- Where ten or more non-permanent workers (including for example casual and fixed-term employees, contractors, and labour hire workers) are employed in a place of work at any time in a year, a worker should be elected to represent their interests with regard to health and safety. The election should be by those workers (if practicable or by other health and safety representatives if not). The representatives should be on the health and safety committee. All representatives should be trained to represent workers in "non standard" employment.
- The legislation should prescribe the information made available to representatives and to committees (for example, accident and incident reports).
- If a union is present the union should be responsible for managing the election of health and safety representatives.
- The Code of Practice for worker participation in health and safety anticipated by the Act in sections 19B(3) and 20(1)(ad) be completed and implemented.
- Representatives of the regulator should be required to consult with health and safety representatives in all matters concerning their workplace such

³⁷ *Report of the Royal Commission on the Pike River Coal Mine Tragedy*, Chapter 30, para 14

as inspections and investigations of breaches of the legislation and incidents.

- Health and safety representatives should have the right to be trained annually and employers should have the responsibility to ensure this occurs.

Strengthening the Role of Workers in the Regulatory Framework

5.16. The worker role in the “workplace component of the Robens model is vital to its effectiveness. Yet the history of this “third leg of the stool” of this “self-regulatory” model under the HSE Act 1992 has been lamentable:

- No enforceable worker participation at all in the 1992 Act until the 2002 amendments.
- Lack of promotion, let alone enforcement, of Part 2A
- Continuing hostility of some employers to the worker participation provisions, particularly as a representative role.
- Poor resourcing of health and safety representatives and inadequate authority and legal support to do their job.

5.17. One of the consequence of policies which have resulted in the substantial de-unionisation of the private sector is poor health and safety practice. Legislative provisions need to be strengthened and additional resourcing of worker participation at all levels is required that takes this gap in representation into account. Worker participation is the “third leg of the stool” in the Robens model with regulator, employer and worker providing the balance needed. It is not a coincidence that four of the five most dangerous industries in New Zealand are almost completely without unionisation (agriculture, forestry, fishing, construction).

5.18. Increasing representation and training will ensure that workers and their health and safety representatives feel they have an effective ability to influence and where necessary control the aspects of their working lives

that impact on their health and safety. Without this it is likely many will continue to feel apathetic or cynical about health and safety in the workplace and measures taken to improve it. As the New Zealand study “In Harm’s Way” noted, workers who feel they have no control over their work situation are less likely to take action even if they know they are at risk .

5.19. The CTU recommends strengthening the regulatory powers and protections for Health and Safety Representatives. These should include:

- Extending the function of Health and Safety representatives to include all workers such as temporary employees, and those working under contracts for service (see also the above proposal under Health and Safety Committees).
- Ensuring the selection process for representatives on health and safety by workers is free from employer influence.
- Providing Health and Safety Representatives with effective legal protection against discrimination and unjustified actions (including dismissal) if there is any cause to suspect that it may be related to the duties undertaken as an HSR.
- Paid time away from normal duties to carry out the function of representative.
- Paid time away from normal duties to be trained as a representative preferably by worker oriented trainers such as the CTU, but with representatives having the right to select who trains them.
- The right to receive adequate information from the employer or principal on current and future hazards to the health and safety of workers at the workplace.
- The right to inspect the workplace.

- The right to investigate complaints from workers on health and safety matters. Including the right to be involved in accident investigation.
- The right to make representations to the employer or principal on these matters.
- The right to be consulted over health and safety arrangements, including future plans. This includes strengthening the requirement on employers to consult Health and Safety Representatives with regard to process and systems such as risk management and health and safety systems (as recommended by Quinlan)³⁸.
- The right to be consulted about the use of specialists in health and safety by the employer or principal.
- Requiring the inspectorate to recognise, engage, cooperate and consult with Health and Safety Representatives. This includes the right to accompany health and safety inspectors when they inspect the workplace and to make complaints to them when necessary.
- For appropriately trained representatives, the power to serve written improvement notices to employers or principals when such a representative observes a contravention of the HSE Act. This is in addition to their current power to issue a Hazard Notice and is described in more detail below.
- For appropriately trained representatives, the power to require other workers to stop dangerous work.
- Rights of access to representation for workers in small enterprises and measures to address the problems of representation in multi-employer worksites and where work has been outsourced as a result of organisational changes. We note and agree with the Royal Commission's recommendation that the Health and Safety

³⁸ Quinlan Michael, *Analysis Report: Reviewing Evidence to Assess whether the Conclusions and Recommendations of the 2006-2009 Mine Safety Review Still Relevant and Changes in Regulatory Framework the Royal Commission might consider*" DOL4000010003 at para 71.

Amendment Bill (No. 2) introduced in August 2008 should be progressed insofar as it provides a positive duty on all those (excluding employees) who have duties in the same place of work to collaborate to meet those duties (including employee participation duties).

5.20. Many of our proposals are consistent with the 2009 report of Gunningham and Associates to the Department of Labour in which they identify several ways that workers' rights might be strengthened such as:³⁹

- Extending employee representation rights to include all workers (including both employees and contractors)
- Improved rights of access to intervene in unsafe situations and to represent workers interests on issues of work intensity, work organisation and working time, all of which can increase the risk of ill health (see the CTU proposal below for Health and Safety Advisors).
- Strengthening the requirement to consult with regard to process and systems such as risk management and OSH systems.
- Increasing the role of the inspectorate in ensuring consultation.

Health and Safety Centres

5.21. As the consultation document points out, there are significant barriers to participation in health and safety for a large number of workers including many in small firms, in de-unionised workplaces, in temporary or contract employment, or those with English as a second language. This exacerbates the higher risk of injury that these workers in general face. It is with this in mind that the CTU makes the following set of recommendations.

5.22. We recommend that regionally based Health and Safety Centres be introduced. These centres would be government-funded yet independent,

³⁹ Gunningham and Associates, *Underground Mining Information: Contextual Advice on International Standards and Literature Review* June 2009 DOL0010020402/19.

and report to the Board of the Crown Entity recommended above, or in its absence to the Workplace Health and Safety Council. The centres would employ Safety Advisors who would be available to advise and mediate on health and safety issues in any workplace.

5.23. The primary role of the Health and Safety Advisors would be to support Health and Safety Representatives in all their duties. Health and Safety Advisors have been piloted in the UK and have been found to be effective in reducing injury at work.⁴⁰

5.24. Health and Safety Advisors should also have powers to enter into workplaces at the request of workers where no health and safety representative structure exists, or where they have good reason to believe a significant hazard exists, and assist workers in resolving health and safety issues with their employer, and in setting up representative structures.

5.25. Shift work, targets, work arrangements, and workloads are areas in which a more collective response is required to health and safety. The results of the health and safety representative survey show that speed, fatigue, stress and workload are believed to be the cause of most accidents at work.⁴¹ The introduction of Health and Safety Centres and advisors and a new process for resolving health and safety issues could make significant improvements in this area.

Administration of Hazard Notices

5.26. The CTU believes that there should be a binding obligation on the employer (or receiving employer) to go to mediation after a Hazard

In your opinion, what is the cause of the majority of incidents causing injury or illness in your workplace?

“Too many shortcuts being taken to meet production deadlines”

“Stress. Workers do not think of consequences of their actions when under duress and stress. They take risks with equipment from time restraints put on them.”

“Fatigue and stress, particularly as fewer and fewer workers are required to do more and more work.”

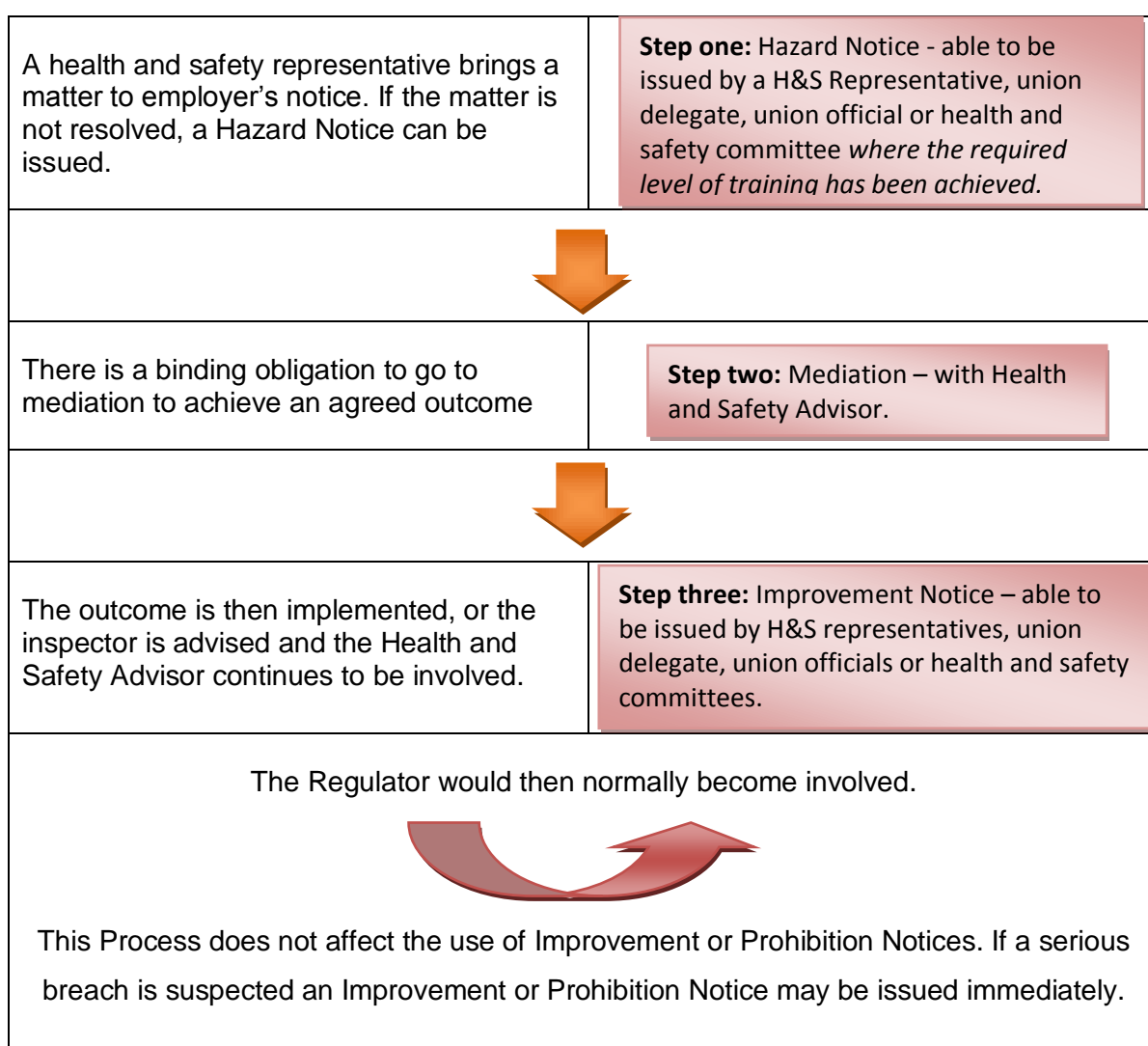
“Unrealistic performance expectations from employers coupled with lack of focus on H&S in favour of production, or employee productivity.”

⁴⁰ HSE commissioned report on the pilot of Health and Safety Advisors, York Consulting, United Kingdom

⁴¹ Appendix Two

Notice has been issued. We receive regular reports of these notices being ignored and of representatives feeling unable to progress the concerns they raise leaving the safety issues unresolved. A Health and Safety Advisor from a regional health and safety centre could act as mediator when a notice is issued, helping the issue to be resolved in good faith at this point. However, if the mediation has failed to resolve the issue, a Health and Safety Representative could call in an inspector and if warranted should be able to serve an Improvement Notice. We provide more comment on this proposal later in the submission.

5.27. The diagram below illustrates the CTU proposal re Hazard notices:



Improvement Notices

5.28. The CTU recommends that Health and Safety Representatives are empowered to issue an Improvement Notice. This would require additional training but add considerably to their options where safety matters are ignored

5.29. In a comparative study on inspection regimes, Walters and others comment that:

“OHS statutes in countries like Sweden and Australia have gone beyond the Robens’ approach of consultation with working people to vest health and safety representatives with powers to stop dangerous work and to issue ‘provisional improvement notices’.”⁴²

5.30. The suggestion that health and safety representatives be provided with the right to issue provisional improvement notices and provisional prohibition notes was discussed in 2002, but did not go ahead because of concerns about potential abuse. However, Walters et al have demonstrated that such rights are seldom used in practice and this has been confirmed by the results of our survey of representatives in New Zealand. In Sweden they are invoked on average 50-100 times a year. In New Zealand 72% of the representatives surveyed had never issued a Hazard Notice. Nevertheless, their availability rather than necessarily their actual use would enhance the effectiveness and standing of representatives in keeping their workplaces safe.

5.31. Greater support for health and safety participation systems at the workplace

5.32. The regulator should also be required to actively enforce Part 2A of the HSE Act. This should include:

- Ensuring (with the force of a compliance order if necessary) that employers that are required to, have in place an agreed employee participation system which complies with a standard format ensuring that the provisions of an agreed Code of Practice are applied.

⁴² Walters D, Johnstone R, Frick K, Quinlan M, Baril-Gingris G, and Thebaud-Mony *Regulating Workplace Risks* Edward Elgar Publishing 2011.

- Ensuring that employers provide reasonable opportunities for employees to participate effectively in ongoing processes for improvement of health and safety in the employees' place of work.

5.33. There should be provisions for infringement fees and fines for employers that do not comply with the worker participation provisions of the HSE Act such as in sections 19C to 19E, as well as the existing 19B.

Strengthening Training and Support for Health and Safety Representatives

5.34. The CTU has specific concerns about the programme of training of health and safety representatives. The CTU developed a two-day training course for worker representatives in 2002 and entered into a joint venture with the Accident Compensation Corporation. In doing this, the CTU has accepted responsibility to act on behalf of all workers and not just union members. It does so because it regards workplace health and safety as a crucially important issue and because, although its resources are very limited, the union movement has the networks and the experience to reach out to all workplaces.

5.35. Since 2002, more than 27,500 health and safety representatives have been trained by the CTU and the training courses have received overwhelmingly positive feedback from participants. An independent evaluation confirmed participant views.⁴³ This evaluation said the training contributed to a “sea change” of interest in health and safety occurring in workplaces.

5.36. The New Zealand evaluations are consistent with a meta-analysis conducted for the International Labour Organisation which concluded that research evidence demonstrates a strong link between arrangements for worker representation and consultation and improved health and safety outcomes.⁴⁴ It is important to note, however, that improved outcomes are subject to certain conditions, including:

- A strong legislative steer

⁴³ Innovation & Systems Limited

⁴⁴ Walters D.R. *The Role of Worker Representation and Consultation in Managing health and safety in the construction industry* International Labour Organisation 2008.

- Effective external inspection and control
- Demonstrable senior management commitment to both OHS and a participative approach, and sufficient capacity to adopt and support participative OHS management
- Competent management of hazard/risk evaluation and control
- Effective autonomous worker representation at the workplace and external trade union support
- Consultation and communication between worker representatives and their constituencies.

5.37. This analysis points to the fact that it is not enough to legislate for worker participation systems, or even to elect health and safety representatives in every workplace. It is what they actually do, and are supported to do, by the law, their employers and others in their workplace which has the potential to make a real difference.

5.38. A common problem in New Zealand workplaces is also that Health and Safety Representatives are often not permitted time, or given support, to undertake their statutory functions. The results of the CTU survey of representatives shows that 21% of health and safety representatives did not get time away from their normal duties to perform their health and safety role.⁴⁵ Representatives need a reasonable level of respect, time and resources in the workplace in order to undertake the role effectively. In some workplaces that is working well; in others the reps are expected to carry out their health and safety duties in addition to their normal workload, in their own time and with no access to support or facilities.

5.39. In addition, uncertainty about resources for training is problematic. The former Department of Labour has never taken steps to fund training and with the proposed government changes to ACC, there is uncertainty about the future funding of health and safety representative training and there is

⁴⁵ Appendix Two

no obligation on employers to provide it within the Act. Without regular training refreshment, research evidence suggests that workplace activity tends to tail off and the representative's feelings of adequacy and support also diminish, particularly if they are facing challenges to their role.⁴⁶

5.40. The CTU recommends that the two-day training continues to be funded and supplied for representatives in order for them to issue Hazard Notices. However the training needs to be increased to facilitate an increase in effectiveness. In particular an additional two-days training is recommended for representatives to be qualified to issue an Improvement Notice. These notices should be able to be issued by health and safety representatives, union delegates, union officials and health and safety committees.

5.41. In addition, all health and safety training material should be reviewed by the Crown Entity recommended above to ensure that it includes training in the appropriate Codes of Practice for particular industries. The training requirements set out in the Act also need to be enforced to ensure complete compliance.

5.42. The CTU recommends further levels of training be made available for those who would like to be involved in setting industry standards. Under a tripartite arrangement this higher level training would be necessary for Health and Safety Representatives and union delegates and officials who would represent worker interests in the standard setting and risk assessment processes.

In your opinion, what is the cause of the majority of incidents causing injury or illness in your workplace?

“Not all near misses or incidents are reported as they either don't get followed up or depending on who you are you get disciplined or sweep it under the carpet. Companies are more concerned about stats as the staff see it and when it comes down to getting something fixed it takes too long but yet we get told there is no price on health and safety.”

In your opinion, what is the cause of the majority of incidents causing injury or illness in your workplace?

“[Health and safety] it's made out to be a tick box exercise until someone gets hurt then the finger pointing and pot shots start about how H&S is a joke and load of crap”

⁴⁶ Walters, D.R., Kirby, P and Daly, F (2001). *The impact of trade union education and training in health and safety on the workplace activity of health and safety representatives* Health and Safety Executive Contract Research Reports, No 321/2001.

5.43. We note the Royal Commission's support for this: "Health and safety representatives need to be well trained.... ACC's funding has dropped substantially in recent years. DOL has provided more money, but has not been able to meet the entire shortfall. The Government should ensure sufficient funding is available to train health and safety representatives."⁴⁷ The report states that:

"The number of people completing ACC-funded health and safety representative courses dropped from 9735 in 2008–09 to 4153 in 2010–11 mainly as a result of a 44% funding cut in 2009–10."⁴⁸

5.44. Demand far outstrips supply for CTU training with many workers outside of the five core industries (targeted in the ACC contract for training with the CTU) unable to be offered the training they seek. Funding should be increased and training made mandatory on employers.

5.45. Because of the vulnerability of funding the CTU training programme has not been as effective as it could be. It would be significantly increased if follow-up support for trained representatives was funded, including support for the continued information and interaction with representatives from a worker perspective. Currently there is no follow up available and an unspoken requirement that other work rights and sources of support for workers are not promoted by the CTU during this training – despite often there being a link between employment right infringements generally (including lack of representation) and health and safety breaches.

Worker participation at higher levels

5.46. At an industry level workers should be represented in standard setting processes and other tripartite bodies, which should be established under the aegis of, and funded by, the Crown Entity recommended above. The worker representatives must be supported and advised by independent OSH professionals who should also be funded for that work.

⁴⁷ *Report of the Royal Commission on the Pike River Coal Mine Tragedy*, Chapter 30, para 42.

⁴⁸ *Ibid* Vol 2, p.249

5.47. In addition the CTU has identified a need for website specific advice on hazard management and more advice for health and safety committees regarding their role and functions.

6. Leadership

6.1. The tolerance level of workplace injury and death in New Zealand is high compared with, for example, road injury and deaths, and with many comparable countries. One challenge is the public perception and the frequent ridicule of health and safety laws as “political correctness” alongside bitter opposition from employers representatives in 2002, for example, when the HSE Act was strengthened including increasing the level of maximum penalties. It is also reflected in the weak enforcement policy of the Department of Labour.⁴⁹ Few prosecutions under the Act are taken, those that are taken are invariably after an accident has occurred and the penalties imposed are low. The Royal Commission comments that “New Zealand has significantly lower maximum penalties than some comparable overseas jurisdictions” and compares the maximum New Zealand penalty of \$500,000 or two years in prison with AUD \$3 million or five years’ imprisonment in some Australian States.

6.2. In general, in New Zealand the penalties are low and the infringement notice provisions have been ignored.

6.3. In short, the whole system encourages many employers to take a “gaming” approach to whether they will be “caught” for non-compliance.

In your opinion, what is the cause of the majority of incidents causing injury or illness in your workplace?

“Middle managers and Supervisors being so keen to show senior management that they are meeting productivity targets that they side-line H&S whenever they can get away with it and pressurise employees to work unsafely or they turn a blind eye to unsafe practices because it would slow down production or cost money if they were to make the necessary changes to keep people safe. Senior management are generally unaware that this is going on as they rely upon the supervisors and middle managers for accurate information. It's all ok until there is an accident or incident and then the supervisors and middle managers duck for cover and try to blame the employee rather than take responsibility for allowing or encouraging unsafe behaviours or processes.”

⁴⁹ *Keeping Work Safe* Department of Labour 2009 <http://www.dol.govt.nz/PDFs/keeping-work-safe.pdf>.

- 6.4. Strong leadership on health and safety at work and the need for proper protections in law and in practice, is required from all of us – from the Prime Minister and other politicians through to board rooms, ‘smoko’ rooms and society at large. The cost to society of failing to prevent accidents is much higher than most appreciate. There are the most immediate and direct effects on the victim. But then there are other consequences. Most important is the huge impact on people – the pain and anguish to the families and friends of the dead or injured worker.
- 6.5. The introduction of a criminal offence of corporate manslaughter into New Zealand law similar to the UK Corporate Manslaughter and Corporate Homicide Act 2007 would send a strong signal to boardrooms. The UK Act provides sanctions such as unlimited fines (according to Stead and Taefi the fines are envisaged to be between 2.5% and 10% of the company’s annual turnover), publication orders and remedial orders where “gross failures” in the management of health and safety result in a fatality.⁵⁰ Similar legislation is in place in Germany, France, Italy, Sweden, Japan, Canada (four out of fourteen jurisdictions) and Australia (two out of nine jurisdictions).⁵¹ The Royal Commission also recommends consideration of the introduction of corporate manslaughter.⁵²
- 6.6. The corporate manslaughter laws generally impose clear and positive obligations on directors and senior managers to ensure that the company complies with all health and safety obligations. Currently directors are only liable under s56 of the HSE Act if a company fails to ensure the health and safety of its workers and a director “directed, authorised, assented to, acquiesced in or participated in, the failure.” As the Royal Commission notes, this provides invidious results whereby ‘hands-on’ directors are

⁵⁰ For a basic summary see Stead, S & Taefi, N ‘Should New Zealand introduce corporate manslaughter?’ <http://www.kensingtonswan.com/KSPublicWeb/media/Documents/Corporate-Manslaughter.pdf> or for a much fuller treatment Wong, J. ‘Corporate Manslaughter: a proposed corporate killing offence for New Zealand’ [2006] *CanterLawRw* 6

⁵¹ Bergman, D., Davis, C. and Rigby, B. (2007) *International comparison of health and safety responsibilities of company directors* Research Report 535, London: Health and Safety Executive.

⁵² *Report of the Royal Commission on the Pike River Coal Mine Tragedy*, Chapter 26, para 31.

more likely to be punished than those who are hands off (even neglectful) of health and safety.⁵³

- 6.7. New Zealand should ensure that like the UK or Australia, institutional negligence on the part of boards (for example failing to take a proper governance interest) or senior management would result in either individuals or the company being prosecuted. As Wong notes:⁵⁴

“The arguments reflect the view that the Act fails to properly reflect the moral outrage that the community feels when a death occurs through the gross negligence of the employer, and fails to reinforce the notion that all workplace fatalities are unacceptable. This is borne out by factors such as the offences not being indictable and, therefore, generally prosecuted in the lower courts; that prosecution is considered only a last resort; that the fines imposed by the courts are generally small; fines for large corporations are not sufficiently punitive and therefore lack the necessary deterrent and retributive effect; and the small number of proceedings against senior officers of corporations.”

Literacy and Numeracy

- 6.8. The *New Literacy Project for Pasifika in Manufacturing* has a renewed focus on health and safety and union support following the identification of this as a key problem in managing workplace safety within this workforce.
- 6.9. A meeting is being coordinated between the National Centre of Literacy and Numeracy for Adults (NCLANA) (based at the University of Waikato) and the EPMU, FIRST Union and the SFWU on 28 November 2012. The meeting is to discuss future projects around the high injury rate of Pasifika workers in manufacturing. NCLANA wants to expand on research done by the Dept. of Labour, reported in “In Harm’s Way” (March 2012). The report suggests that literacy may be a factor in workplace injury. The report also notes the positive impact of unions: “Participants felt that unions had a

⁵³ Ibid, chapter 28 paras 6-8.

⁵⁴ Wong, Jonathan. *Corporate manslaughter: a proposed corporate killing offence for New Zealand* <http://www.nzlii.org/nz/journals/CanterLawRw/2006/6.html>

two-fold positive influence on health and safety: through being a vehicle of information dissemination and through pushing for stronger practices from employers.” The report recommends that further research should include greater collaboration with unions, because of the positive impact they have on health and safety practice.

6.10. The CTU supports this work.

7. Incentives

- 7.1. Incentives to improve health and safety outcomes can be positive and focused. Monitoring of occupational health hazards is something that many New Zealand employers simply do not do but is required in the UK. An example of a positive incentive scheme is free of charge workplace surveillance of occupational chemicals or substances in the first instance.
- 7.2. The CTU does not support ACC experience rating as it produces a well-known and documented perverse incentive to hide workplace accidents and suppress claims. There are also dangers associated with a Star Rating System as this can also lead to the suppression of claims and underreporting of injuries.
- 7.3. Under-reporting of work injuries and linking low injury rates with bonus payments of managers is a practice that is fraught with problems. This is most apparent in lagging indicators – effectively a measure of failure after the event (such as Lost Time Injury rates (LTIs). Linking these to monetary incentives exposes a weakness in a health and safety system.
- 7.4. Of particular concern is the underreporting of LTIs, as a high injury rate will affect the discount employers receive from ACC.
- 7.5. LTIs may also be used as a measure of performance which could affect a senior manager’s bonus payment.⁵⁵

⁵⁵ paragraph 16, Royal Commission on the Pike River Coal Mine Tragedy, Chapter 2, Vol 2

7.6. Linking injury rates to bonus payments and effectively giving incentives for underreporting of injuries is not acceptable and undermines a Health and Safety system which depends, not just on have the correct policies, procedures and sound practice, but also on trust, openness and transparency in order to operate effectively and safely.

“Because of inconsistent recording of safety there is now a growing group that believe, if nothing is said, there will be no repercussions and therefore no ongoing victimisation of themselves and other like minded employees.”

7.7. The HSE Act imposes penalties where employers fail to comply with the requirements of the law. In the CTU's opinion, there should be a firm and fair enforcement of the law and the penalties. A more robust approach should be taken in situations where breaches of the Act have occurred - through the issuing of improvement, prohibition, infringement notices, and prosecutions.

In your opinion, what is the cause of the majority of incidents causing injury or illness in your workplace?

“Employers failing to have adequate health and safety systems or focusing on compliance (paper-based) rather than the actual performance, poor educational and lack of understanding of obligations and failure or reluctance to find out what required (number 8 wire mentality) failure to maintain knowledge of current industry best practice or standards, do not deliberately set out to have unsafe workplaces that allow commercial and other pressures to override, ultimately cannot see it is important, little chance of being caught and although concerned about levels of fines ultimately these are imposed on their companies rather than themselves personally.”

7.8. The rationale for not imposing penalties is often based on costs to business. The cost to society of failing to prevent accidents is very high. Further, it is important that businesses see that there is a level playing field: businesses that take the trouble to put good health and safety processes in place should not be penalised by the regulator allowing poor practices to persist without consequences. Without these shortcuts in health and safety can be used as a competitive advantage in pricing. It is in everyone's interest that enforcement is certain, robust, and well publicised. In addition, the ILO Committee of experts noted, in 2010, the importance of the Government taking all appropriate measures to ensure a proper balance between preventative and advisory functions on the one hand, and enforcement functions on the other.

7.9. In comparable jurisdictions, the rates of prosecutions for breaches of the OHS legislation are much higher than in New Zealand. This warrants change to the rate of penalty. Professor Quinlan questions the adequacy of our HSE Act penalty regime compared with other jurisdictions.⁵⁶ When the then Minister of Labour Bill Birch promoted the Health and Safety in Employment Act in 1992, he strongly emphasised the deterrent effect of heavy penalties. Given the weakness of the “self-regulatory” framework and practice in New Zealand, it is vital that a rigorous approach is taken by the regulator, backed by substantial penalties. The deterrent effect of heavy penalties has not occurred, which has meant that the Department of Labour has been largely ineffective.

7.10. The CTU also questions why New Zealand persists in using the criminal law as the exclusive means of pursuing penalties. While we agree that the criminal basis of the Act is the correct one, effective use could be made of a system of administrative penalties imposed by inspectors on observed non-compliance. The advantages are that expensive criminal cases are avoided (although there would be a right of appeal against an inspector’s decision), and it is linking the penalty closely with the observed non-compliance and is therefore preventative rather than after the accident (as more than 90% of current prosecutions are). This system has proved effective in other jurisdictions such as British Columbia and France and New Zealand could easily adopt and enhance the infringement fees system introduced in 2003 (which has barely been used by the Department of Labour) to this end.

7.11. Currently the Act limits who can take a prosecution against an employer that has breached the provisions of the Act. The Department has first say and if it determines to take any action against any party to the incident, all other actions including actions against other parties are ruled out. The CTU believes this is wrong. In the example provided earlier regarding the death of Charanpreet Dhaliwal, the Department has taken action against his immediate employer, CNE Security. The CTU believes an action

⁵⁶ Quinlan Michael, *Report Comparing Mine Health and Safety Regulation in New Zealand with other Countries* Prepared for the New Zealand Department of Labour.

should have been issues regarding the role of Fulton Hogan in this death. We have been stopped from doing so because of the Act.

7.12. Where there is no union present in an investigation into a workplace accident, consideration to separate legal representation to workers involved in the investigation should be considered. At present, in most cases, this role is carried out by a company lawyer with no-one advocating for the injured worker. This creates an imbalance of power, unequal access to the law and a conflict of interest.

8. Government, Industry, Corporate and Other Influences

8.1. We strongly support the use of government procurement to require suppliers to have strong health and safety standards. The Government not only has the ability to exert substantial influence on a large number of employers, but it also has a moral obligation to use that influence, even more so given New Zealand's appalling health and safety record, due in part to inaction of successive Governments. Procurement policy can also be used to encourage innovation in safety practice in NZ.

8.2. Government procurement policies could be used in the following ways:

- Procurement policies apply to not only procurement but to a variety of relationships with Government including acting as an agent for Government or receiving funding (such as DHBs, tertiary educational institutions and private training establishments, and companies receiving funding for R&D).
- Standards set that require "best practice" rather than simply require employers to meet legal requirements. These should be reviewed periodically to reflect improved practice.
- Making these standards a requirement for tendering, responding to Requests for Proposals, being put on an approved supplier list, applying for funding etc, not just for successfully obtaining the government's business.

- Including a requirement that large companies and members of groups of companies meeting Government procurement standards also have similar requirements of their own suppliers so that the effects are rippled down the supply chain.
- Setting up robust certification procedures, with regular audits to maintain standards, so that certified companies do not have to demonstrate their practice every time they seek to supply the government. Simplified systems may be appropriate for smaller firms, but they should not compromise the final health and safety outcomes. The certification should be based largely on the quality of company health and safety management processes rather than records of harm in order to avoid incentives to suppress reporting, but there should be provision to withdraw certification in the face of serious or sustained breaches of the HSE Act. Certification procedures, criteria and audit processes should be developed under a tripartite process.
- Providing incentives to companies to become certified by providing free advice and assistance.
- Applying the standards to international as well as local suppliers so that low health and safety standards cannot become a competitive cost advantage. The Government could explore mutual recognition of certification standards.

8.3. There should also be encouragement to industry associations to develop the health and safety practice in their own sectors. This can help counteract neglecting health and safety to obtain competitive advantage. Union participation in these developments should also be encouraged both to encourage good practice at firm level and to build capability for involvement in industry standard setting.

8.4. Professional bodies and educational institutions should ensure they include health and safety knowledge in qualifications and certification.

9. Major Hazards

- 9.1. Higher risk industries need commensurate enhancements of the employee participation systems. In the coal mining and other high hazard industries this should include a check inspector/roving health and safety representative system as described by Professor Quinlan in his report to the Department of Labour reviewing the 2006-9 Mine Safety Review:⁵⁷

“In sum, in the light of my review of the evidence (and regulatory frameworks) I think that the findings and recommendations of the 2006-9 mine safety review on employee participation should be re-considered.

There is a case for strengthening the regulatory requirements by establishing a tripartite advisory body, requiring consultation with regard to risk assessment about changes to work conditions that could have OHS effects, and establishing a system of district and mine site check inspectors with appropriate training and powers”.

In your opinion, what is the cause of the majority of incidents causing injury or illness in your workplace?

“Men not trained for the job , unskilled labour working in a dangerous work place, lack of or no onsite training, no safety gear supplied, lack of safety knowledge from company excessive work hours, dead line pushed too hard forcing accidents”

- 9.2. The recognised international authority on worker participation systems Professor Walters has advised that these forms of participation:⁵⁸

“would help to improve the operational effectiveness of the multi-level risk management practices required to help prevent the occurrence of such tragedies as Pike River in the future”.

- 9.3. The Queensland check inspector system provides a model for adoption as this is already working well as an integral part of the regulatory model there, although it is desirable that the system be subject to consultation in the proposed tripartite industry committee before being put in place by

⁵⁷ Quinlan Michael, *Analysis Report: Reviewing Evidence to Assess whether the Conclusions and Recommendations of the 2006-2009 Mine Safety Review Still Relevant and Changes in Regulatory Framework the Royal Commission might consider*” DOL4000010003 at para 71.

⁵⁸ Walters David *The Role of Worker Representation in Managing Health and Safety – A report in support of the EPMU submission to the Royal Commission of Inquiry on the Pike River Coal Mine Tragedy*.

regulations under the HSE Act. The operation of the system, including the salaries and other costs of the check inspectors, should properly be funded out of the HSE levy income as a legitimate cost of the regulatory system.

- 9.4. We note the Royal Commission's strong support for the check inspector system in coal mining:⁵⁹

"A union check inspector would be an extra set of eyes and ears, and a further line of defence. Such inspectors may have made a difference at Pike River. Experience in Queensland show that workers are more willing to report problems to their industry safety and health representatives than to the mines inspector, which means the representatives may be better informed... Union check inspectors, appointed and paid by the union representing coal mine workers, should be introduced."

- 9.5. In other high-risk industry sectors there is a need to put in place similarly enhanced employee participation systems, possibly based on the roving health and safety representative systems which have worked well in Sweden where the Robens model originated. This could be a specialised aspect of the Health and Safety Advisors in the regional Health and Safety Centres proposed earlier in this submission.

10. Health and Hazardous Substances

- 10.1. The HSE Act should prevail over other Acts in terms of occupational health monitoring. Environmental monitoring needs to be taken out of the private sphere (where conflicts of interest are present) and the regulator needs to undertake monitoring and enforcement. An excellent place to start would be to begin monitoring the diseases in schedule 2 of the Accident Compensation Act.

- 10.2. Issues related to occupational health have been a poor relation in comparison to occupational safety issues. The recently released Occupational Health plan identifies the high rate of occupational disease in

⁵⁹ *Report of the Royal Commission on the Pike River Coal Mine Tragedy*, Chapter 30, paras 27-30.

New Zealand. NOHSAC has estimated that every year there are around about 700-1,000 deaths from occupational disease, particularly cancer, respiratory and heart disease and that of all deaths in people age 20 or older, 2% - 4% are due to occupational disease.⁶⁰

10.3. There is an urgent need to take stronger action in relation to occupational health. Current legislation requires employers to monitor employee exposure to hazards and also to monitor employee health where a hazard is known to result in harm and supply this information to employees, but this is not effectively policed. In addition, labour inspectors do not have adequate knowledge of occupational health issues, resourcing for dealing with occupational health is inadequate and the department has never made proper use of the Notifiable Occupational Disease panels.

10.4. Action needs to be taken on a number of fronts. Firstly, priority needs to be given to effectively address some of the most common conditions which contribute to poor health amongst workers, including noise-induced hearing loss, muscular-skeletal disorders, respiratory disorders and mental harm arising from psycho-social hazards.

10.5. Secondly, there is an urgent need to ensure that attention is paid to more systematically addressing wider workplace issues that affect health and safety. ILO Convention 155 covers not just occupational safety and occupational health, but also the working environment. Walters points out that this includes a wide range of issues including work organisation, hours of work and workplace culture. A step change in the way in which these issues are dealt with in New Zealand workplaces would make a substantial contribution to improving health and safety outcomes. The CTU proposal on Health and Safety Centres and Advisors, and a process where mediation is binding is a practical solution to address these issues.

10.6. Thirdly, the medical profession needs to be better trained to recognise when workers are presenting with occupational disease related illness. Doctors rarely ask about a patient's work history. This question should be

⁶⁰ NOHSAC 2004.

mandatory and a system should be built that facilitates the collection of this information. Focus should be around specialists like Orthopaedics, ENT and General Medicine. The collected information should then be available for statistical analysis.

11. SMEs

11.1. It is commonly claimed that health and safety legislation constitutes a “drain” on small business by imposing unnecessary compliance costs but this is not a reason for regulatory requirements, including workplace health and safety, to be loosened.

11.2. In fact, the nature and structure of small business in New Zealand is not too dissimilar to that of many other countries including countries that achieve much better health and safety outcomes. This can be seen in Table Two below.

11.3. Table Two: Percentage of enterprises by size for New Zealand (2011) and the United Kingdom (2009)

Employee size group	Percentage of all enterprises – NZ ⁶¹	Percentage of all enterprises – UK, private sector ⁶²
0	68.9	74.8
1-9	25.0	21.2
10-19	3.4	2.4
20-49	1.8	1.1
50-99	0.5	0.4
100-499	0.4	0.3
500+	0.1	0.1

Source: MED (2011), Department of Business Innovation and Skills (2010)

11.4. The CTU believes there is no justification in an argument that suggests that a worker’s right to work in a healthy and safe work environment should be dependent on the size of the workplace in which they work. Exposures to hazards have the same impact and all workers should be protected from their effects, whatever the size of workplace.

⁶¹ MED (2011) SMEs in New Zealand: Structure and Dynamics 2011

⁶² Department of Innovation and Skills (2010) <http://webarchive.nationalarchives.gov.uk/+/http://stats.bis.gov.uk/ed/sme/>

11.5. In addition, clear standards have been shown to actually reduce compliance costs. Research suggests use of standards cause this reduction in costs (eg food safety, product design standards etc) by not having to 'reinvent the wheel' each time a process is developed.

11.6. When requirements are not standardised for small businesses there is a danger that contracting-out is incentivised. An example of this is found in the construction industry. If a large construction company must comply with prescriptive regulations but its contractors do not, then there is an incentive is to contract out the non-regulated work.

11.7. The CTU believes that the compliance with health and safety requirements (and other employment legislation) needs to be seen as being part of the costs of doing business in the same way that compliance with tax legislation and resource management requirements are. To argue that business growth can only be achieved through reducing compliance costs associated with health and safety regulation is, in effect, to argue that workers are subsidising that growth by risking their personal health.

11.8. Nevertheless, the CTU recognises that a number of SMEs experience uncertainty about how to properly discharge their responsibilities. The CTU believes that the answer to the problem is a more pro-active approach by the regulator to providing standards, assistance and guidance on health and safety requirements. We note that the UK Health and Safety Executive has had a web-based tool designed to help SMEs improve their health and safety performance since 2005 and that this has proved to be an effective and relatively inexpensive means by which the Government has been able to provide assistance to small firms. The HSE has also developed case studies specifically on health and safety systems in SMEs, which demonstrate the business benefits of good health and safety systems. Within New Zealand, the regulator should develop guidance or tools designed to meet the needs of SMEs, specifically to ensure that they are aware of both their general duties under the Act and clear requirements around specific hazards. There should be no uncertainty about what needs to be done to comply with the law.

12. Data

- 12.1. There is a critical need for national workplace injury register with consistent and rich data, coding, etc. Understanding causes and context of injuries and (ideally) “near misses” is essential for improving health and safety performance.
- 12.2. We need to be aware that there can be conflicts between good reporting practice and incentives to reduce reported injuries. In addition there is evidence of workers being afraid of reporting accidents, let alone near misses. Good management practices which improve health and safety and encourage workers to talk openly and without blame about incidents will also improve data quality.
- 12.3. The safe staffing research undertaken by the New Zealand Nurses Organisation is a good case study showing how quality data could be generated.
- 12.4. The link to this data is at: The NZNO website Care Capacity Demand Management March 2012 ['Care Capacity Demand Management' \(CCDM\) Powerpoint](#) (PDF, 3.8 MB, 89 slides) - author Jane Lawless SSHWU Also, August 2012 Safe [Safe Staffing CCDM publication](#) (PDF, 321 KB).
- 12.5. With the disestablishment of NOHSAC there has been a huge loss of ongoing quality independent research into workplace health and safety. NOHSAC should be resurrected immediately.

13. Societal Expectations and National Culture

- 13.1. The CTU has carried out an extensive survey of Health and Safety Representatives (see our report at Appendix Two). An open ended question was asked about the causes of injury and illness and the responses were comprehensive and included insightful comments on New Zealand safety culture.
- 13.2. The main themes revolved around working too fast, work arrangements, workload, deadlines, stress and fatigue, management style and

communication and cost factors. Matthew Palmer has identified three elements of the New Zealand constitutional culture in relation to public affairs, they are: egalitarian, authoritarian and pragmatic.⁶³

13.3. Based on our egalitarian past New Zealanders place much importance and cultural value on a strong work ethic. Many people will strive to get the job done often using a pragmatic number eight wire approach simply to meet deadlines or production targets and achieve a 'good job'. New Zealanders place a high amount of value on personal financial benefits and keeping the economy strong so health and safety is seen as a cost and is therefore undervalued.

13.4. The authoritarian culture brings about tough management styles with tight production targets and performance bonuses. Workers sometimes fear the boss and accident reporting is driven underground due to a 'culture of blame'. There is a strong patriarchal culture in New Zealand and this is seen in a particularly macho cultural which values a 'she'll be right' 'harden up' type attitude. These cultural themes come through in the CTU survey.

Therefore to conclude this submission a sample from the comments made on the CTU survey that are illustrative of New Zealand national culture and expectations is provided below:

"In your opinion, what is the cause of the majority of incidents causing injury or illness in your workplace?"

- A desire to please the management, so people work long hours, work at the weekend, ignore H&S guidance in the belief that is what the company wants. It isn't.
- Familiarity within work environments, tools not up to standard for task, management unwilling to listen to staff "at the coal face", companies baulk at H&S initiatives as soon as the word money is used, workers being too lazy to contribute to H&S policies, people sitting in offices making decisions

⁶³ New Zealand Constitutional Culture Matthew S.R. Palmer , Thorndon Chambers, New Zealand Universities Law Review, Vol. 22, p. 565, 2007

and rules surrounding a workplace they have never been to thereby endangering staff

- Older age people set in their ways wanting to get the job done to please the management.
- Employers increasing the workload on individual employees by not employing the correct number of people to do a job safely. Rushing and lack of proper training are the leading causes in my opinion. These are generally the result of management cost cutting measures.
- People attitudes towards health and safety, it's made out to be a tick box exercise until someone gets hurt then the finger pointing and pot shots start about how H&S is a joke and load of crap.
- ...The typical Kiwi (and Australian and South African) male is prepared to take a calculated risk. It is in our nature. More emphasis should be placed on training staff to recognise this trait and encourage them to stop and think about their situation.
- Staff failing to take personal responsibility. Staff failing to say 'no'. This could be through fear?
- We don't actually have many accidents... but drunk or stoned humans who think they are Mike Tyson are where our incidents come from!!!!
- Inside work walls pressers (??) to get jobs done on a minimal amount of time that is provided to them as wages are tight and employers need to make good returns to keep job security.
- Accidents .. lack of support by management for team leaders when "shortcuts" are being taken or bad work practices are being performed. Illness ... coercion by management on workers to come to work when ill by inferring someone is not "pulling their weight" or threatening to require a medical certificate for what is an illness that only requires bed rest and over the counter medication to get better ie influenza or colds.

- People being complacent when it comes to being aware of your surroundings.
- Where ever you are, unfortunately the world we now live they are always looking for someone to blame and you need to cover yourself and your actions.
- Being over-confident, lack of skilled workers/ leaders/ people frightened to stand up to the boss, drug alcohol testing means accidents go unreported.
- Negative and "she'll be right" attitudes to safety. Some people think that near miss reporting is a negative thing where it clearly isn't.
- OVER FAMILIAR WITH EQUIPMENT "CAN DO ATTITUDE"
- Short cuts on tasks, cost, equipment, staffing levels and long hours (working more than one job to make ends meet) and an "it won't happen to me" attitude.
- Subtly being pushed by managers and supervisors to hurry on tasks and break downs to minimise downtime. Staff are constantly rushing instead of planning jobs for themselves. We work 24/7 shifts therefore more care is needed at night.
- Under staffing - overworked staff who struggle to get annual leave and 4 days off per fortnight, lack of adequate protective equipment, lack of sleep due to lack of staff and having to work 7 or 8 sleep overs in a fortnight. We constantly struggle to get adequate supplies of protective equipment and are now 'rationed' so we don't use too much as it is costly!
- Our work environment is cramped and we have many people working in limited space which causes injuries. Shortage of staff creates more pressure issues to complete the mountain of work. Management make the staff feel like they are clumsy fools when we report an injury so some do not get reported and as a result continuous repetitive movement creates a worst problem.

- Employees failing to follow instructions and their training, taking shortcuts or ignoring obvious hazards, being pressured to work and safely, failing to speak up or report a trivial accidents and hazards, poor literacy and understanding. Employers failing to have adequate health and safety systems or focusing on compliance (paper-based) rather than the actual performance, poor education and lack of understanding of obligations and failure or reluctance to find out what required (number 8 wire mentality) failure to maintain knowledge of current industry best practice or standards, do not deliberately set out to have unsafe workplaces that allow commercial and other pressures to override, ultimately cannot see it is important, little chance of being caught and although concerned about levels of fines ultimately these are imposed on their companies rather than themselves personally.
- People think having to comply with safety requirements takes too long. Need to put on equipment or have assistance etc. think it will be quicker to do it another way. Also pressure from management to complete work quickly leads to people thinking they need to take short cuts. Poor communication between management and staff is a contributing factor in a lot of incidents. "Someone" knows about a particular task or chemical or equipment but the person doing the job is not given that information.
- ...Management paying lip service to H & S only so staff feel nervous about bringing things into the open.
- People not evaluating the potential risk before undertaking a task. The time to evaluate (and keep safe) must be factored into each job.
- Lack of foresight or awareness of what could happen by not following the correct procedure. People are more concerned with getting the job done than with getting the job done safely.
- Carelessness, (rip-shit-and-bust).
- People not following procedures - It is a "She'll be right" culture problem seen throughout NZ.

- Lack of supervision, Fatigue, Macho culture.
- ARROGANCE
- People thinking they are bulletproof.
- The harden-up culture which everyone is conditioned to.
- Production focussed mind-sets from both workers and management