

To the Independent Task Force on Workplace Health and Safety

Submissions on the Safer Workplaces Consultation Document.

26 November 2012



Contact:
Hans Buwalda
Tel:
Email:

Contents

	<u>Page</u>
Executive Summary	1
Introduction	3
Leadership for Safety	5
Motivations	5
Safety Culture	7
Legislative Requirements	8
Business Leadership	9
Controlling Risks and Hazards: Legislative Requirements for Risk Assessment	12
The Role of the Regulator	17
References	19

Executive Summary

Fletcher Building Limited (FBL) is a New Zealand-based company. We have approximately 20 business units and 350 work sites in New Zealand, employing approximately 8,000 people. In addition, there are large numbers of contractors working on our sites at any one time.

We manufacture a range of building and infrastructure products for both the domestic market and also for export. In addition, we manage a range of infrastructure and building construction projects, and residential building projects. We are involved in several parts of the Christchurch “rebuild”. We are also involved in the distribution of building products.

We believe that improved safety performance is dependent on business organisations setting goals for continual improvement, reinforced by regulatory requirements that require them to address safety performance with due diligence. Directors and senior managers have a critical role in setting and communicating safety goals, as well as verifying that these are met.

The Pike River Royal Commission’s report states that industry knowledge and experience are required at the board level – this is a critical element in ensuring the

board asks the right questions, obtains the right information and is able to fulfil its obligation to hold management to account.

We believe that the expression of officer responsibility in the model Work Health and Safety Act 2011 (Australia) is an appropriate expression of these responsibilities and recommend that these are added to the New Zealand Health and Safety in Employment Act 1992 (HASE). However, we do not consider that it is appropriate for a breach of these responsibilities this to constitute a criminal offence.

We believe that pan-industry leadership is also required. The Business Leaders Forum was initiated with the facilitation of the then Department of Labour. This provides another example of business leadership.

In New Zealand, there is an urgent requirement for business organisations, academic providers, and safety professional and practitioner bodies to work together to develop professional and practitioner standards, and accreditation requirements.

Executive Summary

Fletcher Building believes that the HASE fails to facilitate rigorous risk assessment. We believe that a risk-based approach is necessary to improve the efficacy of the hazard controls being used in New Zealand. We believe that under the current hierarchy of “eliminate, isolate and minimise”, there is often a default to “minimise”, even in situations where the hazard could result in fatal injuries.

We note that the New Zealand approach differs from the regulatory approach in Australia, as set out in the recent Work Health and Safety Act 2011. This shares a similar approach to the HASE, in imposing a duty to take all practicable steps to ensure the health and safety of employees. However, it differs in that it requires an assessment of risks associated with each hazard, as part of the process for determining controls. We believe that this direction for a risk assessment approach results in more rigorous development of controls to manage workplace hazards, and is more likely to lead to engineering solutions to remove hazards.

Worker participation in safety management, occurring in an organisation with a safety culture that includes open reporting, flexibility and learning, is a necessary

objective. There needs to be careful consideration as to the best methods to achieve this. We believe that more progress will be made through business leadership and support from other Government and non-Government organisations than from further legislation. Prescriptive legislation will not enable the flexible approaches that are required to further develop reporting and engagement.

We believe that there is further scope for the development of a co-regulatory role for the Health and Safety Group within the Ministry of Business, Innovation and Employment. We are aware that this will require further resources. We believe that the Group has been unable to adequately balance its enforcement and co-regulatory roles because it has had inadequate resources. In particular, it has been unable to develop sufficient industry guidance and codes of practice that describe adequate safety controls for common hazards in New Zealand workplaces. This inadequacy has also resulted in a lack of professional development opportunities for its staff. Thus the issues inherent in the lack of a qualifications framework for safety managers and practitioners in New Zealand, is exacerbated in the Group.

Introduction

Fletcher Building Limited (FBL) is a New Zealand-based company that manufactures and distributes building materials, and constructs houses, commercial and civil infrastructure. It has an annual turnover of over \$10 billion with total assets of \$8 billion. It employs approximately 8,500 people in 30 business units located in New Zealand, a further 7,000 in Australia, and a further 4,500 in other parts of the world. In New Zealand, FBL has over 350 manufacturing sites, offices and outlets in 100 different localities.

FBL makes a significant contribution to the New Zealand economy and is:

- The largest of two cement manufacturers;
- One of two steel manufacturers;
- The sole manufacturer of plasterboard and glasswool insulation;
- One of several manufacturers of plastic pipes.
- One of two manufacturers of particleboard.

Fletcher Building has a strong commitment to improving its safety performance.

LEGACY OF Departing Fletcher Building CEO's hard line on workplace SAFETY

Sunday Star-Times: 23 September 2012

© 2012 Fairfax New Zealand Limited.

FLETCHER BUILDING'S outgoing chief executive Jonathan Ling believes the country will achieve its ambition to cut workplace death and injury only if it can get the country's chief executives to make health and safety their number one priority.

The Government has set a target to reduce workplace death and injury rates by 25 per cent by 2020. But Fletcher has reduced accidents across its constellation of businesses by far more than that in the six years Ling has been in the top seat.

Fletcher's annual report for the year to the end of July 2011 shows the 12-month rolling average injury frequency rate per million employee and contractor hours dropped from 14.09 to 10.57. The rate is now 8, said Ling.

Even more startling, back in June 2006, the rate was over 60.

Introduction

There are many programmes, both company-wide and within business units, to support this. Fletcher Building programmes have included:

- Our annual Awards to celebrate successes.
- Company-wide Fatal Risk standards.
- Sharing experiences and best practices through shared electronic incident reporting and the Intranet.
- Building an understanding of human factors in safety management.
- Adopting the Incident Cause Analysis Method (ICAM) to investigate incidents.

We are now aware that, having achieved much lower injury rates, our injury incidents no longer reflect the range of safety incidents and significant hazards on our sites. Most of our recordable injury incidents are sprains, strains and lacerations, arising from incidents such as slips and trips, using hand-tools and moving products. Our significant hazards include high-temperature manufacturing plants, using cranes and mobile plant to move product on our sites and to transport to customers,

exposed, moving machinery and work at height.

Our current safety plans increase our focus on managing hazards that could result in serious injuries or fatalities. This means more focus on significant operational risks.

We believe there are parallels between our safety journey and that which is required in other New Zealand workplaces, that is committed leadership, a higher focus on significant hazards, and improving the controls for these.

To achieve this will require changes in business leadership attitude to health and safety, legislation, and regulator capability. Our recommendations for these changes are contained in this submission.

Leadership for Safety: Motivations

We believe that improved safety performance is dependent on business organisations setting goals for continual improvement, reinforced by regulatory requirements that require them to address safety performance with due diligence. Directors and senior managers have a critical role in setting and communicating safety goals, as well as verifying that these are met.

Organisations are compelled to improve safety performance for several reasons:

- Values that recognise employees.
- Corporate recognition
- Financial reasons
- Regulatory requirements

Aiming for regulatory compliance alone is insufficient to assure that an organisation will achieve a high standard of safety performance. However, regulatory requirements make a significant contribution, particularly when these are supported by regulations, and codes of practice.

Business organisations are also improving their safety performance because of increasing focus from external stakeholders, including investors.

Safety Spotlight: ASX100 Companies

A company's safety performance and approach can provide a window into "management quality". A "safe" business may also be a well run, efficient business.

There can be costs, production disruptions or shut downs associated with safety incidents. Safety performance influences companies' workers compensation costs. A contracting company's safety record may affect its ability to win contracts, particularly with some companies in the resources and heavy industry sectors.

Safety can impact a company's reputation, its "licence to operate", and its relationship with employees and governments. At times, a government regulator may step in to address safety concerns, imposing operational constraints.

Some investors may consider avoiding companies that, in their view, do not address safety appropriately.

Investors increasingly expect companies to report safety data and demonstrate active programs to manage safety. If companies do not publicly report on workplace safety, this raises doubts about whether safety is being managed.¹

Leadership for Safety: Motivations

Leading organisations are aware that poor safety performance imposes costs. All incidents have direct and indirect costs, and many have human costs which are not easily calculated. However, while preventing incidents to save costs is a good goal, organisations also need higher-level goals.

Finally, many companies change their safety culture and improve safety performance because it is “the right thing to do”. Company values recognise the importance of employees, and the right of every employee to return home after work, without suffering an injury.

In practice, companies that have successfully improved safety performance will have been motivated by all these drivers. For various companies, the influence of each of these factors will differ. It is the role of directors and senior managers to identify the appropriate motivators for their organisations and effectively communicate these.

The Pike River Royal Commission has identified that, in the case of that company, leadership, direction, prioritization and oversight from the Board and senior managers was not adequate.

Pike River Royal Commission

The board needed to have a company-wide risk framework and keep its eye firmly on health and safety risks. It should have ensured that good risk assessment processes were operating throughout the company. An alert board would have ensured that these things had been done and done properly. It would have familiarised itself with good health and safety management systems. It would have regularly commissioned independent audit and advice. It would have held management strictly and continuously to account.”²

Leadership for Safety: Safety Culture

Many organisations, including Fletcher Building have used the aspiration of “zero harm” to motivate further safety improvements. Some safety literature now questions this concept. James Reason states that such a target implies that success can be achieved and a more useful framework is “... *an abiding concern with failure*”³. Organisations that recognise this:

- Are aware that not all hazards can be eliminated.
- Accept the likelihood of incidents.
- Prepare themselves to anticipate worst-case scenarios and equip themselves to both mitigate the risk of these occurring, and to recover from them, if they do occur.

James Reason uses terms such as “... *a chronic state of unease...and ... intelligent wariness...*” to characterise the safety culture of these organisations. He acknowledges that “...*no organisation is just in the business of being safe...*”. Engaging managers and workers in a safety culture requires a balance between meeting the organisation’s production objectives, and developing resilience to mitigate potential failures.

Setting aspirational targets and expressing organisational intolerance for injuries to people, is a necessary part of safety management. However, safety management is complex, and care must be taken that the use of simple slogans does not diminish this complexity, and does not lead to a diminished focus on managing hazards with low-frequency, high consequence risks.

An important aim for business leaders is to communicate a safety culture for their organisations. Reason³ states that a safe culture is the product of a number of inter-dependent sub-cultures. An formed culture, is built on a reporting culture, which is in turn dependent on a just culture. Other elements include a flexible culture and a learning culture.

These cultures are required to enable an organisation to learn its “free lessons”. These are incidents that could have, but didn’t result in injuries. Establishing trust is the first part of developing a reporting culture, as well as establishing the skills and resources to adequately collect and analyse incident data. Further leadership on these issues is needed in New Zealand organisations.

Leadership for Safety: Business Leadership

A director is responsible for ensuring that risks within an organisation are appropriately assessed and that plans to mitigate and address these risks are effectively put in place. Safety risks have significant consequences safety; sometimes people's lives depend on the organisation getting it right. Health and safety should make a regular appearance on the agenda of the board of every organisation.

The Commission's report states that industry knowledge and experience are required at the board level – this is a critical element in ensuring the board asks the right questions, obtains the right information and is able to fulfil its obligation to hold management to account.

The report is also a stark reminder of the importance of industry knowledge and experience at the board level – this is a critical element in ensuring the board asks the right questions, obtains the right information and is able to fulfill its obligation to hold management to account.

We believe that the expression of officer responsibility in the model Work Health and Safety Act 2011 (Australia) appropriately expresses the responsibilities of directors and officers and should be included within the HASE Act.

Work Health and Safety Act 2011 (Australia)⁴

27(1) An officer must exercise due diligence.

27(5) In this section, due diligence includes taking reasonable steps:

- a. to acquire and keep up-to-date knowledge of work health and safety matters; and
- b. to gain an understanding of the nature of the operations of the business or undertaking of the person conducting the business or undertaking and generally of the hazards and risks associated with those operations; and
- c. to ensure that the person conducting the business or undertaking has available for use, and uses, appropriate resources and processes to eliminate or minimise risks to health and safety from work carried out as part of the conduct of the business or undertaking; and
- d. to ensure that the person conducting the business or undertaking has appropriate processes for receiving and considering information regarding incidents, hazards and risks and responding in a timely way to that information; and
- e. to ensure that the person conducting the business or undertaking has, and implements, processes for complying with any duty or obligation of the person conducting the business or undertaking under this Act; and
- f. to verify the provision and use of the resources and processes referred to in paragraphs (c) to (e).

Leadership for Safety: Business Leadership

While we consider it is appropriate that the duties of directors under the HASE Act be strengthened, we consider that if these responsibilities are breached, it is not appropriate for this to constitute a criminal offence.

The current regime for enforcement of breaches in the HASE Act is still appropriate. We believe that to constitute a criminal offence, there needs to be some element of knowledge or recklessness associated with the action or omission. It is not appropriate for there to be strict liability offences created under the HASE Act for a breach of these duties.

This is consistent with the recent changes to other legislation involving breaches of duties by directors, for example the securities law and companies law regime, where recent and proposed changes have removed strict liability offences in favour of a regime which imposes criminal liability only in the event of deliberate or reckless actions or omissions in breach of the relevant requirements.

Business organisations also play an important part in providing leadership and direction to companies.

In New Zealand, Fletcher Building was an inaugural participant in the Business Leader's Safety Forum. The Forum has provided safety leadership in several ways:

- Through member seminars and published case studies, it has provided opportunities for chief executives to communicate their safety leadership. New Zealand has many chief executives who are highly motivated to improve safety performance and willing to publicly advocate their goals.
- The Forum is raising new issues that need to be better addressed in New Zealand. It has begun work on the issue of process safety, to enable New Zealand organisations to understand the differences between personal safety and process safety.

The Business Leaders Forum was initiated with the facilitation of the then Department of Labour, and continues its close association. This provides another example of business leadership; illustrating the value of a working relationship with the safety regulator.

Leadership for Safety: Business Leadership

Leaders make a difference

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

Our focus is to make workplaces safer by growing world-class CEO safety leadership in New Zealand, and by leveraging the combined skill, influence and resources of members.⁵

Personal Injury vs Process Safety

Our focus on personal safety in this report is not intended to diminish the importance of process safety, particularly in industries where "lack of containment" of potentially explosive or otherwise harmful substances can lead to major disaster. Process safety incidents can arise from a raft of factors including: poor design, inadequate maintenance, faulty equipment, cost cutting, inadequate hazard analysis, procedures inadequate or not followed, inadequate training, and operator fatigue¹.

Business leaders and managers need to also ensure that they are seeking advice from suitably qualified safety professionals, and the advice is evidence-based.

In New Zealand, there is no regulatory framework or education requirements to practice occupational health and safety. There is no benchmark for assessing the competence of those giving health and safety advice. There is confusion between the roles of expert advisers and workplace practitioners. Health and safety management often does not use an evidence-based perspective.

These issues have also been recognized in Australia. Its model legislation requires that an officer must be able to demonstrate, if relying on advice from others, that this advice is based on credible information and comes from appropriate people.

In New Zealand, there is an urgent requirement for business organisations, academic providers, and safety professional and practitioner bodies to work together to develop professional and practitioner standards, and accreditation requirements.

Leadership for Safety: Business Leadership

Australian OHS Education Accreditation Board

We accredit OHS professional education programs.

Our vision is that OHS professional education in Australia is based on strong scientific and technical concepts, is evidenced-informed, and is delivered by competent professionals who are recognised by the industry, government, and the community.

Accreditation provides guidance for students, employers, advisors and recruiters in assessing education, staff, and industry qualifications.⁶

Controlling Hazards and Risks: Legislative Requirements for Risk Assessment

The purpose of the HASE is to promote the prevention of harm to all people at work, or in the vicinity of places of work. The emphasis of the Act is on the systematic management of health and safety in workplaces. It requires employers such as Fletcher Building, to maintain safe working environments, and implement sound practice. We understand that the Act requires good faith co-operation with people carrying out work to achieve successful health and safety management

We also understand that there are specific duties on employers and principals to take all practicable steps to ensure the safety of people at work. The Act provides direction as to how this is to be achieved. It requires all hazards in the workplace to be identified. In the first instance, these are to be eliminated. If this cannot be achieved, then it requires employers to isolate these. Finally, if elimination or isolation cannot be practicably achieved, then these hazards should be minimised. This includes a requirement to provide personal protective clothing and to carry out health monitoring where applicable.

These directions are expressed in relatively simple terms.

In January 2012, a serious injury incident occurred on a Fletcher Building site in Christchurch. We believe this incident illustrates the limitations of this approach.

TV3 News: 20 January 2012⁷

A Fletcher Construction worker has been seriously injured at the demolition site of the quake-damaged Hotel Grand Chancellor in Christchurch⁷.

Emergency services were called to the demolition site about 8.30am on Friday. The worker was taken to Christchurch Hospital where he was in a critical condition, a hospital spokeswoman told NZ Newswire. The man's family are by his side at the hospital.

All work at the site has been suspended, and the Department of Labour has been notified about the incident.

The building - one of the tallest in Christchurch - suffered major damage in last year's February 22 earthquake, and was declared unstable. Its demolition is expected to be completed by mid-April.

Controlling Hazards and Risks: Legislative Requirements for Risk Assessment

We carried out an extensive internal investigation into this incident. The results of this investigation included the following:

- The Task Analysis did not adequately identify alternatives to ladders for access and work at height and therefore a ladder was available for the task he had identified. Following the incident, order picker ladders have been trialled. These provide an enclosed working platform and therefore isolate the work at height hazard. The Task Analysis referred to controls that would minimise the hazard only, not isolate it.
- There are provisions in the Fletcher Building safety management system that impose controls on work at height. However, these convey too much flexibility with regard to the choice of ladders, and the methods used to secure these.
- The primary organisational factor that contributed to this incident was the acceptance of ladders as a suitable method for gaining access to height.

- The Fletcher Building Work at Height standards require an assessment of alternatives to ladders whenever access or work at height is required. This incident provides evidence that alternatives to ladders are not considered with sufficient rigour. It is evident that this is an industry-wide issue as ladders are used on construction sites as an everyday piece of plant for access and work platforms.
- Coupled with this issue is that of training for ladder use. There is evidence of conscientious efforts to train employees about the hazards of ladder use. However, it is likely that this training does not provide sufficient material on alternatives to ladders. Nor does it compel employees to consider ladders as a tool of last resort, because of their inherent hazards.

Fletcher Building believes that this is illustrative of the failure of the current legislation to facilitate rigorous risk assessment. A different process and the availability of more explicit industry guidance, would have reached a different outcome. We believe that this example will be replicated with many different examples of hazards in New Zealand workplaces.

Controlling Hazards and Risks: Legislative Requirements for Risk Assessment

Of particular concern is that Sections 7-10 of the HASE do not direct focus on the degree of harm that might result from the hazard or the risk. This has two consequences:

- All hazards are treated equally, in spite of significant differences in the degree of harm that may result.
- There is insufficient focus on engineering solutions (eliminating hazards).

We believe that a risk-based approach is necessary to improve the efficacy of the hazard controls being used in New Zealand. We believe that the current hierarchy of “eliminate, isolate and minimise” does not facilitate rigorous risk assessment. There is often a default to “minimise”, even in situations where the hazard could result in serious or fatal injuries.

We note that this approach differs from the regulatory approach in Australia, as set out in the recent Work, Health and Safety Act 2011. This shares a similar approach to the HASE, in imposing a duty to take all practicable steps to ensure the health and safety of employees. However, it differs in that it requires an assessment of risks associated with each hazard, as part

of the process for determining controls.

Work Health and Safety Act 2011 (Australia)⁴

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 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;
- 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
- 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.

Controlling Hazards and Risks: Legislative Requirements for Risk Assessment

Guidance to the Act provides detailed interpretation of “reasonably practicable”⁸. This requires consideration of everything that may be relevant to the hazards, risks or means of eliminating or minimising the risks. It includes:

- The likelihood of the hazard or the risk concerned occurring. The greater the likelihood of a risk eventuating, the greater the significance this will play when weighing up all matters and determining what is reasonably practicable. If harm is more likely to occur, then it may be reasonable to expect more to be done to eliminate or minimise the risk.
- Degree of harm that may result if the hazard or risk eventuated. The greater the degree of harm that could result from the hazard or risk, the more significant this factor will be when weighing up all matters to be taken into account and identifying what is reasonably required (what is reasonably practicable) in the circumstances. Clearly, more may reasonably be expected of a duty-holder to eliminate or minimise the risk of death or serious injury than a lesser harm.

- What the person concerned knows, or ought reasonably to know, about the hazard or risk and any ways of eliminating or minimising the risk

We believe that this direction for a risk assessment approach results in a more rigorous assessment of controls to manage workplace hazards, and is more likely to lead to engineering solutions to remove hazards. If used early enough, there will be opportunities to “design-in safety”.

Controlling Hazards and Risks: Worker Participation

We noted earlier the contribution of leaders to developing an organisation's safety culture. In particular, a reporting culture is an essential component, because of the need to continually learn and improve. A reporting culture requires both leaders and workers to share a common understanding and commitment to reporting "near miss" incidents. This requires a common understanding that the purpose of reporting instances is to enable investigation so that improvements can be made; it is not to attribute blame to an individual.

This is one of the most important contributions of worker participation to an organisation's or site's safety management. A reporting culture will not only lead to more incidents being reported; it will also extend to proactive reviews of hazards and controls. It will encourage worker participation in the development of controls. The value of this contribution is recognised in legislative regimes such as New Zealand's HASE.

Worker participation in safety management, occurring in an organisation with a safety culture that includes open reporting, flexibility and learning, is an appropriate aim. There needs to be careful consideration as to the best

methods to achieve this. We believe that more progress will be made through business leadership and support from other Government and non-Government organisations than from further legislation. Prescriptive legislation will not enable the flexible approaches that are required to further develop reporting and engagement.

Pike River Royal Commission

The workplace environment needs to encourage workers to exercise their rights and perform their duties effectively. Employer's should create a culture that values health and safety and that supports workers who raise health and safety concerns. This requires leadership and commitment by management and the building of trust with workers, including health and safety representatives.

The development of high-trust relationships takes time. Senior management must be willing to listen to workers' concerns about health and safety and should respond promptly.

The effectiveness of worker participation systems should be regularly reviewed and any problems addressed.²

The Role of the Regulator

In New Zealand, the HASE Act is an example of “command and control” legislation, with some inherent flexibility for co-regulation. There are no reasons to change this model or the balance between these. Health and safety requires strong legislative direction and “bottom lines” to be explicitly described and enforced, to ensure the rights of workers to safe workplaces. However, given the high variability in workplaces in terms of hazards and demographics, some flexibility in application is required. A co-regulatory model, which has specific provisions to enable compliance with regulatory requirements, is therefore suitable.

Requirements for regulatory compliance can be expressed in a number of ways, including standards, codes of practice, and descriptions of best practice. These may be prepared by Governmental agencies including the regulator, by quasi-Governmental agencies such as Standards NZ, or by industry organisations.

We believe there is more scope for the development and use of codes of practice in New Zealand. These can be used to achieve several objectives:

Approved Codes of Practice: HASE Act⁹

Approved codes of practice are provided for in the Act. They are statements of approved work practice or arrangements, and may include procedures which could be taken into account when deciding on the practicable steps to be taken. Compliance with codes of practice is not mandatory; however, compliance with an approved code of practice may be used in Court as evidence of good practice of an employer or other duty holder having taken “all practicable steps” to meet the duty.

Approved Codes of Practice: Work Health and Safety Act 2011 (Australia)¹⁰

To support the Model Work Health and Safety Act, Safe Work Australia released the fourth set of draft model Codes of Practice and an Issues Paper for public comment.

The Role of the Regulator

To provide more direction to the control of hazards and risks by lifting the standard and achieving greater consistency within industry sectors.

- To provide more opportunities for industry sector collaboration.
- To provide a tool that can be used in procurement processes to ensure that competition for products and contractual services does not result in lowered safety standards.
- To enable the regulator to work in a collaborative manner with sectors and organisations that would otherwise struggle to achieve adequate and equivalent safety standards.

We believe that this is a significant need for New Zealand's safety regulator. We believe that the Health and Safety Group within the Ministry of Business, Innovation and Employment has developed appropriate guidelines and an effective approach to enforcement of the HASE Act. However, we believe there is scope for significant further development of the Group's co-regulatory role through the development and regular

review of codes of practice.

We are aware that this will require further resources. We believe that the Group has been unable to adequately balance its enforcement and co-regulatory roles because it has had inadequate resources. This inadequacy has also resulted in a lack of professional development opportunities for its staff. Thus the issues inherent in the lack of a qualifications framework for safety managers and practitioners in New Zealand, are exacerbated in the Group.

References

1. Safety Spotlight: ASX100 Companies and More: Injuries and Fatalities Data FY05 to FY11 Presented and Interpreted. Elaine Prior (+61-2-8225-4891) Elaine.prior@citi.com Citigroup Global Markets
2. [http://pikeriver.royalcommission.govt.nz/vwluResources/Final-Report-Volume-Two/\\$file/ReportVol2-whole.pdf](http://pikeriver.royalcommission.govt.nz/vwluResources/Final-Report-Volume-Two/$file/ReportVol2-whole.pdf)
3. Safety Paradoxes and Safety Culture. James Reason, (2000). International Journal of Injury Control and Safety Promotion, 7:1, 3-14.
4. <http://www.safeworkaustralia.gov.au/sites/SWA/AboutSafeWorkAustralia/WhatWeDo/Publications/Pages/model-work-health-safety-act-23-June-2011.aspx>
5. <http://www.zeroharm.org.nz/>
6. <http://www.ohseducationaccreditation.org.au/>
7. <http://www.3news.co.nz/Worker-critical-after-Christchurch-Grand-Chancellor-demolition-incident/tabid/423/articleID/240042/Default.aspx#ixzz1jxSRkFxW>
8. <http://www.safeworkaustralia.gov.au/sites/SWA/AboutSafeWorkAustralia/WhatWeDo/Publications/Documents/607/Interpretive%20guideline%20-%20reasonably%20practicable.pdf>
9. <http://www.osh.govt.nz/order/catalogue/pdf/cranes-acop-2009.pdf>
10. <http://www.safeworkaustralia.gov.au/sites/SWA/Legislation/PublicComment/Pages/ModelWHSCoPPC-4thSet.aspx>