

Submission to the Independent Taskforce on Workplace Health and Safety

Submission by the New Zealand Society for Risk Management

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Introduction

1. This submission is in response to the Taskforce call for submission in its document “Safer Workplaces.” As the views and recommendations presented in this evidence are overarching in nature, this submission does not follow the series of questions set out in the consultation document “Safer Workplaces.”
2. The submission contends that achieving ‘safer’ workplaces is no more or less than applying contemporary best risk management practice to the objective of ensuring the health and wellbeing of workers in workplaces. We further contend that these practices in reality can and should be extended to the objective of ensuring the health and safety of others (i.e. persons other than workers) while in workplaces.
3. It proposes modifications to the current framework for workplace health and wellbeing at a number of levels including;
 - legislative (law, regulation and other legal instruments)
 - administrative
 - advisory (including the provision of good practice advice)
 - educational (including the knowledge of the management of *risk*, and expertise in conducting tasks in the workplace in a way which manages the *risks* arising from the activities)
 - organisational capacity, governance and leadership.
4. The Society draws particular attention to the use of the words health and wellbeing in the previous paragraphs. We do not consider it realistic to found the protection of workers from harm on the concept of ‘safety’. This is because, in the Society’s observation, this concept has become the (in practice unattainable) idea of an absolute absence of hazard. In any circumstance where there is an absolute absence of hazard, it logically follows that nothing can be undertaken, made or created. Since a fundamental aspect of workplaces is that they exist to create wealth for all workplace participants, safety or a total absence of hazard is never possible. In particular, the Society considers there is a balance to be struck between imposing of controls on workplaces for the protection of workers and the ability of commercial or public entities to conduct business.
5. This submission is made by resolution of the Management Committee of the New Zealand Society for Risk Management Inc [“the Society”]. The Society’s Management Committee is its governing body and is established by election from the Society’s members.
6. Following the Society’s normal practice, the Taskforce’s call for submissions and consultation documents was referred to a technical advisory committee established for the purpose, and then an opportunity was provided for the total membership of the Society to comment on the draft the submission produced by the committee, before the submission was finalised and formally approved by the Management Committee. In this instance, the technical committee included Society members with direct professional experience in mining, construction, including industrial construction, health and safety inspection and enforcement, fire engineering, and in the development of risk management based policy and legislation.
7. Also, following the Society’s established practices, this evidence was formulated without input from or involvement by the Society’s sponsors.
8. This submission contains a considerable amount of terminology that has both an ordinary meaning and a technical meaning for risk management purposes. These technical terms are highlighted (***bold italic***) in the text which follows. The terminology used follows that of *AS/NZS ISO 31000:2009*, the current international standard setting out good practice in risk management, and adopted through the New Zealand Standards promulgation process under the Standards Act 1988. For the Taskforce’s convenience, definition and explanation of key risk management terms, abstracted from the above Standard, is annexed to this document.
9. In considering this submission, the Society urges the Taskforce to familiarise itself with these expressions, as these are central to the rationale of the submission. The Society would also be happy to meet with the Taskforce and answer questions or clarify any of the points made in this submission, should this be of assistance to the Taskforce.

10. AS/NZS ISO 31000:2009 is based on concepts developed largely in New Zealand and Australia since 1995. As evidenced by an international survey conducted last year, it is clear that the standard is becoming widely accepted internationally¹. Significantly, the purpose of the standard is to provide generic guidelines suitable for application to all types of organisation and for managing all forms of risk.
11. Notwithstanding the date shown at the top of this document, the majority of this submission was written before the report of the Royal Commission on the Pike River Coal Mine Tragedy was made public. Accordingly, most references to this disaster are to public evidence to the Royal Commission and not to the report itself.

Summary of this submission

12. The Society, having reviewed the current workplace health and safety system from both legislative design and operational perspectives, is of the view that the current New Zealand reliance on the concept of safety (as defined in law), and on the identification and elimination of hazards, is both fundamentally flawed and is providing an impediment to improved health and wellbeing in workplaces. We consider that the requirement to achieve safety (i.e. 'not exposing a person to any hazards') has as a direct consequence the undertaking of no activity, which is contrary to the purpose of workplaces to provide for society's economic and social wellbeing. We further consider that the current requirements lead to the misdirection of resources in a way that is actually detrimental to the health and wellbeing of people in workplaces.
13. The Society considers that there is now sufficient evidence to support a restructure of the New Zealand 'workplace health and safety system'² to require those in charge of workplaces (i.e. management and governing entities) to manage the **risks** to workers and other persons in workplaces in a coordinated and integrated manner. This approach includes clear understanding of, and responding to the **consequences** of hazards manifesting as well as to the **likelihood** of those **consequences**. The society considers that this will require changes to New Zealand's legislation, administration, and educational systems pertaining to workplace health and wellbeing. We also propose that changes be made to the obligations of governing entities to require that they ensure that risk management is undertaken as a core function by the management of the organisation for which they hold governance responsibility.
14. We acknowledge that use of **risk management** in contexts such as worker safety is prone to lack of clarity. This is because the terms required for the proper application of **risk management** also have everyday meanings, and have been defined in different ways in the past. We therefore strongly recommend that revisions to the New Zealand workplace health and safety system be based on the defined terminology and concepts in documented contemporary international best practice in **risk management** as set out in AS/NZS ISO 31000: 2009.
15. The Society acknowledges that the changes proposed are significant and will require considerable support. This will include;
 - a. change, updating and potentially increased resourcing of education systems (particularly at the tertiary and industry training organisation level)
 - b. revision of the advisory services provided by the government, including supporting change in societal attitudes towards those structures, rituals and routines that, when combined, serve to identify, assess and controls **risks**
 - c. improved design and implementation of enforceable standards (including use of standards from related legislation)
 - d. shifting the focus of workplace inspection (and, where required, enforcement actions) from the cataloguing and elimination of hazards to the review of complete systems against properly formulated enforceable standards
 - e. duties to ensure competence of workers deployed on tasks relevant to workplace health and safety
 - f. changes to the basis on which the Accident Compensation Corporation (ACC) assess workplaces.

¹ See for example the Global ISO 31000 survey 2011: Results & analysis - obtainable here:
http://www.iso31000survey.com/Global_Survey_ISO_31000_English.pdf

The Society

16. The Society was established in 2000 for the purpose of *Improving knowledge and practice of risk management in New Zealand*. As a matter of policy the Society does not take a particular viewpoint in questions of policy, law, regulation or codification of good practice (whether such codification has regulatory force or not). The Society's overarching concern therefore is that, irrespective of subject, practices related to managing risk (whether documented or not) reflect contemporary risk management knowledge and practice.
17. The Society's current membership is approximately 300 individual members and 60 corporate members drawn from a wide range of sectors and disciplines. These include: engineering, insurance, legal and auditing professionals, technology managers, environmental specialists, government officials, local authority managers, academics and others.
18. From these two membership classes the Society regularly reaches and obtains views from some 800 professionals in these disciplines, all of whom are involved in the management of risk.
19. Further details of the Society can be obtained from its website www.risksociety.org.nz.

The unsound basis of New Zealand's workplace health and safety

20. Workplaces exist because they generate economic activity, which enables people to provide for their own wellbeing. This is not and cannot be seen as separate from the legislation and administration of workplaces to protect workers from harm.
21. We therefore regard the application of controls on workplace safety that does not account for this reality as flawed. This means that any attempt to regulate workplace health and safety separate from the other purposes of workplaces is in our view failing or likely to fail. New Zealand's current workplace health and safety law is flawed in this way, as it attempts to provide obligations on those in charge of workplaces which are totally disconnected from the everyday purposes of workplaces.
22. At a legislative purpose level this disconnect is most starkly illustrated by absolute duties imposed on employers to 'ensure the safety of workers in workplaces' in the current Health and Safety in Employment (HSE) Act 1992. This contrasts with similar parts of the Hazardous Substances and New Organisms (HSNO) Act 1996, which requires both the protection of people and the environment and the "maintenance and enhancement of the capacity of people and communities to provide for their own economic, social, and cultural wellbeing."
23. In particular, the Society has major reservations about the use and definition of the term 'safety' in relation to workplaces. The HSE Act says:

"safe, –
(a) in relation to a person, means not exposed to any hazards; and
(b) in every other case, means free from hazards; –
*and unsafe and **safety** have corresponding meanings"*
24. In our view, the absolute nature of this obligation lies at the core of New Zealand's current poor performance in terms of reported harm to workers. This is particularly because those controlling workplaces must follow this absolute obligation while still attempting to serve the goals of workplaces in respect of economic activity and providing for the wellbeing of workers, and indeed of other persons in workplaces. As we have already noted, actually achieving 'not exposing a person to **any** hazards' (our emphasis) has as a direct consequence the undertaking of no activity. This tension has, in the Society's view, led to a series of outcomes which border on the bizarre.
25. On the one hand, those in control of workplaces are obliged to continually expend effort and resources on the identification and elimination of (or at least reduction and separation of workers from) **any** hazards, regardless of **consequence** of that exposure or the **likelihood** of exposure occurring. On the other, the organisations concerned must pursue their business **objectives** in order to generate the wealth required to provide employment and so the broader wellbeing of workers.
26. The Society considers this basis for providing for the wellbeing of workers is fundamentally unsound. Not only does it artificially separate protecting workers in workplaces from harm from the other

aspects of providing for those workers wellbeing, but it also provides no reasonable basis for allocating resources to manage those hazards which are of sufficient magnitude to warrant greater attention.

27. We therefore consider that the first and most critical task of any improvement in workplace health and safety is to provide a sound basis for allocation of effort and for intervention by the regulatory agencies and by courts in the case of prosecutions. In our view, this basis should be the obligation on all those involved to manage workplace **risks** (including those relating to worker health and wellbeing) in a way that integrates all aspects of the workplace and serves to achieve the organisation's objectives as efficiently as possible. We emphasise this last point. The Society is not advocating subordination of the objective of worker health and wellbeing to other objectives of organisations in charge of workplaces. The objectives must be met together, and meeting one without the others is neither reasonable nor practicable.

The fundamental problem – risks V hazards

28. In the Society's reading, New Zealand's present 'workplace health and safety system'² is
- a. focussed almost entirely on the identification and reduction of hazards in the workplace
 - b. in large measure disconnected from the other areas where society intervenes in the operation of workplaces and organisations
29. The consequence of this is a failure to focus on the matters most likely to actually affect worker wellbeing. As an extreme example, in the published evidence presented to the Royal Commission investigating the Pike River Coal Mine disaster, there are examples of considerable effort spent on identifying and minimising exposure of workers to the hazards of tripping and falling. At the same time **risks** with much more severe **consequences**, including fire and explosion from the introduction of ignition sources into the mine did not appear to be accorded either the same level of analysis or the same level of prevention and response effort. The result of this distorted focus on hazards with inadequate regard for consequence and likelihood is well documented and led not only to the loss of 29 lives but also to the loss of livelihood for all those employed by the Pike River Coal company.
30. Experience of Society members suggests that this situation is of considerable frustration to safety managers in high-hazard and complex industries. These people see frequent instances of efforts to progress significant upgrades to reduce **risks** to workers at times delayed or compromised by inspectors (driven by the current statutory framework) focussing on the cataloguing and elimination of hazards which, if even they eventuated, would have relatively minor consequences.
31. More generally the document 'Safer Workplaces' points out that New Zealand's performance in protecting workers from harm is significantly poorer than comparator countries including Australia and the United Kingdom³. These two jurisdictions have moved at least some distance towards the introduction of controls on workplace health and wellbeing based on the **risks** to workers.
32. These workplace health and safety systems focus action on the **identification, assessment** and considered **treatment of risks** to worker health and wellbeing. Although relatively 'new', this approach can already be shown to provide significantly better performance in terms of worker deaths injuries and illness. For example, figure 3 of the 'Safer Workplaces' document shows that both Australia and the UK have significantly lower rates of workplace fatalities and that these rates are trending downwards consistent with the introduction of a more **risk management** based approach to workplace health and safety.
33. We acknowledge that the management of workplace health and safety through a **risk management** based approach is prone to lack of clarity because the terms required for the proper application of risk management also have everyday meanings. We therefore consider that a major priority in the improvement of workplace health and safety is using a clearly defined and understandable terminology to describe both what is sought and the nature of the obligations imposed.

² We note the expression 'workplace health and safety system' is used frequently in the document 'Safer Workplaces' but is not defined. For the purposes of this submission, we define the expression as meaning the legislative, administrative, guidance, and learning elements that make up the interventions by society in the conduct of workplace activities to provide for the health and wellbeing of workers and others present in workplaces.

³ Safer Workplaces Consultation Document P9 ff

The need for clear terminology

34. Every endeavour faces the prospect of factors and influences that make it uncertain whether or not the objectives of that endeavour or organisation can be achieved. The maintaining or enhancing of the health and wellbeing of workers in workplaces is no different from any other endeavour in this respect.
35. The effect of this uncertainty on objectives is in a professional context termed '*risk*'. The term however is frequently more loosely and generally used to mean chance, likelihood, consequence or impact.
36. We also note that the well informed taking and managing of *risk* is an essential part of any organisational endeavour, whether it is protecting individual workers from injury or ill health or sustaining the operation of the organisation which pays those workers wages. Put another way, there is no fundamental difference between the managing of risks related to workplace health and wellbeing and managing any other risk that the organisation faces.
37. Further, the Society is aware of many different methods by which risks are managed. For example, the Society is aware of inconsistent methods of *identifying, assessing, evaluating* and finally *treating risks* embedded in areas such as legislation, regulation, and the practices of agencies of state. In our experience, these inconsistencies extend to practices of persons charged with the operation of various aspects of organisations, such as financial control or occupational health and safety. The consequence of these different definitions, methods etc is the potential for confusion and the degradation of decision-making capacity.
38. The Society therefore considers that the first step in improving the health and safety system is the adoption of clear and unambiguous terminology in managing *risk*. The most widely used framework is that laid out in documents produced through the standards setting processes of the International Standards Organisation (ISO). The preferred terminology is that of *AS/NZS ISO 31000:2009 Risk Management - Principles and Guidelines*, the current international standard setting out good practice in risk management, and adopted through the New Zealand Standards promulgation process under the Standards Act 1988.
39. This standard is also increasingly being supplemented by other related guidance such as AS HB 89:2012. Risk management - Guidelines on risk assessment techniques. Inconsistent and ill disciplined use of terminology has the effect of undermining the use of these publications also.
40. We therefore recommend that:
 - a. the Taskforce advise the government to change the basis of New Zealand's workplace health and safety system from one requiring the identification and elimination or minimisation of hazards to one requiring the management of *risks* to workers and other persons in workplaces.
 - b. the taskforce advise that this system be designed using the risk management terminology and concepts explained and defined in *AS/NZS ISO 31000:2009 Risk Management - Principles and Guidelines*

A risk management based approach

41. Failures in workplace health and safety that result in harm to workers can generally be thought of as the manifestation of hazards present, usually as a consequence of the work being done. As a simple example, if the work involves the felling of trees, it is not possible to remove the hazard of falling trees. However, it is not axiomatic that the felling of trees will cause harm to workers, or to others in the workplace. In fact, the likelihood that forestry workers will be harmed by the everyday event of felling of trees is generally low.
42. This simplistic example illustrates several key concepts in the understanding of workplace related *risk*. First, it is only when a hazard actually eventuates that there is a *consequence* for worker health and safety. Second, the event occurring and causing consequences for the wellbeing of workers is uncertain, or has some *likelihood*. Third, it is generally this *likelihood* of a *consequence* actually occurring which is the matter within the control of those managing workplaces.
43. Put another way, hazards are often intrinsic to whatever is being undertaken to generate useful work and so provide benefit to workers (i.e. pay wages etc.), but what matters for worker health and safety

is the *likelihood* that those hazards will eventuate, and the *consequences* if they do. While it may be possible to alter the nature or scale of the *consequences* from a hazard, it is often the case that altering the *likelihood* of the *consequences* occurring will have more effect and is more likely to be practically achievable. Mechanisms that alter either *likelihood* of *consequences* or the scale of those consequences are called *controls* in risk management terminology.

44. While it may be useful to identify hazards in a workplace, the foregoing example shows that this is not sufficient. The meaningful protection of workers from harm in workplaces must take the succeeding steps outlined above. Not only must hazards be identified, but their *consequences* must be understood, as must the *likelihood* of these *consequences* actually occurring. Only then can effective steps be taken to reduce or prevent harm actually occurring.
45. In the Society's observation, New Zealand's current workplace health and safety system requires the identification of hazards and then compels that various options are chosen to eliminate, minimise or isolate workers from these hazards. This misses several fundamental steps in the *risk management process* described in the previous paragraphs.
46. We have already shown from the Taskforce's own material that those jurisdictions that oblige the identification and management of risks to the objective of protecting workers from harm are achieving better results (less harm to workers) than New Zealand. We contend that this reinforces our recommendation in paragraph 40 above that

The legislative, administrative, and guidance elements of the New Zealand workplace safety system be altered to one requiring the management of *risks* to workers and other persons in workplaces

Integration with workplace design and operation

47. We have already referred several times to the fact that workplaces do not exist in isolation. Workplaces are an integral part of the objectives of the organisations to which they belong. These objectives vary from the providing of a return on shareholder capital in the case of commercial entities to the providing of various services to the community in the case of government organisations and not for profit entities.
48. The activities undertaken in the workplace of each organisation must be to meet the all the objectives of that organisation including; worker health and wellbeing, delivering the required services, maintaining shareholder value, protecting and enhancing reputation etc. A moment's thought will show that in the real world there are *risks* relating to all of these objectives. It is therefore unrealistic to assume that those responsible for the operation of workplaces (the organisation's management and its governing entities) can or should manage the risks to each objective in isolation from each other. We would actually argue that it is not possible to do so; the wellbeing of workers in workplaces can only be managed if the organisation is succeeding in its objectives, and the organisation's continued operation requires that workplace safety is maintained. An extreme example of this is provided by the Pike River Coal Mine disaster where not only did a failure of workplace safety result in multiple deaths, but it also resulted in the failure of the organisation with the loss of the total shareholder value.
49. Considering this, the Society is of the view that the management of *risks* to worker health and safety can and should form part of the total management of *risks* to all aspect of an organisation's operation. Achieving this requires two ingredients; management capability and competence, and the attention (with necessary knowledge) of the organisation's governing entity.
50. In our view, prudent governing entities of any organisation (commercial or otherwise) should pay specific attention to the management of *risks* that the organisation faces. This attention must be consistent with the context of its commercial and operational environment, its activities, and the stage in the lifecycle of the entity concerned (e.g. development, operation, redevelopments, decommissioning etc). In the final analysis, any governing entity (such as a company board) can only consider and act on information supplied to it by the organisation's management. However, it should be sufficiently informed and expert to be able to judge the completeness and general quality of the information it should see, and to test and challenge information presented to it.
51. Notwithstanding that such a general level of competency should be expected of directors, it is in our view absolutely essential that the management structures in any organisation include sufficient management capacity and specialist professional knowledge to adequately oversee the management of all aspects of *risk* with respect to its operations.

52. This capacity must include:

- a. The necessary expertise (at each organisational level) to fully understand and adequately describe (and keep up to date) the **context** in which the organisation operates and therefore the nature of the **risks** that it must manage
- b. The necessary expertise to construct and apply an effective **framework** for managing **risk** that meets the accepted principles of effective **risk management**
- c. The capability to apply a systematic **risk management process** that ensures that **risk identification** and **risk assessment** are adequately undertaken across all types of **risk** arising from the organisation's activities.
- d. The mechanisms to appropriately communicate **risks** to the required level of decision maker (including where necessary the board or other governing entity)
- e. The skills and resources to put in place and keep current (and effective) the **controls** designed to manage risks
- f. Clear accountability for the managing of identified **risks**. This includes assigning **risk owners**, for each identified **risk** and or **control**, with the necessary authority to manage each **risk** and or **control**.

53. While a board (or other governing entity) cannot be expected to carry out the detail of a **risk management** programme, it is the Society's view that Boards have the responsibility to ensure that the framework and processes for managing risk are being properly applied and the associated disciplines maintained within the organisation. A Board may choose to use techniques such as process review and **risk** reporting, process and **control** effectiveness audits, and monitor key risk indicators by internal processes as well as by independent external parties to assist in providing the required level of assurance.

54. In New Zealand, the primary instrument for setting the responsibilities of governing entities is the Companies Act. At present there are **no** specific obligations imposed on directors by the Companies Act to ensure the adequate management of **risks** to which the company is exposed. However, in a guidance document originally produced by the Securities Commission (whose functions are now part of the Financial Markets Authority) advice is given that:

"6.1 The board [of directors] should require the entity to operate rigorous processes for risk management and internal control.

6.2 The board should receive regular reports on the operation of risk management and internal control processes.

*6.3 Boards of issuers should report annually to investors and stakeholders on risk identification and management and on relevant internal controls."*⁴

55. The above advice represents at its core a direction to provide for the adequate management of the **risks** (including risks to worker health and wellbeing) that the company faces. This has already been taken further in Australia where the Australian Stock Exchange (ASX) listing rules (specifically Listing Rule 4.10.3) require companies to provide a statement in their annual report disclosing the extent to which they have followed the recommendations, given in the document *Corporate Governance Principles and Recommendations with 2010 Amendments*. This document, published by the ASX Corporate Governance Council includes clear requirements for managing **risk**. That document has been augmented by the *Supplementary Guidance to Principle 7* issued in June 2008 by the ASX Corporate Governance Council.

56. The Society therefore recommends that

the Taskforce recommend to government (in addition to the matters covered in paragraph 40 above (which largely affect management of organisations)), the strengthening of the duties of directors to include a requirement to ensure that risk management is undertaken as a core function by the management of the company for which they hold governance responsibility. As these requirements would need to be stated within the context of the commercial regulations, it is critical that they explicitly require the terms 'risk management' and 'internal control' to include management of all types of risk including worker health and safety, and that the

⁴ Corporate Governance in New Zealand: Principles and Guidelines. Securities Commission. 2004. (Reprinted 2011)

interpretation of ‘stakeholders’ be explicitly include all those who may be threatened by events caused by the company’s activities⁵.

The need for effective tools – knowledge and culture

57. We acknowledge that simply changing obligations on workers, and workplace management and governance will of itself achieve little. Such changes need to be supported by providing adequate skills and knowledge to actually undertake effective management of risks to worker health and wellbeing.
58. In the Society’s view, the available training and education in **risk management** is at the very least inadequate and in many cases training currently offered may be ineffective and misleading. Few management programmes in New Zealand offer any training in **risk management** principles and processes, and those that do offer these only as electives. More disturbingly, a recent survey by a senior member of the Society showed that, of some 40 NZ Qualifications Authority unit standards purporting to be concerned with **risk management**, many were not on the topic at all, while others used seriously outdated and obsolete concepts, and yet others provided poor or incorrect guidance to institutions wishing to offer ‘accredit-able’ training on the subject.
59. Only if there is adequate training leading to the application of the resulting expertise can we expect to see the required cultural shift within an organisation that will make the management of **risks** to worker health and safety effective.
60. In the Society’s experience, providing this capacity and expertise is only part of ensuring effective **risk management**. Of even greater importance is the day-to-day behaviour of people in organisation. Without behaviours that systematically and rigorously consider and address the **risks** inherent in an organisation’s activities, the provision of professional **risk management** capacity is in itself often largely ineffective. The development of a culture which understands and responds to **risks** effectively is probably the single largest internal change that can be made in an organisation to improve workplace health and safety.
61. Evidence of inappropriate behaviours is often quite simple to recognise. For example, in evidence from the hearings of the Royal Commission’s of inquiry into the Pike River Coal Mine Disaster, it appears that mine staff at times shielded gas detection equipment to isolate it from the surrounding mine atmosphere, and that ignition devices (such as cigarette lighters) were, at least occasionally, taken underground. Such practices would have circumvented critical **controls** designed to manage the **risks** of gas explosions in the mine with the type of serious consequences that in fact occurred⁶.
62. They also point to a culture that appeared to openly tolerate such practices, and would have made it difficult for personnel to raise matters of concern with regard to safety. It is of particular note that sectors with highly developed systems for managing **risks**, such as the aviation industry, put considerable emphasises on the development and maintenance of an open reporting no-blame culture (sometimes termed a ‘just’ culture).
63. It needs also to be recognised that attitudes to safety in the workplace develop within the context of societal attitudes and culture. More specifically, improving the workplace culture so that workers and others behave in a way that identifies and assess **risks** and consciously take actions to reduce them will only come from changes in societal attitudes. A ‘she’ll be right’ culture does not result in improved workplace health and wellbeing. This is understood by some high performing commercial organisations, which put effort into ‘safety in the home’ programmes for their workers.
64. There are many references to **risk management** culture, however the Society considers the following comment by a senior member of the Standards Australia/Standards New Zealand Joint Technical Committee on Risk Management summarises what is required for an effective **risk management** culture.

“An effective risk management regime is a combination of an organization’s culture (beliefs, values and behaviours), processes and structures that are directed toward realizing potential gains whilst avoiding or limiting losses. An organization’s culture is the sum of its people, symbols, stories, business experiences, power structures, control systems, organizational

⁵ This usage of the term ‘stakeholder’ is consistent with the definition used in AS/NZS ISO 31000.

⁶ At the time of writing, the Royal Commission had not reported so the Society wishes to make it clear that it is not drawing and properly cannot draw any conclusions about the cause of the disaster at Pike River.

structures, rituals and routines that, when combined, make it unique. The structure adopted must ensure that all risks have owners who have accountability for their management and who also have the authority to make decisions with respect to the management of the risk.”⁷

65. The Society therefore **recommends** that the Taskforce advise the government to:
- a. **review the currently available training in *risk management* (especially at tertiary and industry training organisation level) and require that all training that is offered be based on the terminology and concepts explained and defined in AS/NZS ISO 31000:2009 *Risk Management - Principles and Guidelines***
 - b. **provide adequate resources within the tertiary sector to enable institutions to provide courses and other forms of training in *risk management* to all levels of workplace management from ‘shop floor’ to senior executive level**
 - c. **change the policies governing the administration of the health and safety system to encourage the development of *risk management* cultures in all workplaces.**
 - d. **couple changes to workplace culture to advice and resources intended to change wider societal attitudes towards taking and managing risks. This recognises that attitudes and culture in the workplace do not exist in isolation to those in society as a whole, and improving one is a key element in improving the other.**

The need for effective tools - personnel competency

66. Beyond the matter of knowledge and skills in managing (*identifying, analysing, evaluating treating, communicating and monitoring*) **risks**, and the development of a culture of **risk management** lies an area of at least as great an importance to providing for worker health and safety. This is the matter of the competency of persons to undertake tasks in the workplace in a way that manages **risks** as effectively as possible.
67. This competency at a minimum requires knowledge of how to undertake the tasks required by the organisation as well as sufficient knowledge to avoid behaviours that put others at **risk**. Depending on the nature of the task or tasks, it may also require practical skills in doing particular things. Often this competency is inextricably linked to the expertise which the organisation employs particular workers for. For example; a person employed in a mining operation to manage explosives and detonate explosive charges must not only know how handle and store these chemical mixtures so that they do not detonate in the wrong place or time, but also have the knowledge to decide on the correct amount of explosive and its placement to obtain the required result when the charge is detonated. That worker must also be familiar with the general mine environment in order to function effectively.
68. While it is arguable that the community should intervene to require that organisations employ only suitably skilled people in their business, it is clear that specific types and levels of worker competency are a key element in maintaining worker safety. In some cases, including the management of hazardous chemicals, installing and modifying electrical wiring, and the installation of gas equipment, the specialised legislation and their attached administrative systems do demand demonstration of specific knowledge and skills of the people responsible for doing this work.
69. In other cases, levels of qualification are required for particular commercial reasons. For example, a code of practice (the JORC Code⁸) demands that only persons with certain levels of professional qualification and experience may provide estimates of mineral resources. This Code is incorporated with the rules of stock exchanges here and in Australia, effectively preventing a mining company from listing publicly without providing mineral estimates developed by specifically qualified persons. The net effect is to require a given level of competency for this activity. We acknowledge this case is not directly related to health and safety in the workplace, so the example is illustrative only.
70. Considering the above, the Society is therefore of the view that a key element in effectively managing **risks** to worker health and wellbeing is the employment of persons with the required types of skills and knowledge to carry out tasks in a way which manages **risks**. We note that in areas where the **risks**

⁷ Future ISO 31000 standard on risk management. Kevin W. Knight. Pp 8-11, ISO Management Systems July-August 2007

⁸ The Australasian Code for Reporting of Exploration Results, Mineral Resources and Ore Reserves 2004

arise from specific hazardous situations (such as chemical hazards, electricity etc) there are already obligations in law and regulation requiring this expertise.

71. The Society also notes that historically ‘apprenticeships’ (including in trades and postgraduate learning by professionals), provided workers with fundamental skills, knowledge and essentials of behaviours which reduce *risks*. The loss of ‘apprenticeships’ and subsequent failure by successive governments to adequately support efforts to reinstate these must be considered an important factor in the poor safety record in New Zealand.
72. We also acknowledge that the scope of workplaces is so broad that specification of all the required types of skill and knowledge, even for managing the *risks* workers directly face, will be at best difficult and at worst impossible.
73. We therefore **recommend** that the Taskforce
 - a. **consider the imposition of a general duty on those responsible for workplaces to ensure persons employed on particular tasks have and maintain adequate skill and knowledge to undertake the tasks required in a way that manages the *risks* to workers health and wellbeing**
 - b. **recommend that the competencies already required in other law, regulation and related instruments (e.g. adequately scrutinised codes of practice) be accepted as fulfilling this general duty in specific circumstances**
 - c. **advise the government that the best practice work methods learned in apprenticeship type schemes are an important element in developing and maintaining proper safety knowledge in the workforce and recommend support for reinstatement of these schemes.**

The need for effective tools - enforceable standards

74. Within the legislative component of any framework managing risks, acceptable benchmarks or standards need to be set. This need is best illustrated by way of an example from elsewhere in New Zealand legislation. The HSNO Act provides processes and standards for the management of chemicals that pose certain types of hazard to people and the environment. In order for the Act to be enforced in a way that forestalls harm to people or damage to the environment, it provides for measurable standards for matters such as the packaging of those chemicals, information provided with the chemical and so on.
75. These measurable standards appear in regulation and wherever possible are specified in a way which is independent of the technology used. For example, the requirements for packages do not specify materials of construction or design of the package. What is specified is the ability of the container to withstand certain forces or loads in a way that is testable before an incident (which might damage a package so spilling the chemical) has occurred. This does not guarantee that the chemical cannot be spilled. Rather it provides one pre-defined level of acceptable *control* (as containment) of the chemical hazard.
76. Standards of this type are very useful in *risk management* based legislation in that they provide opportunities both for those responsible for workplaces to measure their own actions against what the community pre-defines as acceptable, and for those responsible for enforcement to take action (and if necessary prosecute) actions which are unacceptable.
77. On this latter point, such ‘before the fact’ testable standards provide a basis for inspectors checking for compliance with the law to take action (including prosecutions if necessary) before harm has actually occurred. This contrasts with the current requirement to examine hazards and make often complex judgments about the likelihood of causing serious harm to a person, which appears to form the basis for actions to achieve compliance under the present HSE legislation.
78. Properly constructed, measurable standards set benchmarks for workplace systems designed to manage *risks*. For example, taken together, the electrical standards provide a system that provides effective procedures for managing the *risks* inherent in significant electrical voltages and currents being in close proximity to workers and others in workplaces. Similarly, the full set of performance standards in the HSNO regulations provides a set of procedures (as performance standards) to minimise the *risks* from the inherent hazards of various types of chemicals, while enabling their beneficial use.

79. It follows that in a world where measurable standards are used, efficient inspection can focus on the overall system in place in the workplace rather than diverting (and in our view wasting) resources on the cataloguing and response to hazards without adequate consideration either **consequence** or **likelihood**.
80. We therefore recommend that the Taskforce:
- a. **advise the government that regulation and other instruments which provide enforceable obligations on those in charge of workplaces be rewritten as before the fact, and as far as possible objectively testable, standards against which the performance of workplaces can be measured**
 - b. **recommend that a revised health and safety system explicitly accept as meeting its requirements those testable standards already in place in other legislation**
 - c. **recommend that, as part of a change to focusing on workplace risks, compliance inspections and enforcement actions be focussed on a workplace's risk management systems rather than catalogues of hazards.**

Matters of scale

81. As the consultation document 'Safer Workplaces' points out, a large proportion of New Zealand's workplaces are in the control of small to medium sized enterprises. By definition, such enterprises have limited capacity to undertake activities such as formal **risk assessments**. At first glance, this could present a significant impediment to the use of the approach to workplace health and safety that the Society proposes.
82. However, we think such a view is ill founded. The scale of smaller enterprises mean that, while particular small business may be involved activities where risks are large, the scope or extent of activities will generally be smaller, so requiring less complexity and effort to effectively manage the risks from these activities. Many such enterprises also work in cooperation with larger organisations and will need to use the same risk management processes.
83. We therefore consider it important that the type of obligation we propose as the new basis for managing workplace health and safety is qualified in several ways. These 'qualifications' derive directly from the principles of risk management which form part of the overall internationally agreed risk **management framework** we have already referenced⁹. The suggested 'qualifications' are;
- a. the scale of any risk management activity required must be tailored to the scale of the activity to which it relates. This applies not just to the effort involved in **risk identification, assessment** etc, but also to the scale of recording, documentation and other 'evidence of compliance' activities.
 - b. other obligations must be able to be explicitly relied on to form part of the risk management framework. This includes but is not limited to; obligations under fire safety legislation, electrical safety requirements, gas regulations, HSNO requirements (Hazardous Chemicals), and current building standards.
 - c. the acceptance of compliance with enforceable standards under Health and Safety and other legislation (for example as listed above) as sufficient risk management to comply with workplace health and safety obligations
 - d. retention of the existing 'duties on the principal' concept in the HSE Act, noting that this would be of a somewhat different form given the change in focus from the hazard identification to risk management¹⁰.
84. There is also considerable room for simplified guidance by administering agencies such as the Labour Group of the Ministry of Business, Innovation and Employment. An example which could be drawn on is the type of guidance provided by the UK Health and Safety Executive at its 'Health and Safety Made Simple' Website area¹¹.

⁹ See in particular the principles for risk management as set out in section 3 of AS/NZS ISO 31000:2009

¹⁰ For details see 'A principal's guide to contracting to meet the Health and Safety in Employment Act 1992' obtainable at <http://www.osh.govt.nz/order/catalogue/contracting-guide.shtml>

¹¹ UK Health and Safety Executive: Health and Safety made Simple <http://www.hse.gov.uk/simple-health-safety>

85. A further aid to the *risk management* approach to workplace health and safety the Society proposes is the use of approved documents as 'cookbooks' to provide assured means of achieving an acceptable standard of *risk management* in a given workplace. Such approved documents can and should be written in cooperation with industry bodies and would provide ready-made solutions for smaller enterprises to follow. Experience has shown that what is essential in the application of such 'cookbook' solutions is that the document itself is clear about the circumstance in which it does or does not apply and that the user does not attempt to apply practices intended for one area to another area of the workplace.
86. The Society accordingly recommends that the Taskforce ensure in its advice to government that any changed legislation specifically provide for small - medium enterprises by:
- a. explicitly allowing that the scale of *risk management* required be tailored to the scale of the activity being considered, including consideration of no or limited explicit *risk management* where the activity so indicates (e.g. where risks are all covered by requirements under other systems such as electrical or building requirements) and the scale of the enterprise is small
 - b. explicitly requiring that evidence of *risk management* having been undertaken be tailored to the scale of the organisation and scale of the activity being undertaken, including consideration of no or limited documentation in the circumstances indicated in (a) above
 - c. requiring that the administering agency (presently the Labour Group of the Ministry of Business, Innovation and Employment) provide sufficient guidance for small - medium enterprises to undertake and document the type of *risk management* required by their scale of operation
 - d. providing for adequate advice on proper *risk management* process for larger scale organisations
 - e. providing that adequate resources be available for the development of codes of practice or 'cookbooks' setting out step by step procedures for meeting obligations for workplace health and wellbeing in common circumstances, particularly for smaller enterprises.
 - f. providing in the revised health and safety system that demonstrably adhering to such codes of practice is sufficient for compliance with the law.

The role of the ACC scheme

87. As the Society understands it, New Zealand's ACC regime plays two key roles in assisting the maintaining and improving of workplace health and safety. First, it acts as a universal or near universal insurer to provide compensation to workers who are injured or otherwise have their health affected as a result of workplace risks having eventuated. Second, it spends some of the funds levied to encourage improvement in practices (not only in the workplace) which should lead to lower levels of injury and illness.
88. The levying of funds is done on the basis of an assessment of workplace safety practices using an approach set out in a joint Australian/ New Zealand Standard on 'Health and Safety Management Systems'¹². In the Society's reading, this document and the approach taken by ACC in using it (see for example the ACC self assessment form 'Measuring your capabilities in Workplace Safety Management'¹³) is largely hazard based, i.e. does not assess *risk management* capacity but rather the management of hazards. We consider that the consequence of this approach is a less than optimal consideration of the *likelihood* of hazards manifesting or their *consequences*. This in our view provides an incentive for the misdirection of management effort in 'workplace health and safety' in order that the organisation is levied at a lower rate.

¹² AS/NZS 4801:2001 Occupational Health and Safety Management Systems

¹³ This document may be obtained at
http://www.acc.co.nz/PRD_EXT_CSMP/groups/external_communications/documents/guide/wcm000512.pdf

89. The Society therefore considers that the ACC could assist by changing the basis on which it assess workplaces (and possibly other areas it carries out assessments of) from a system based on consideration of hazards to an assessment of the **risk management** performance of the organisations concerned. Such an assessment can and should be based on the currently accepted good practice in risk management - i.e. on AS/NZS ISO 31000:2009. We note that work is already in progress in the relevant Australian/New Zealand joint standards committee to update existing guidance¹⁴ on workplace **risk management** to be consistent with AS/NZS ISO 31000:2009.
90. We therefore **recommend** that the Taskforce
- a. **advises the government to take the necessary steps to change the basis for levying organisations for ACC contributions to one based on an assessment of the risk management capabilities of the relevant organisation**
 - b. **advises that such organisational risk assessments should be undertaken in a manner complying with AS/NZS ISO 31000:2009**
 - c. **recommends that the relevant agencies of state provide any assistance needed to complete the updating of SA HB 205:2004 OHS Risk Management so that it can be used to guide these assessments for levy setting purposes.**

Conclusion

91. In the Society's view, the current New Zealand workplace 'health and safety system' is flawed at a fundamental level in that it:
- a. requires the expenditure of the finite resources available on the identification of hazards and their subsequent elimination or separation from those in workplaces without regard for either the **consequences** arising from the hazard eventuating or the **likelihood** of those **consequences** actually eventuating
 - b. imposes obligations on those in charge of workplaces which are separate from other actions required to manage **risk** in relation to the conduct of the organisation's business
 - c. provides no, or at best limited, obligations on the management and governance levels of organisations to properly understand and manage **risks** that the organisation faces, including those related to the health and wellbeing of people in workplaces.
92. The Society considers that the remedy required is to:
- a. change the current workplace health and safety system from one based on hazard identification and elimination to obligations (beginning at the legislative level) on those in charge of workplaces to manage the **risks** faced by the organisation in a comprehensive way, so providing efficiently and effectively for the wellbeing of workers and others affected by the operation of workplaces
 - b. support this change with
 - (1) corresponding changes to the obligations on governing entities to clearly require oversight of all aspects of the organisation's **risk management**
 - (2) built in acceptance of existing measurable standards of **risk management** from other legislation which affects workplaces
 - (3) upgrading of the training in **risk management** available to workers, managers and those responsible for governance
 - (4) shifting the focus of inspectors from examining catalogues of hazards to reviewing a workplace's risk management systems, making best use of properly developed enforceable standards
 - (5) a duty to ensure that persons undertaking work with any implication in respect of worker health and wellbeing are competent in the tasks they perform

¹⁴ The current standards handbook on this subject (SA HB 205:2004 OHS Risk Management Handbook) was written considerably before completion of AS/NZS ISO 31000:2009

- (6) updating of the ACC system (and in particular ACC workplace assessment tools) to assess organisations for workplace levies on the basis of ***risk management*** competence
- c. base any revised workplace health and safety system on the definitions, concepts and procedures of internationally recognised contemporary practice in risk management as set out in *AS/NZS ISO 31000:2009 Risk Management - Principles and Guidelines*.

S R Vaughan
Executive Director
for and on behalf of the New Zealand Society for Risk Management

Annex 1: Key definitions of risk management terms and concepts from AS/NZS ISO 31000:2009

<u>risk</u>	effect of uncertainty on objectives
NOTE 1	An effect is a deviation from the expected – positive and/or negative.
NOTE 2	Objectives can have different aspects (such as financial, health and safety, and environmental goals) and can apply at different levels (such as strategic, organization-wide, project, product and process).
NOTE 3	Risk is often characterized by reference to potential events and consequences, or a combination of these.
NOTE 4	Risk is often expressed in terms of a combination of the consequences of an event (including changes in circumstances) and the associated likelihood of occurrence.
NOTE 5	Uncertainty is the state, even partial, of deficiency of information related to, understanding or knowledge of an event, its consequence, or likelihood.
<u>risk management</u>	coordinated activities to direct and control an organization with regard to risk
<u>risk assessment</u>	overall process of risk identification, risk analysis and risk evaluation
<u>risk identification</u>	process of finding, recognizing and describing risks
NOTE 1	Risk identification involves the identification of risk sources, events, their causes and their potential consequences.
NOTE 2	Risk identification can involve historical data, theoretical analysis, informed and expert opinions, and stakeholder's needs.
<u>risk analysis</u>	process to comprehend the nature of risk and to determine the level of risk
NOTE 1	Risk analysis provides the basis for risk evaluation and decisions about risk treatment.
NOTE 2	Risk analysis includes risk estimation.
<u>risk evaluation</u>	process of comparing the results of risk analysis with risk criteria to determine whether the risk and/or its magnitude is acceptable or tolerable
NOTE	Risk evaluation assists in the decision about risk treatment.

risk treatment

process to modify risk

NOTE 1

Risk treatment can involve:

- avoiding the risk by deciding not to start or continue with the activity that gives rise to the risk;
- taking or increasing risk in order to pursue an opportunity;
- removing the risk source;
- changing the likelihood;
- changing the consequences;
- sharing the risk with another party or parties (including contracts and risk financing); and
- retaining the risk by informed choice.

NOTE 2

Risk treatments that deal with negative consequences are sometimes referred to as “risk mitigation”, “risk elimination”, “risk prevention” and “risk reduction”.

NOTE 3

Risk treatment can create new risks or modify existing risks.

control

measure that is modifying risk

NOTE 1

Controls include any process, policy, device, practice, or other actions which modify risk.

NOTE 2

Controls may not always exert the intended or assumed modifying effect.

event

occurrence or change of a particular set of circumstances

NOTE 1

An event can be one or more occurrences, and can have several causes.

NOTE 2

An event can consist of something not happening.

NOTE 3

An event can sometimes be referred to as an “incident” or “accident”.

NOTE 4

An event without consequences can also be referred to as a “near miss”, “incident”, “near hit” or “close call”.

consequence

outcome of an **event** affecting objectives

NOTE 1

An event can lead to a range of consequences.

NOTE 2

A consequence can be certain or uncertain and can have positive or negative effects on objectives.

NOTE 3

Consequences can be expressed qualitatively or quantitatively.

NOTE 4

Initial consequences can escalate through knock-on effects.

likelihood

chance of something happening

NOTE 1

In risk management terminology, the word “likelihood” is used to refer to the chance of something happening, whether defined, measured or determined objectively or subjectively, qualitatively or quantitatively, and described using general terms or mathematically (such as a probability or a frequency over a given time period).

NOTE 2

The English term “likelihood” does not have a direct equivalent in some languages; instead, the equivalent of the term “probability” is often used. However, in English, “probability” is often narrowly interpreted as a mathematical term. Therefore, in risk management terminology, “likelihood” is used with the intent that it should have the same broad interpretation as the term “probability” has in many languages other than English.

<u>residual risk</u>	risk remaining after risk treatment
NOTE 1	Residual risk can contain unidentified risk.
NOTE 2	Residual risk can also be known as “retained risk”
<u>Stakeholder</u>	person or organization that can affect, be affected by, or perceive themselves to be affected by a decision or activity
NOTE	A decision maker can be a stakeholder.
<u>Hazard</u> ¹⁵	source of potential harm
NOTE	hazard can be a risk source

¹⁵ The definition of the term ‘hazard’ is taken from ISO Guide 73: 2009 Risk Management - Vocabulary. Guide 73 is widely used as a reference guide for risk management terminology within the context of AS/NZS ISO 31000.