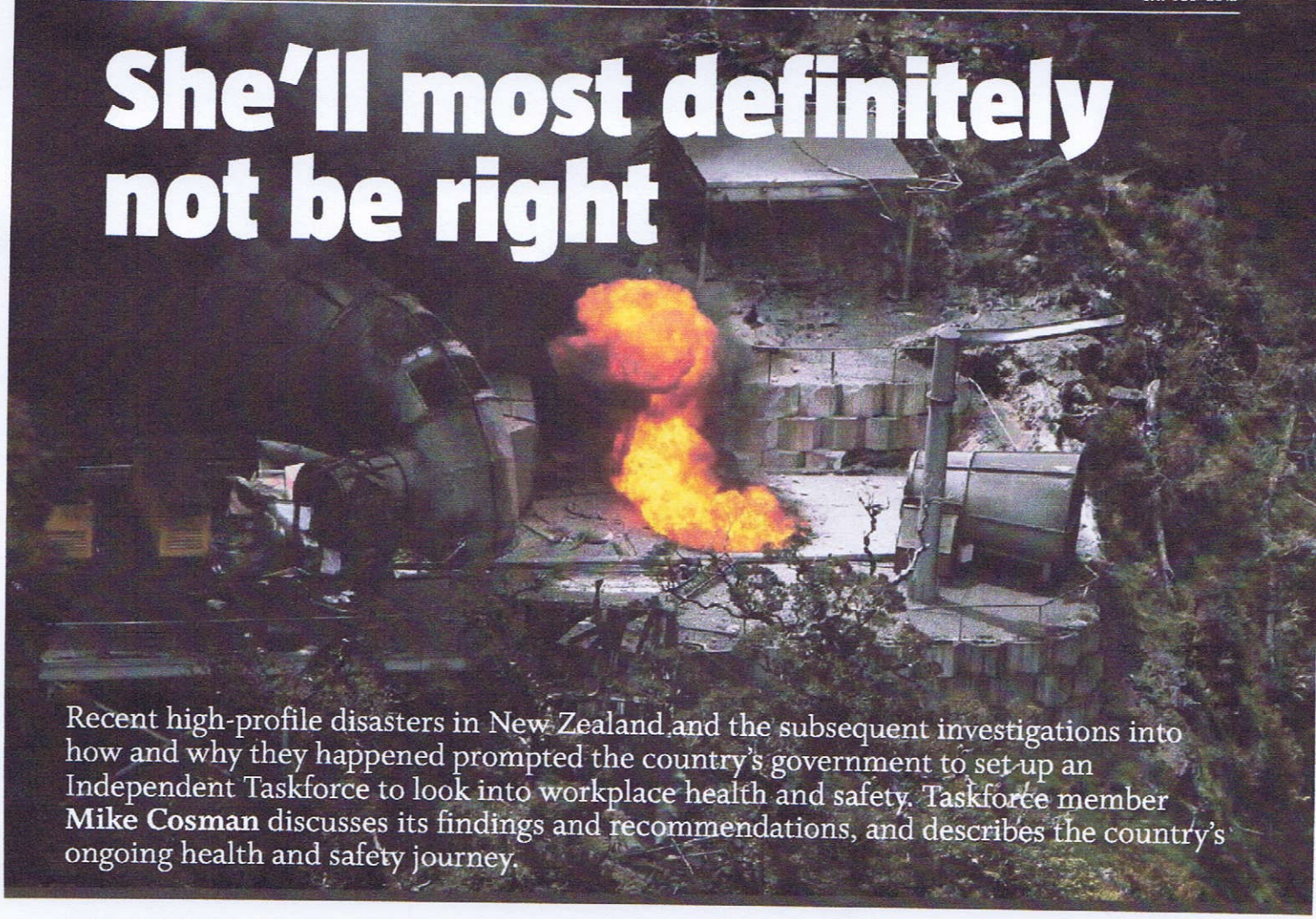
She'll most definitely not be right



Recent high-profile disasters in New Zealand and the subsequent investigations into how and why they happened prompted the country's government to set up an Independent Taskforce to look into workplace health and safety. Taskforce member **Mike Cosman** discusses its findings and recommendations, and describes the country's ongoing health and safety journey.

New Zealand has recently experienced two tragedies that have undermined our self-confidence that "she'll be right". The Christchurch earthquake in February 2011 killed 185 people, injured many more and effectively destroyed large parts of the city. The Pike River mine disaster in November 2010 killed 29 men and destroyed the livelihoods of many others on the West Coast because the mine then closed.

But every year, historic asbestos exposure kills as many as the earthquake, and agriculture and forestry have the same toll as Pike, yet no one seemed to notice. Until now. The ugly truth is that New Zealand is a first-world country but with a health and safety record well below the OECD average.

Royal Commissions into both events revealed some startling similarities. The majority of those directly involved in the issues did not believe something like this could happen and hence had not planned for the eventuality. Regulatory failure led to poorly seismically-designed buildings being approved and construction defects going unnoticed. There was no safety oversight of the Pike River mine planning process, and critical design elements, such as a second means of escape and placing the main ventilation fan deep in the mine, were left to the company.

A 'hands-off' approach to regulation, relying on self-assessment by the building/mine owners, allowed latent failures to creep in undetected. Poor planning also meant emergency response arrangements were ad-hoc rather than rehearsed.

As risk-management consultant Chris Peace CFIOSH commented: "How many failings does it take to make a disaster? Causes would include competence of the legislation, regulatory agencies, boards, management, and OHS practitioners, resources and funding, national and organisational cultures, the 'tone from the top'. Changing any one of the causes may not be enough. All need changing, and this will take years of effort."

Independent and objective

In the wake of Pike the NZ government set up an Independent Taskforce on Workplace Health and Safety to look beyond mining and make on objective assessment of the whole health and safety system 20 years on from the introduction of our principal Act.[1] This was, in effect, our Robens Part 2.

What we discovered was deeply worrying, but also not surprising to those who have been long-term critics of the New Zealand approach. Firstly, no one had a clear view of what the system and its essential components looked like, and how they fitted together. We therefore had to map the system in order to diagnose it and make recommendations for improvements.

Secondly, our datasets on the current harm that is occurring, the activity and effectiveness of the regulator, the state of compliance and the catastrophic risk potential were very poor. We were tasked by the then minister with making recommendations for a 25-per-cent reduction in fatal and serious injuries by 2020, yet we subsequently discovered the baseline had not even been defined and the measure was too unreliable to give us any assurance of genuine sustained changes.

Our regulatory system, from the regulator to the regulations, was

deficient. We described it as "Robens minus", with many of the key elements of the performance-based approach being absent, or out of date, including the infrastructure of current Regulations, ACOPs, guidance and standards that help define "all practicable steps".

The regulator had been downsized, lacked professional leadership, had failed to invest in building capability among its staff (many of whom were demoralised), and was widely seen as ineffective. The courts did not really take health and safety offences seriously, and our unique no-fault accident compensation scheme appeared to be sending out contradictory signals about the kinds of behaviours we should be expecting.

Leadership, especially from the government and through the supply chain, was lacking and we had two major blind spots across the system: in occupational health and major hazards.

Our engagement process as a Taskforce really seemed to hit a chord, however. More than 600 people attended a variety of road shows and other events, and some 400 written submissions were made. Our secretariat scoured the literature for evidence to guide us, and we commissioned a number of pieces of research to ensure we really understood the issues. We socialised our diagnosis with a range of key stakeholders and tested options over a two-day workshop.

Our final report was issued in April this year to almost universal acclaim from employers, workers, health and safety professionals, the media and victims groups (including, most gratifyingly, the Pike River families) – something unprecedented, according to some commentators. The formal government response is expected this month, but against this backdrop we have high hopes that it will be positive.

Recommendations

We structured our findings under three broad headings, or levers for change:

- accountability levers;
- motivating levers; and
- knowledge levers.

The system has to have the right mix of obligations and rights, which are monitored and upheld by a robust, well-resourced and confident regulator. Like the Pike Royal Commission,[2] we recommended a dedicated, standalone body with a clear focus, adequate competent resources and an appropriate legal mandate; in short, a New Zealand HSE. This recommendation has already been accepted, and a new Crown Agency will come into effect from December this year.

Our current law is no longer fit for purpose in the changing world of work and, in order to signal the step-change we are seeking, we proposed that a whole new Act be introduced, rather than tinkering with the existing one. The Act will, in large measure, be based on concepts recently introduced across Australia through its model OHS Act, which will provide many benefits in reducing compliance costs for Trans-Tasman businesses. Duty-holders will be redefined, penalties will be increased, new enforcement tools added, and the central role of the regulator as a change agent will be strengthened.

Worker participation was never included as a core part of our Act in 1992 and bits were only tacked on 10 years later. Fundamentally, we believe that the input of those who work with the risk day in, day out, in all parts of the system – from governance of the new Agency to workplace level – is a vital component that has been lacking, or ineffective up to now.

There must be appropriate carrots and sticks to encourage the right behaviours and to create more reasons to do the right things. Cost of compliance, fines and other deterrents are all very well but motivation and reward are far more powerful incentives. So, we want greater clarity about what "good" looks like and how to identify those who "meet the mark". A national business-performance rating will make it easier to identify good performers and be linked to preferment for contracts, lower insurance premiums and potentially fewer regulatory visits.

Our knowledge levers are designed to ensure that we have greater certainty about what needs to be done, supported by good-quality information and evaluation, and driven by competent people across our workforce. We need to ensure we learn the lessons from past events through greater application of root-cause analysis thinking and data-sharing.

Helen Parkes CMIOSH, national operations manager of the New Zealand Institute of Safety Management, noted: "The Taskforce recommendations provide the opportunity for New Zealand to demonstrate the true Kiwi spirit for which we are known. From an OHS-practitioner perspective, the recommendations provide the clear signal that those in our workplace deserve better from us – no longer will it be acceptable for unqualified people to give health and safety advice.

"Moving towards an accreditation process for health and safety practitioners is the first step to making health and safety a valued profession – and making us accountable for the advice we provide."

Specialist health and safety recruiter Alison Gill CMIOSH noted: "Capability is a very real issue in New Zealand. Employers are increasingly requiring formal tertiary HSE qualifications – not just boots-and-goggles experience, which has, in reality, previously defined the 'competence' of a practitioner in New Zealand."

In order to ensure balance across all the critical elements of our risk profile we need to have discrete units within the regulator driving programmes aimed at improving chronic and catastrophic harm, as well as retaining the current acute-harm focus. Our evidence suggests six-to-eight times more people die prematurely each year as a result of occupational disease than from accidents, yet currently, occupational health consumes probably fewer than 5 per cent of our resources. We currently have no major-hazards facilities regime.

For catastrophic harm, we need to start off by mapping where the risk lies in order to determine where (if) we need to regulate. And while chemical major hazards are an obvious starting point we need to think more holistically and make some tough calls about how far we actively control other risks, such as energy release (milk-powder explosion, or a rollercoaster-ride failure), new forms of mass transit (cable cars and monorails), adventure tourism, or places of public entertainment. Recent events in places such as Texas, Bangladesh and Brazil give us good clues as to where to start.

Being on the Taskforce over the last 10 months has been a privilege and provided a unique insight into the complexity of the challenges we face in developing a world-class health and safety system for New Zealand. The opportunity to make that change should not be squandered.

References

1 www.hstaskforce.govt.nz
2 www.shponline.co.uk/news/international-news/news/full/nz-mining-disaster-sweeping-away-of-old-laws-left-industry-in-limbo

Mike Cosman is a New Zealand-based health and safety consultant and member of the Independent Taskforce on Workplace Health and Safety – see page 4 for more information