



The Taskforce to now – Have we made progress?

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Summary

The journey to improved outcomes for workers and others is a long and winding road that seems to expand as some risks improve and others materialise. Disasters, new laws and regulatory restructure have a limited impact, but the underlying challenges remain.

In this article, the author reviews one part of that journey in New Zealand from 2012 to now but draws on his experience of over 45 years working in this field in the UK, including internationally and in New Zealand since 2004 and reflects on the successes and opportunities that lie ahead.

Keywords

taskforce; regulatory; Pike River; regulator; leadership; culture; Health and Safety at Work Act; coal mining; forestry

Background

On 19th November 2010 New Zealand experienced its worst industrial disaster in recent history with the explosion at the Pike River coal mine on the West Coast of the South Island; 29 miners died and two were injured.

For many people the disaster was unexpected and unprecedented, although for those more closely connected with underground mining and industrial health and safety, such events are regular, if infrequent, occurrences (see, for example, Eves, 2010). The author was directly involved in the investigation of two such events in the 1990s – one involving four deaths¹, the other three plus multiple injuries². What is far more common are the individual life-altering events that occur on a daily basis.

As is often the case, Pike River, and the media and political interest it garnered, was a catalyst for change. A Royal Commission of Inquiry was established and produced a detailed analysis of the issues associated with this operation and to some extent the industry it operated within. However, its remit did not extend to the wider issues in other types of workplaces where the level of harm occurring was still unacceptably high. Accordingly, and under considerable pressure, the then Minister of Labour, Hon Simon Bridges, established a Ministerial Taskforce to look at the overall state of health and safety in New Zealand and make recommendations for change. The scope of the review (Jager et al., 2013) was “to research and evaluate critically the workplace health and safety system in New Zealand, and to recommend practical strategies for reducing the high rate of workplace fatalities and serious injuries by 2020.”

The process for selecting members of the Taskforce was unclear and based on a mixture of advice from officials and Ministerial preference. In the inimitable words of Sir Humphrey Appleby in the BBC comedy *Yes Minister*, “A basic rule of government is never look into anything you don’t have to, and never set up an inquiry unless you know in advance what its findings will be”! Whether this was the case here remains unknown.

The Taskforce was chaired by an experienced CEO (Rob Jager), had representation from the social partners Business NZ (Paul Mackay) and the Combined Trade Unions (Bill Rosenberg) with a small/agri/Māori business voice (Mavis Mullins) a regulator (Paula Rose ex NZ Police Road Policing Manager) and a health and safety professional (the author). The Secretariat was led by Craig Smith, an experienced public servant and former Chief Advisor Employment Relations at the Department of Labour.

The process of undertaking the review was as important as its findings as it was vital to engage with a diverse range of stakeholders to build consensus, commission expert reports, consider contemporary thinking and international best practice. The Taskforce travelled throughout New Zealand meeting

¹ <https://www.newcivilengineer.com/archive/avonmouth-contractors-fined-500000-over-fatal-gantry-failure-06-12-2001/>

² <https://www.icheme.org/media/9293/xxii-paper-83.pdf>

business leaders, workers, victims, including the Pike River families, and others. In phase two, 429 written submissions were received and 500 people attended 28 public meetings (including open forums, hui, fono, workplace visits and business network meetings). The third phase involved synthesising the Taskforce's thinking around key issues and opportunities and sharing a high-level discussion document with a range of stakeholders for feedback. Around 100 people attended a two-day February 2013 conference.

The team operated in a very collegial manner with robust discussion and, ultimately, little disagreement on the diagnosis and recommendations for action.

The Taskforce report was a comprehensive review of the New Zealand context and looked at international models to see what could be learnt from their approach. It landed on the Australian exposition of the UK Robens model³ as being the most relevant and current, given that Australia had recently completed its own review⁴ which led to the Model Act developed by SafeWork Australia with the agreement (at the time) of all the States and Territories.

More broadly, the Taskforce acknowledged the complexity of the health and safety ecosystem⁵ which had not previously been clearly understood or articulated. The interaction of the Regulatory, Economic, Knowledge and Social-cultural factors was critical to making change.

Key themes

The Report identified 12 key themes:

1. **Confusing regulation:** The system currently fails to make clear expectations of duty holders, and the regulator does not make compliance easy for the vast majority who want to comply. Sanctions for those who intentionally, or through neglect, break the law are not adequate. The framework is confusing, with multiple pieces of legislation, blending hazard- and risk-management specifications, falling across overlapping and ambiguous jurisdictional boundaries. There is a lack of coordination between agencies and gaps in coverage.

2. **A weak regulator:** The primary regulator has failed to deliver on core responsibilities under the Robens model. Overall, it has failed to provide the system with sufficient certainty on how duty holders and regulated entities should comply. The regulator lacks capacity and capabilities, and it has failed to collaborate with other agencies on effective harm prevention.

3. **Poor worker engagement:** Worker engagement in health and safety is generally ineffective and often virtually absent. New Zealand falls well short of the strength of worker representative legislation and levels of engagement operating in comparable jurisdictions.

4. **Inadequate leadership:** There is little leadership being shown by a large number of people and organisations who have influence in the workplace. The issues include a lack of capability among managers generally, New Zealand's shortage of large private sector employers who could become exemplars, and defensive attitudes in some industry bodies.

5. **Capacity and capability shortcomings:** These shortcomings exist among workers, managers, health and safety practitioners, business leaders and the regulator. The shortcomings include insufficient knowledge of workplace health and safety risks and specific hazards, and insufficient knowledge of workplace health and safety regulatory requirements, including of rights and obligations.

6. **Inadequate Incentives:** New Zealand lacks the positive incentives and deterrents needed to drive compliance with minimum health and safety standards or to foster behaviours that lead to continual improvement. The low likelihood of inspector visits, and of prosecution or other action, creates an uneven playing field and effectively rewards non-compliance. The regulators' resources are not applied optimally, penalties are far too low and the tools available are limited.

7. **Poor data and measurement:** New Zealand has poor information and intelligence on health and safety risk concentrations, causes of workplace injuries and illnesses, and the effectiveness of interventions to improve health and safety outcomes. We do not know the full extent of the issues or what to target. Reviewers and committees have reported on the issues before, but their recommendations have been largely ignored.

³ <https://search.informit.org/doi/abs/10.3316/ielapa.200006100>

⁴ <https://www.safeworkaustralia.gov.au/law-and-regulation/model-whs-laws/review-model-whs-laws/review-model-whs-laws-terms-reference>

⁵ *ibid* page 44

8. Risk-tolerant culture: Our national culture includes a high level of tolerance for risk, and negative perceptions of health and safety. Kiwi stoicism, deference to authority, laid-back complacency and suspicion of red tape all affect behaviour from the boardroom to the shop floor. If recognition and support for health and safety are low or intermittent, workplaces are liable to develop, accept and defend low standards, dangerous practices and inadequate systems.

9. Hidden occupational health: New Zealand's estimated 500-800 premature deaths per year from occupational ill-health received little government, media or business attention. Inadequate data systems and research mean the scale and nature of the issues are largely unknown – and the system is unresponsive to new and emerging risks. Activity is fragmented across multiple regulators, disciplines and sectors with no effective coordination or leadership.

10. Major hazard facilities: Some major hazard facilities have insufficient oversight. The current framework focuses on certain industries (e.g. Offshore petroleum, mining, geothermal energy) but other facilities with comparable dangers are not subject to the same degree of oversight and regulation. This reflects the gaps in knowledge about major hazards, and the fact that the risk landscape in New Zealand is not understood.

11. Particular challenges to SMEs:

Challenges arise for SMEs from the generally less formal management style of smaller businesses, their resource constraints, limited access to external advice and support, and lack of systems fit for health and safety purposes. The current regulator has provided insufficient, relevant advice to SMEs which are particularly dependent on it.

12. Particular at-risk populations:

Some groups experience disproportionate levels of workplace-related poor health and injury. Low literacy and poor communication skills are, in themselves, risk factors especially in workplaces that are inherently more risky. This presents a particular challenge to policy-makers and regulators, as a one-size-fits-all response to population-specific outcomes, without a careful analysis of all underlying causes, may result in poorly targeted and ill-conceived interventions.

These 12 themes could be reduced to four key influences on organisations (to be known as person conducting a business or undertaking - PCBU), that needed to be strengthened. These were:

- governance – tone from the top, to reflect widespread concerns about the blinkered (but not unlawful) approach taken by the board of Pike River Coal Ltd
- workers – to enhance the worker voice in making key decisions about their own operating environment based on evidence of the effectiveness of this
- regulator – to resource and focus the new regulator on workplace health and safety as its primary function rather than as one part of the former Department of Labour
- business to business – through empowering supply chains and others who engage or influence (particularly) small firms to raise their performance.

The Report emphasised that the performance-based model of the previous Health and Safety in Employment Act 1992, which in turn reflected the Robens model, was still sound but that implementation over the past 20 years had been weak. It acknowledged, however, that for many small- and medium-sized enterprises (SME) the process of assessing risk and implementing controls based on a first principles approach was too hard, given that most did not have the expertise to do so and that the market for health and safety advisors was unregulated meaning that there were both capacity and capability restraints. It encouraged the development of 'safe harbours' in the form of specific Regulations for high-risk activities, Approved Codes of Practice, Guidance and Standards which would make it easier for SMEs and others to understand and follow.

The Report cautioned against normalisation of harm and encouraged a state of "chronic unease where accidents in our workplaces (and beyond) are socially unacceptable".

It took a wide view of workplace harm that should be addressed by the reform and described this in three contexts – acute, chronic and catastrophic harm; recognising that at the time most of the focus had been on acute injury or accident with much less attention being paid by business or regulators to ill health and an almost complete absence of regulation specifically targeted at major hazard facilities such as chemical plants or fuel storage depots.

The Taskforce Chair expressed his view that "regrettably, there is no silver bullet, and a piecemeal approach will not suffice. To the contrary, it is our firm conviction that the Government must adopt the

full range of recommendations made in this report if we are to deliver the outcomes that all working New Zealanders deserve.”

This complexity was reflected in the whakatauki that prefaced the Report “He korowai āta raranga He korowai whakaruruhau, Mo- tātou katoa A carefully woven cloak, is a protective cloak for us all.”

His warning was very apt as the reality is that the recommendations were only implemented in a piecemeal fashion and hence have not achieved the desired result, expressed in the Taskforce’s vision: “Within 10 years New Zealand will be among the best places in the world for people to go to work each day and come home safe and sound. We believe that this is absolutely possible, but it will require an urgent, broad-based step-change in approach and a seismic shift in attitude.”

The initial signs were positive. The Report received almost universal support from the Minister, other parties in Parliament and the social partners and a Blueprint for the legislative changes that made up one part of the recommendations was published by the Ministry of Business, Innovation and Employment (MBIE, 2013).

In his foreword, the Minister stated “Working Safer represents the most significant reform of New Zealand’s workplace health and safety system in 20 years. This reform includes an overhaul of the law to provide clear, consistent guidelines and information for business, additional funding to strengthen enforcement and education with a focus on high-risk areas, and better coordination between government agencies. But this is not a job for government alone. Success requires government, businesses and workers to work collaboratively to drive solutions.”

WorkSafe NZ was established as a Crown Entity in 2013 and became the primary regulator for most workplaces. The Health and Safety at Work Act 2015 and four sets of supporting regulations came into effect on 4 April 2016 (although missing the target of the end of 2014 set out in Working Safer).

There was a high degree of initial investment in understanding and adopting the new concepts they contained. Fatal injury rates started to fall and there was a general sense of the journey having begun.

A dirty little secret

Shortly after the Taskforce report was issued, a number of other concerns arose that suggested the problems identified in coal mining were not isolated and that other sectors were consistently killing and injuring disproportionate numbers of workers. Thanks to tireless campaigning by the CTU and its leader the late Helen Kelly, attention focused on forestry and vulnerable workers such as new migrants, security guards, casual and seasonal workers. But it was the forestry campaign that really gained traction, leading to the establishment in 2014 of an Independent Forestry Safety Review, funded by the industry but under strong pressure from Government to get its house in order. At that time the forestry industry fatal accident rate was 15 times the industry average, but largely unknown to most New Zealanders – perhaps because they occurred mostly in rural areas and disproportionately to Māori. The biggest and most powerful threat to the industry was that it might lose its social licence to operate -something that has emerged again in recent times regarding the environmental damage caused by ‘slash’ or forestry waste particularly in the aftermath of Cyclone Gabrielle.

The Review panel was chaired by another business leader and economist (George Adams) with Union lawyer Hazel Armstrong and the author again as the health and safety specialist. The purpose of the Review was quite similar to the Taskforce, as was the approach. It heard from over 540 stakeholders, received 111 submissions to the consultation document, and over 350 workers completed a survey.

Its findings aligned with those of the Taskforce but at a more granular, sector level:

- better supply chain leadership from forest owners and forest managers
- change the contracting model to allow more investment in mechanised machinery
- a contractor accreditation scheme to encourage and highlight those who invested in safety
- enhance the worker voice
- updating the ACOP and Regulations to provide greater clarity on best practice, especially around competency requirements for safety critical roles
- analysing and sharing data to enable better targeting of effort
- improving investigations to enable more prosecutions

- better support for families.

In order to emphasise the need for the sector to own and implement the findings, the first of what became a series of sector safety groups was established in the form of the Forestry Industry Safety Council (FISC), funded from the existing log levy scheme. Interestingly a follow up review of its progress 5 years on conducted by the author⁶ identified significant progress by the sector, but less so by MBIE and WorkSafe and a perception from FISC's governance that its remit did not include holding Government Agencies to account. This lack of system governance is a theme that applies at a macro as well as a meso level.

How are we doing?

Despite calls for a formal review of the implementation of the Taskforce recommendations – both in terms of actioning them and assessing their effectiveness, there has been no appetite from MBIE or subsequent Ministers to do so. Likewise, until very recently there has been no review of the effectiveness of HSWA and the first tranche of Regulation introduced in 2016.

Measuring lag data at a company, sector or national level is always problematic, due to a range of factors including under-reporting, inconsistent data sets, changes to definitions, one-off factors such as COVID-19, one-off incidents like the volcanic eruption at Whakaari that killed 22 tourists and workers, and demographic, technological and other changes.

Without meaningful baselines, ongoing monitoring, accounting for counterfactuals and trying to isolate cause and effects, it is difficult to know what has led to particular changes and whether these result from one or more actions taken in response to the Taskforce report or other unrelated factors.

The author's inevitably biased, unscientific and subjective conclusions are as follows.

- Health and safety is being talked about more – but not always as a positive thing.
- Compliance is seen as the key objective for many rather than a by-product of caring for workers and others and managing risks well.
- 'Blue tape' (HSE, 2019) – what firms and their advisors think they need to do to comply has ballooned and has often led to greater compliance costs and burdens than required to meet best practice -without necessarily achieving the desired goal.
- The regulatory framework is still incomplete, disjointed and inequitably enforced.
- WorkSafe NZ has lost its way and the confidence of Ministers and will struggle to regain the promise it had in its early years against a backdrop of public sector cuts.
- The funding mechanism between ACC, WorkSafe NZ and other regulators is dysfunctional and there is a lack of clarity of their respective roles in the system.
- Despite there being a National Health and Safety Strategy as required by S.195 of HSWA it is moribund, has had no effect and is not monitored and reported on
- The range of quicker and cheaper enforcement tools provided for under HSWA as an alternative to prosecution have not been fully utilised.
- The HASANZ register of qualified health and safety professionals is poorly used and many of those working in health and safety, including at WorkSafe NZ, lack relevant tertiary qualifications or demonstrated competence against recognised frameworks.
- We are still killing and harming workers in mostly the same ways as we have for the past 50 years (at a slightly lower rate) but with new risks emerging on top - such as psychosocial harm, violence and aggression, accelerated silicosis, infectious diseases such as COVID-19 that can be spread through workplaces, etc.
- Occupational health remains the poor cousin to safety.
- Catastrophic industrial risks from major hazard facilities, mines, etc, are better understood and managed but there remains a lack of insight and oversight of other types of catastrophic risks, particularly in the public safety space.
- Directors of large companies are more engaged and there is increased stakeholder interest as part of the movement towards Environmental, Social and Governance (ESG) reporting.
- Effective worker engagement is still the exception, not the norm and there is a lack of appreciation of the gap between work as imagined (the policy) and work as done (the reality). The move towards accreditation and certification including pre-qualification and ISO 45001 based largely on documentation reinforces this gap.

⁶ https://www.fisc.org.nz/uploads/6/6/2/5/66257655/8a3_cosmanparkes_review_report.pdf

- Human factors that affect safety outcomes are poorly understood, as many businesses take a simplistic view of risk controls and place over-reliance on procedures being followed instead of more reliable engineered controls.
- Our relative performance in terms of acute fatalities is about twice that of Australia and is where the UK was in the 1980s. The cost to our economy is at least \$4.4bn/year (Eaqub, 2023) and as illustrated in this cartoon © Sharon Murdoch published by Stuff.



- Upstream duties of suppliers, designers, etc, are often poorly understood and rarely enforced, leading to residual risks being passed to others to manage.
- The concept of overlapping duties is an important driver for change but is not well articulated in guidance, leading to some overreach and inefficient practices.
- There is no longer a cross-party consensus on health and safety as a human right ⁷, with road and workplace safety initiatives now being described as burdens on business, compliance costs, and the cause of economic inefficiency and cost overrun.
- Normalisation of harm continues, until it becomes personal.

Opportunities and risks

Having painted a somewhat depressing view of the past 12 years it is appropriate to offer some possible solutions that are readily achievable.

1. The current Minister for Workplace Relations and Safety has announced a wide-ranging review of the health and safety system due to start in June 2024. Whilst the motivation for this is de-regulation and removing burdens on business it provides a further opportunity for a national conversation about what we want our health and safety system and key players in it to achieve.
2. There may be opportunities to quickly address some of the obvious gaps and inconsistencies in the legislative and guidance framework, working on the basis of 'steal with pride'⁸, using what is already available from Australia, the UK and other comparable countries rather than trying to reinvent the wheel.
3. Review the National Health and Safety Strategy and give it some teeth including an oversight group to provide advice, monitor progress, and produce an action plan with clear deliverables and an independent research capability. This could be based on the Queensland Work Health and Safety Board⁹ whose primary function is to "give advice and make recommendations to the Minister about policies, strategies, allocation of resources and legislative arrangements for work health and safety through consulting with employers, workers and their representative organisations, as well as the work health and safety community to get industry feedback."
4. Develop integrated sector leadership groups to provide advice to WorkSafe/ACC about how to implement their strategies more effectively. This model has been used for over

⁷ At its 110th Session in June 2022, the International Labour Conference decided to include "a safe and healthy working environment" in the ILO's framework of fundamental principles and rights at work and to designate the [Occupational Safety and Health Convention, 1981 \(No. 155\)](#) and the [Promotional Framework for Occupational Safety and Health Convention, 2006 \(No. 187\)](#) as fundamental Conventions.

⁸ A phrase regularly used by the Taskforce Chair that led to the widescale adoption of the Australian model Act and Regulations

⁹ <https://www.worksafe.qld.gov.au/about/who-we-are/workplace-health-and-safety-queensland/work-health-and-safety-board-and-committees>

30 years by the UK Health and Safety Executive¹⁰ in its priority sectors and is also used in Queensland¹¹.

5. Enhance the role of the regulators and policy agencies to be more effective. This should include:
 - a. reviewing and refining the respective roles and funding mechanisms of MBIE, ACC and WorkSafe
 - b. developing Memoranda of Understanding (MoU) with other regulators and industry bodies to clarify respective roles in sectors such as Health and Disability, Police, Education, NZTA, etc. Currently, there is a tendency to 'cherry pick' issues without a wider understanding of the context, which can lead to unintended consequences.¹²
 - c. all qualified frontline Inspectors having a tertiary qualification in health and safety as well as regulator competencies such as those provided by the Government Regulatory Practice Initiative (G-Reg).¹³
 - d. create small specialist teams, similar to the WorkSafe High Hazards Unit, with specific competence in areas such as governance
 - e. use data and intelligence more effectively to target proactive and reactive activity.¹⁴
 - f. develop and publicise the regulatory expectations aligned to WorkSafe's priorities, including its prosecution decision-making. This should include more frequent use of the full range of tools provided for in HSWA (such as Infringement Notices and Enforceable Undertakings) as well as seeking and monitoring voluntary action plans and commitments in lieu of formal action
 - g. publicise a register of all formal enforcement action taken – not just prosecutions and Enforceable Undertakings to encourage others to act
 - h. develop and publish a light touch evaluation of its priority issues such as "What percentage of farms visited had roll-over protection on their quad bikes?" What percentage of engineered stone workshops had regular exposure monitoring programmes?"

Conclusion

As a nation, we are rightly concerned about the burden of regulation, especially at a time of economic uncertainty. However, most workers and businesses would agree that preventing serious injury and ill health at work is a priority and something we are not currently achieving particularly well or efficiently. Health and safety has become a derogatory term associated with a bureaucratic, fear-based approach led by a dysfunctional, under-resourced regulator and sometimes undermined by well-meaning, but poorly qualified advisors. But it doesn't have to be so.

At the time of finalising this paper, the Business Leaders Health and Safety Forum has just published its own Taskforce 2.0 report (Business Leaders' Health & Safety Forum, 2024) with the title *Been there, Done that A Report into New Zealand's repeated health and safety failures*. It echoes many of the themes in this paper which suggests a clear alignment of diagnosis and remedy between the engaged business community and health and safety professionals. All we need it to bring SMEs and Ministers on board and we can restart the stalled journey towards achieving the Taskforce's vision.

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¹⁰ See for example <https://www.hse.gov.uk/agriculture/agriculture-industry-advisory-committee.htm>

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¹² <https://www.stuff.co.nz/pou-tiaki/127893116/cutting-corners-worksafe-rejects-ihcs-bath-ban-for-disabled-people>

¹³ <https://www.mbie.govt.nz/cross-government-functions/government-regulatory-practice-initiative>

¹⁴ A recent OIA request identified that WorkSafe is only applying its risk prioritization tool to around 30% of its inspections and not at all in its triaging of incident notifications

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