



What's missing in the New Zealand workplace health and safety system?

Christopher Peace, Lecturer in Workplace Health and Safety, Victoria University of Wellington

Email: christopher.peace@vuw.ac.nz

<http://orcid.org/0000-0003-0688-6263>

DOI: 10.26686/nzjhsp.v1i2.9550

Abstract

This article was initially planned to mark the 50th anniversary of the UK Health and Safety at Work etc Act which came into force on 31 July 2024. It was expanded to help respond to consultation by the New Zealand Government on experience with the New Zealand Act of the same name.

I briefly review aspects of system thinking and then report on the origins of the New Zealand Health and Safety at Work Act 2015. Experience from New Zealand, the UK and Australia is used to help suggest some areas where there are gaps in the workplace health and safety system.

Keywords

workplace health and safety; regulatory system; management system; Health and Safety at Work Act; gap analysis; system thinking

Introduction

The New Zealand (NZ) Coalition Government agreement includes "Reform health and safety law and regulation (Luxon & Seymour, 2023, p. 5) and led to the announcement of a "Major health and safety consultation" (Van Velden, 2024) that included:

Our health and safety culture can be summed up by the sea of orange road cones that have taken over the country. From Santa parades to property development, you can't get a lot done without having to set up a barricade of cones.

While they may improve health and safety in some places, in other situations their prevalence just doesn't make any sense.

Businesses and community organisations spend a huge amount of money trying to keep people safe, but it's worthwhile asking: are the rules and expectations proportionate to the actual risks, and when should common sense prevail?

Lawyers and company directors should not have to be kept up late at night anguishing over what 'so far as is reasonably practicable' means.

The Minister added: "I want to listen to experiences with our work health and safety system."

As part of gathering evidence for a submission on that consultation, the New Zealand Institute of Safety Management (NZISM, 2024) carried out an online survey of its more than 4,000 members and others in its database and had 1,4321 responses. Respondents' thoughts are summarised below.

- *The Health and Safety at Work Act 2015 is not viewed as fundamentally broken. Most of those replying to our survey think the main elements of the Act are either working well or only requires minor changes.*
- *The existing regulations are also seen as working well or in need of small tweaks.*
- *Respondents want the Government to complete the suite of regulations planned when the Health and Safety at Work Act 2015 was passed. Following Australia's lead, there is a strong call for greater regulation of psychosocial harm.*
- *Across the Board, there is a call for greater guidance and information as to how to meet duties under the Act and regulations. WorkSafe guidance is referred to often but could be improved and expanded.*
- *Those surveyed want WorkSafe to get back on its feet through being adequately resourced and effectively managed. WorkSafe inspector capacity and capability is an area of significant potential investment.*

But does this summary fairly reflect what may be missing in the New Zealand workplace health and safety system?

System thinking and management systems

Meadows & Wright (2009) define a system as “an interconnected set of elements that is coherently organised in a way that achieves something (a function or purpose)” that includes elements, interconnections, and a function or purpose.

Management system is defined by the International Standards Organization (ISO/IEC Annex SL, 2020) as a “set of interrelated or interacting elements of an organisation to establish policies and objectives and processes to achieve those objectives”.

Munkman (1975, pp. 131-132), an eminent UK common law litigation lawyer, anticipated the modern need to think about systems of work, writing:

In adding as a further component the system of work, the law does no more than adopt and clarify a distinction accepted in everyday life. The employer is responsible for the general organisation of the factory, mine or other undertaking ...

Further work in the 1980s (Peters & Waterman, 1982) led to the development of the McKinsey 7-S model. Later, Makin & Winder (2008) developed a different but WHS-specific model. Both models showed that making a change in one part of a system required changes in other parts of the system.

Taken together, these definitions and models suggest the NZ WHS system should include WHS objectives set by the government and businesses; effective legislation, regulatory agencies and enforcement procedures; policies and guidance documents; applied research about unique NZ needs; and dialogue between the key stakeholders. Changes to one will require changes to all. For example, changing the current legal requirements will require changes to the whole NZ WHS system.

To identify what may be missing in the New Zealand (NZ) workplace health and safety (WHS) system I explore the origins of the NZ Health and Safety at Work Act 2015 in the Robens Committee report (Lord Robens et al., 1972), subsequent UK and Australian legislation and why they are a key part of the NZ health and safety system. I then consider whether there are gaps in the overall WHS system.

The UK: Robens Committee and Report

The Robens Committee was appointed by the UK Government in 1970 and received a substantial body of evidence from many and diverse stakeholders. The committee reported that a new UK Act (Lord Robens et al., 1972):

... should begin by enunciating the basic and overriding responsibilities of employers and employees, spelling out the basic duty of an employer to provide a safe working system including safe premises, a safe working environment, safe equipment, trained and competent personnel, and adequate instruction and supervision ... (para 129)

The report advocated that new legislation should give a:

... positive declaration of over-riding duties, carrying the stamp of Parliamentary approval, [that] would establish clearly in the mind of all concerned that the preservation of safety and health at work is a continuous legal and social responsibility of all those who have control over the conditions and circumstances in which work is performed... (para 130)

The new Act should make clear to an average employer that work should be arranged in a way to not kill or injure workers. Inspectors should not be limited to any specific purpose for a visit as they might then miss unhealthy or unsafe conditions outside that purpose.

When an inspector visits a workplace he should be concerned with the total picture as much as with those particular details which happened to have been made the subject of specific regulation ... (para 131)

The overall regulatory system would be designed to:

... comprise of a main Act, plus statutory regulations plus codes of practice; but the intermediate stage of statutory regulations would often be dispensed with ... (para 131)

Such codes of practice might be written jointly by the regulatory organisation and industry sector groups.

The UK Health and Safety at Work etc Act (HSWA, 1974) came into force on 31 July 1974 and brought into statute law the English common law duty of care that had evolved from the mid-19th century. Section 2(1) of the Act sets out a high-level “duty of every employer to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all his employees”.

A web of regulations, approved codes of practice, and guidance documents underpin the Act. Together with the Robens report it has since been influential in many Commonwealth jurisdictions, including NZ. Although the Act has remained substantially unchanged, a small-scale survey published by Drager Safety UK Ltd (2024) found that “94% [of respondents] think that, in the light of changing workplaces and different working styles, the Health and Safety legislation introduced in 1974 should be overhauled”. Spencer (2024) reviewed the first 50 years of the UK Act and suggested possible gaps. He noted Australian developments (see below); issues with GPs missing links between symptoms of ill-health and workplace exposures; and the need to consider better delivery of occupational health services.

NZ legislation

Attempted Robens-style legislation 1992-2015

The NZ Health and Safety in Employment Act (1992) replaced the Factories and Commercial Premises Act (1981). The content and characteristics of the 1981 Act were well behind Robens-style legislation making it an inadequate step towards modern legislation. When enacted, the 1992 Act introduced a novel duty of care based on “all practicable steps” that were “reasonably practicable”, and a requirement to distinguish between hazards and significant hazards. This distinction caused many debates that substantially detracted from work to eliminate or reduce work-related deaths and injuries (Peace et al., 2019). Matters were exacerbated by chronic underfunding of the Department of Labour, the main regulatory agency.

In NZ, the introduction of accident compensation legislation in the 1970s removed the need for injured workers to sue for damages (Peace et al., 2019). This therefore removed developments in workers’ compensation case law that might have kept employers and their advisers aware of changes in work patterns and technologies causing harm to workers. The emphasis remained on workers’ compensation after injury rather than the prevention of harm.

In 2010 a methane gas explosion in the Pike River mine killed 29 men. The disaster led to a series of enquiries, reports and books (Ewen, 2014; Jager et al., 2013; Macfie, 2021; Panckhurst et al., 2012). These led to the adoption of the Australian Model Work Health and Safety Bill (WHSB, 2011) as the basis of the Health and Safety at Work Act (2015). The WorkSafe NZ Act (2013) established WorkSafe NZ as the new lead regulator. Some new regulations were made under the 2015 Act with promises of additional regulations and up-to-date guidance material.

NZ Health and Safety at Work Act 2015

The drafters of the Australian Model WHSB (2011) were able to draw on 37 years of experience with the UK Act and the new business and worker relationships that had developed in Australia and elsewhere. Similar relationships had developed here and were included in the NZ Health and Safety at Work Act (2015).

Section 36(1) of HSWA sets out a high-level duty “to ensure, so far as is reasonably practicable, the health and safety” of workers. Section 36(3) of the NZ HSWA strongly resembles section 2(2) of the UK HSWA, requiring a person conducting a business or undertaking to provide “so far as is reasonably practicable”:

- a work environment that is safe and without risks to health
- safe plant and structures
- safe systems of work
- safe handling and storage of plant, substances, and structures
- facilities for the welfare at work of workers
- information, training, instruction, or supervision
- monitoring of the health of workers and the workplace.

Health is defined in the 2015 Act to include mental health. Psychosocial health is now of increasing importance in NZ and elsewhere.

“Person conducting a business or undertaking”

Extensive ‘contractorisation’ of businesses in Australia and elsewhere led to the concept of a “person conducting a business or undertaking” (PCBU) in the Australian WHSB. The term PCBU was adopted in the NZ Bill. PCBUs were given the duty of care for workers who were not their employees but who might be under their control at work.

As noted, the Australian WHSB had drawn on the UK statute and common law to include these and other duties. While the term PCBU was new in Australia (and apparently still in NZ) it reflected how the common law duty of care had developed in the UK. Munkman (1975, pp. 131-132), an eminent UK common law litigation lawyer, anticipated the need for such control, writing:

An organisation of this kind is required – independently of safety – for the purpose of ensuring that the work is carried on smoothly and competently: and the principle of law is that in setting up and enforcing the system, due care and skill must be exercised for the safety of the workmen. Accordingly, the employer’s personal liability for an unsafe system – independently of the negligence of fellow-servants – is not founded on an artificial concept, but is directly related to the facts of industrial organisation.

For some business managers such requirements may now seem strange, but they remain “directly related to the facts of [work] organisation”.

However, “PCBU” does not match the wording of the NZ Accident Compensation Act (2001). This may leave an employer with the liability for accident compensation (contracted out to the Accident Compensation Corporation) but with no direct control over its workers who work in a workplace controlled by another employer.

Development of NZ law and practice

In 2013 the Ministry of Business, Innovation and Employment (MBIE) published “A Blueprint for Health and Safety at Work” (MBIE, 2013) and subsequently published a report on progress towards the goals (MBIE, 2015). There has been little progress to achievement of these goals. Indeed, in the nearly 15 years since the Pike River tragedy approximately 900 people per year have died at or because of work, a total of more than 13,000 men, women and children. To this must be added psychosocial harm to the workmates, whanau and friends of each victim. This lack of progress may be due to the lack of regulations, approved codes of practice, and plain English guidance to help PCBUs comply with their duties. The government and regulatory agencies were responsible for the development of this guidance.

Sector groups (eg, the Business Leaders Forum and Institute of Directors) have provided leadership and led the development of guidance (eg, IoD & WorkSafe NZ, 2024).

The Health and Safety Association of NZ (HASANZ) was formed as the umbrella organisation for workplace health and safety professional organisations and has helped promote professionalism in health and safety practitioners.

Another of the recommendations from the Pike River enquiries led to 2019 WorkSafe funding the development of the generalist Master of Health in Workplace Health and Safety at Victoria University of Wellington. Together these are key elements in the development of the NZ WHS system.

In 2019 the Whakaari volcano erupted (Zanini & Bennett, 2024) killing 22 tourists and their guides and also causing physical and psychosocial harm to many other people. Despite the adventure activity regulatory system, WorkSafe had not foreseen the event (Logan et al., 2024). This tragedy and the subsequent COVID-19 pandemic disrupted the development of planned regulations and guidance, even though some drafts had been developed and awaited ministerial approval.

Liability of directors and officers

Common law in the UK and elsewhere has, for many years, recognised the directing mind of directors and managers for workplace health and safety. For example, Denning LJ (1956) wrote in a common law decision:

Some of the people in the company are mere servants and agents who are nothing more than hands to do the work and cannot be said to represent the mind or will. Others are directors and managers who represent the directing mind and will of the company, and control what it does. The state of mind of these managers is the state of mind of the company and is treated by the law as such.

This was recognised in the Australian WHSB with the introduction of a requirement for “officers” (ie, directors and chief executives, section 18) to use due diligence to ensure a PCBU was complying with its duties. In NZ this became section 44 of the HSWA. Peace et al (2017) identified a range of possible compliance mechanisms with the section. Anecdotal evidence suggests many PCBUs have used such mechanisms and others to give effect to due diligence compliance. Further guidance on compliance is now freely available. For example, “Health & Safety Governance” published jointly by the Institute of Directors and WorkSafe (2024) revised and expanded on earlier guidance.

There have been prosecutions of officers under section 44 HSWA, but most appear to have been directors of closely held small- or medium-sized businesses. A prominent exception at the time of writing was the prosecution of the ex-CEO of the Ports of Auckland for a breach (Rooney et al., 2024); the Auckland District Court had not given a decision in this case at the time of writing.

Commentaries on some recent Australian cases (Ferrier et al., 2024; Forno, 2024) suggest that in larger PCBUs an officer cannot be expected to know all the circumstances subject to due diligence and may delegate some functions to management. To demonstrate compliance with their duty, officers should regularly receive reports from, and meet with, managers responsible for health and safety. Officers in closely held PCBUs should consult competent people who can give professional advice about due diligence obligations.

Recidivist PCBUs and disqualification of directors

Some PCBUs have been convicted for breaches of section 36 HSWA several times (some have also been convicted for breaches of the Resource Management Act). In such cases WorkSafe could serve an Improvement Notice on the officers of a recidivist PCBU, requiring compliance with section 44, giving clear expectations of officer performance, and citing sources of guidance. However, some repeated breaches may be so egregious that stronger remedies are required.

In the UK the Company Directors Disqualification Act (1986) allows prosecutors to apply to the courts for disqualification of company directors convicted for breaches of the UK HSWA (Neal & Wright, 2005). This could be achieved in NZ by amending the Companies Act section 383(1)(c) to allow disqualification of directors convicted of a breach of section 44 HSWA. Such a power might help persuade directors to comply with section 44, or to prevent convicted directors from continuing to control a recidivist business. If such directors were, for example, the resident director of an offshore company (as required under the Companies Act), their disqualification would require the company to find a new, local director who might improve compliance with HSWA.

Why comply with HSWA?

In a research report for the UK Health and Safety Executive, Amodu (2008) argued that businesses may have a range of reasons for non-compliance with WHS legislation, including:

- “Disagreement with the regime” (ie, the will of Parliament)
- “Incompetence (in the sense of being unable to meet the standards set)”
- “Amoral calculation” (fines and penalties are just the cost of doing business).

The International Labour Organization has proposed that sanctions under national legislation should be proportionate to the degree of severity of a breach, taking account of factors including (ILO, 2021, p. 25):

- *the severity of the outcome or conduct (for example, a fatal accident);*
- *the degree of culpable mind (for example, intentional or gross negligence);*
- *a pattern of repeated violations of different or same nature (known as recidivism);*
- *a pattern of persistency (for example, a significant duration of the violation);*
- *the vulnerability of the victims exposed to the violation (for example, workers under 18 years of age);*
- *the specific work context or type of work (for example, high-risk industries and assignments).*

This guidance from the ILO should be considered when reviewing the effectiveness of HSWA and is used below to help identify possible penalties.

Scale of fines and penalties

Small fines can negatively affect victims and their families (Matthews et al., 2019) while the potential for large fines can be a deterrent, especially when framed as severe retribution and widely publicised (Kurz et al., 2014).

Hutter (1997, p. 225) thought large fines also act to enhance the credibility of the regulatory agency and that:

The effects of weak sanctions may also involve a possible lack of deterrence; a negative impact upon victims and their families; and concerns about the effectiveness and the credibility of both the law and the regulatory agency.

Fines and penalties imposed under HSWA may have been significant in 2015 when the Act was passed but inflation has eroded their impact. Fines are now small compared with penalties under the Commerce Act (1986) under which, for example, a restrictive trade practice can result in a fine of up to \$10 million. However, if such a breach occurred when producing a commercial gain, a business could be fined three times the value of any commercial gain. Increasing fines for breaches of HSWA to a similar level would help demonstrate a “positive declaration of over-riding duties, carrying the stamp of Parliamentary approval” (Lord Robens et al., 1972 para 130).

In cases where an officer or a PCBU is convicted for reckless behaviour, section 47(3)(c) HSWA should allow the District Court to send the case to the High Court for sentencing. There, the fine should be unlimited.

An amendment of the UK Health and Safety at Work etc Act (1974) in 1991 increased penalties to “Imprisonment for a term not exceeding two years, or a fine, or both” for convictions on indictment; no limit was placed on the size of the fine. This has subsequently allowed the Crown Court to impose substantial fines (Anon, 2016a) that can affect the financial results of large businesses. In some cases, owners or managers have been sentenced to prison (Anon, 2016b, 2017).

Does the threat of such large fines work? In an early case in 1992, this author saw at first-hand the effect on a business that narrowly avoided multiple charges being heard in the Crown Court. The Board subsequently directed the chief executive officer to change health and safety practices and prevent such future breaches, leading to a corporate culture change for workplace health and safety.

Corporate manslaughter

The UK and all but one Australian State (Billing & Billing, 2024; Selinger & Hamer, 2024) now have corporate manslaughter laws available for WHS regulatory agencies to use, especially when an event results in several workplace deaths (Warburton, 2022); fines can be very large (Lamy, 2022, 2023) and also result in prison sentences (Selinger, 2018). Would such legislation in NZ help improve WHS performance of PCBUs? At the time, of writing a Private Members Bill promoted by a Labour MP is before Parliament and the issues may be debated there.

Further options

Further options for strengthening penalties could require a convicted PCBU, officer or other duty-holder to:

1. pay any reparation awarded to a victim under the Sentencing Act (2002)
2. reimburse the full costs of an investigation and subsequent prosecution
3. pay any fine imposed under the Act.

This hierarchy would help deliver justice for victims and reduce the costs of investigation and prosecution currently covered by public funds; it might require amendment of the Sentencing Act (2002).

Another option might be to allow ACC to use subrogated rights (Mitchell, 1994; Mitchell et al., 2007) to recover the costs of medical treatment or compensation or both if a claim was due to reckless behaviour or gross negligence of a PCBU. The ACC claim from an injured worker or other person would still be paid by ACC but the costs could be recovered from the reckless PCBU.

A further option being explored by NZ Police in 2024 is use of the Proceeds of Crime Act (1991) for alleged continued breaches of the HSWA by a business (Shortall et al., 2024). Such action might be an effective deterrent for recidivists whose continued ownership of their business assets would be in jeopardy.

From detection to conviction

A key deterrent for breaches is a high probability of detection and conviction (Clark, 1980; Hutter, 1997). Fatalities and serious harm are likely to be reported to WorkSafe and other regulatory agencies, but a prosecution may take two or more years to reach the courts. In that time an unscrupulous PCBU owner can cease trading and sell on the business and assets to a new company they have set up. Such delays and subterfuges amount to denial of justice for whanau, friends, and workmates. One remedy is to prosecute the officers of the PCBU and, for significant breaches, seek disqualification of the directors.

Public accountability of businesses and undertakings

Research into WHS reporting in annual reports of large businesses by the Strategic Policy (2003) of the then-Department of Labour found:

... there was major variance in the quality of the information presented. The focus was largely on injury statistics, with little evidence of health monitoring. Where employers are part of a multinational company, the quality of their triple bottom line reporting is generally of a superior standard to that of New Zealand only reports.

Reform of the WHS system could include the requirement for PCBUs listed on the NZ Stock Exchange to report against key performance indicators for WHS, including occupational health. This would help demonstrate the concern of the PCBU officers for WHS.

Missing Regulations and ACOPs

A current issue is the lengthy delay in publishing regulations outlawing exposure to respirable crystalline silica (RCS) due to work with engineered stone. Australia published legislation and guidance on RCS for PCBUs earlier in 2024. Evidence for this being a high-risk activity has been available for 15 years (Bradshaw et al., 2010) but has not led to legislation in New Zealand despite recent research findings (Hoy et al., 2023). Such delays in the WHS legislative system are causing deaths and serious harm to NZ workers.

If a PCBU delayed action to eliminate or effectively control a highly hazardous substance or activity, WorkSafe might take enforcement action for reckless behaviour.

Improving the effectiveness of the regulators

Current reductions in the number of frontline WorkSafe inspectors and technical support staff may reduce the effectiveness of regulatory activities and the probability of detecting WHS failures. Funding for both needs to be increased to help reduce the very large costs to the NZ economy of nearly \$1 billion per year (Eaqub, 2023).

WorkSafe inspectors are given inhouse training before they are warranted and start work in the field. However, it is not known if that training meets any New Zealand Qualifications Authority (NZQA) standard. The qualification should meet NZQA standards, or WorkSafe inspectors trained at a tertiary level in WHS, or both.

Unpublished research by Doust (2021) showed that most prosecutions by WorkSafe followed traumatic injuries or deaths, whereas most work-related deaths were due to occupational disease. That is, most breaches did not lead to enforcement action, perhaps due to the difficulty of proving a link between exposure and subsequent disease. This has been a long-running problem that requires research.

Another area requiring research is knowing “what works” in delivering better WHS in NZ. Under the WorkSafe New Zealand Act (2013) one of the functions of WorkSafe is to “promote and support research, education, and training in work health and safety”. In the UK, the Health and Safety Executive (HSE) commissions and publishes research and has reviewed its work in this area (see, for example, Cox et al., 2008). Similar research to validate the WorkSafe approach is needed.

Lack of an online register of enforcement action

Researching enforcement action for breaches of HSWA currently requires a manual, case-by-case search of the WorkSafe, Civil Aviation Authority, and Maritime New Zealand websites and academic databases to identify convictions and enforceable undertakings. This does not yield reports of prohibition notices, improvement notices, or failed prosecutions; some convictions thought by a regulatory agency to be minor may not be published.

A unified, online register of enforcement actions taken by the three main regulatory agencies would enable legal advisers, investors, investigative journalists, and academics to research the breaches by officers, PCBUs, and workers. It would also enable research into factors giving rise to enforcement action including prosecutions, convictions, enforceable undertakings, prohibition notices and improvement notices. Such research would help hold the key stakeholders to account. Such research would be at little public cost.

Risk assessments and competent advice to PCBUs

The UK Management of Health and Safety at Work Regulations (MHSWR, 2000) require employers to carry out “suitable and sufficient” risk assessments. The MHSWR also require employers to have access to, and use, competent advice about WHS. The NZ Health and Safety at Work (General Risk and Workplace) Regulations (HSWGR, 2016) should be amended to similarly require every PCBU to carry out effective risk assessments and to have access to competent WHS advice. This could be an inhouse or external adviser who should be competent in an area of concern. Such risk assessments could then aid compliance by officers with their section 44 due diligence duties, especially section 44(4)(b).

Is the HSWA fit for purpose?

From the above review, section 36(3) of the Act makes requirements that are directly related to the organisation of workplaces. The Act seems to be fit for purpose from the point of view of large PCBUs, trades unions, lawyers, and health and safety practitioners.

Missing guidance

What is missing in the overall WHS system is sector- or business-specific guidance. Some examples follow.

- Sets of regulations have been in final draft form in the Ministry of Business, Innovation and Employment for some years. Of considerable concern is the urgent need to introduce controls for respirable crystalline silica. All the drafts are needed to explain to duty-holders how the HSWA applies to them.
- Underpinning the existing and proposed regulations should be plain English guidance illustrating commonly accepted solutions for business-as-usual and temporary activities.
- The temporary control of road works and on-road events will normally include a range of controls that meet the requirements of the hierarchy of control set out in the General Risk and Workplace Regulations (HSWGR, 2016) for the safety of motorists, pedestrians and workers. The roading industry has been developing a risk-based guidance document since at least early 2023 (but this does not include on-road voluntary events). The draft document should be promoted by MBIE to approved code of practice status and a similar code published for voluntary on-road events.
- NZ lacks current data on the costs of work-related harm. The Ministry of Transport provides regular updates for the social cost of road crashes, showing that a fatality due to a road crash currently costs about \$12 million (MoT, 2023); in previous years the cost was about \$5 million (MoT, 2021). These figures indicate that a PCBU should be willing to spend between \$5 million and \$12 million to prevent a work-related death. Authoritative and accurate data published by MBIE, ACC or WorkSafe would be welcome.

Reasonably practicable

From personal experience, defence lawyers and directors have little difficulty with the concept of “reasonably practicable”. However, WorkSafe could revise its guidance to aid understanding of the test.

- Such guidance might reverse the words to require that thought be given to whether anything could be done to reduce the potential for harm that is practicable – “capable of being done” (Concise Oxford Dictionary, 2022). Searching for guidance, or consultation with workers or health and safety practitioners, will often reveal cost-effective solutions.
- The guidance would then explain that ‘reasonably’ is “as much as is appropriate or fair” (Concise Oxford Dictionary, 2022) compared with the current amount a PCBU should be willing to spend to prevent a work-related death.

- One element that is missing from the current definition of reasonably practicable in HSWA is the speed with which circumstances can change from “safe” to life-threatening. The concept of risk velocity is very often overlooked and is a causal factor in many unintended deaths and injuries.

Summary

The Health and Safety at Work Act 2015 essentially remains flexible and relevant to “the facts of industrial organisation” in 2024 and is a key component of the New Zealand workplace health and safety system.

When the Health and Safety at Work Act 2015 was introduced, further work developing additional regulations, approved codes of practice and other guidance was needed. Such guidance and its supporting evidence still needs to be published. The failure to publish these documents led to the failure of some businesses to adapt to the then new legislation.

This article provides suggestions for improving the Act and its enforcement.

Funding

This article was self-funded.

Conflicts of interest

I have no known conflicts of interest.

References

- Accident Compensation Act (2001). <http://www.legislation.govt.nz/>
- Amodu, T. (2008). *The determinants of compliance with laws and regulations with special reference to health and safety: A literature review* [Research Report RR0638]. Health and Safety Executive, Sudbury <https://www.hse.gov.uk/research/publish.htm>
- Anon. (2016a). Baldwins lands highest corp killing fine. *IOSH Magazine*. www.ioshmagazine.com/
- Anon. (2016b). Construction co director jailed for six years. *IOSH Magazine*. www.ioshmagazine.com/
- Anon. (2017). “Reckless” businessman jailed following factory roof death. *Safety & Health Practitioner*. <https://www.shponline.co.uk/news/reckless-businessman-jailed-following-factory-roof-death/>
- Billing, S., & Billing, S. (2024). *Industrial manslaughter offence in Australia: A state-by-state analysis*. Lexology. Retrieved 10 July 2024 from <https://www.lexology.com/>
- Bradshaw, L., Bowen, J., Fishwick, D., & Powell, S. (2010). *Health surveillance in silica exposed workers* [Research Report RR0827]. Health and Safety Executive, Sudbury <https://www.hse.gov.uk/research/publish.htm>
- Clark, R. B. (1980, 1980/11/01). Are fines a deterrent? *Marine Pollution Bulletin*, 11(11), 305-306. [https://doi.org/10.1016/0025-326X\(80\)90029-6](https://doi.org/10.1016/0025-326X(80)90029-6)
- Commerce Act (1986).
- Company Directors Disqualification Act (1986). <https://www.legislation.gov.uk/ukpga/1986/46/contents>
- Concise Oxford Dictionary. (2022). (12th ed.). Oxford University Press Ltd.
- Cox, A., O'Regan, S., Denvir, A., Broughton, A., Pearmain, D., Tyers, C., & Hillage, J. (2008). *What works in delivering improved health and safety outcomes: A review of the existing evidence* [Research Report RR0654]. Health and Safety Executive, Sudbury <https://www.hse.gov.uk/research/publish.htm>
- HL Bolton (Engineering) Co Ltd v TJ Graham & Sons Ltd* [1956] Court of Appeal.
- Doust, E. (2021). *Enforcement and promotion of work-related ill health in New Zealand: Have we made progress under the Health and Safety at Work Act 2015?* [Master of Health research report, Victoria University of Wellington]. Wellington.
- Dräger Safety UK Ltd. (2024). *The Dräger Safety and Health at Work Report* [Research Report]. Author, Blyth, UK https://www.draeger.com/en_uk/Home

- Eaqub, S. (2023). *State of a Thriving Nation: Health, Safety and Wellbeing in New Zealand* [Report]. Business Leaders' Health and Safety Forum, Wellington <http://www.forum.org.nz>
- Ewen, P. (2014). *Pike: Death by Parliament*. Pit Pony Press.
- Factories and Commercial Premises Act (1981). http://www.nzlii.org/nz/legis/hist_bill/
- Ferrier, M., Shortall, S., & Hardacre, J. (2024). *Lessons for New Zealand officers from Australian health and safety prosecutions*. MinterEllisonRuddWatts. Retrieved 10 July 2024 from <https://www.minterellison.co.nz/insights/lessons-for-new-zealand-officers-from-australian-h>
- Forno, T. (2024). *Officer acquitted of alleged breach of WHS due diligence duty*. MinterEllison. Retrieved 10 July 2024 from <https://www.minterellison.com/articles/officer-acquitted-of-alleged-breach-of-whs-due-diligence-duty>
- Health and Safety at Work Act (2015). <http://www.legislation.govt.nz/>
- Health and Safety at Work etc Act (1974). <http://www.legislation.gov.uk/ukpga/1974/37>
- Health and Safety in Employment Act (1992). <http://www.legislation.govt.nz/>
- Hoy, R., Dimitriadis, C., Abramson, M., Glass, D., Gwini, S., Hore-Lacy, Fiona, Jimenez-Martin, J., Walker-Bone, K., & Sim, M. (2023). Prevalence and risk factors for silicosis among a large cohort of stone benchtop industry workers. *Occupational and Environmental Medicine*, 80(8), 439. <https://doi.org/10.1136/oemed-2023-108892>
- HSWGR (2016). <http://www.legislation.govt.nz/>
- Hutter, B. (1997). *Compliance: Regulation and Environment*. Clarendon Press.
- ILO. (2021). *Key principles underlying sanctioning procedures applicable to occupational safety and health violations* [Report 79746]. International Labour Organization, Geneva <http://www.ilo.org/>
- IoD, & WorkSafe NZ. (2024). *Health & Safety Governance* [Good Practice Guide]. Institute of Directors of New Zealand Inc, Wellington <https://www.iod.org.nz/>
- ISO/IEC Annex SL. (2020). Proposals for management system standards. In *Directives, Part 1: Consolidated ISO Supplement - Procedures specific to ISO* (11th ed.). International Standards Organization. <https://www.iso.org/directives-and-policies.html>
- Jager, R., Cosman, M., Mackay, P., Mullins, M., Rose, P., & Rosenberg, W. (2013). *Independent Taskforce on Workplace Health & Safety*. Wellington www.hstaskforce.govt.nz
- Kurz, T., Thomas, W. E., & Fonseca, M. A. (2014, 2014/09/01). A fine is a more effective financial deterrent when framed retributively and extracted publicly. *Journal of Experimental Social Psychology*, 54, 170-177. <https://doi.org/10.1016/j.jesp.2014.04.015>
- Lamy, M. (2022). £3M fine for Carlsberg after 'entirely preventable' fatality [Electronic article]. *IOSH Magazine*.
- Lamy, M. (2023). £1.2M Fine for Network Rail Follows Rail Factory Maintenance Fatality. *IOSH Magazine*.
- Logan, R. J., Cavana, R. Y., Howell, B. E., & Yeoman, I. (2024). Why Do Key Decision-Makers Fail to Foresee Extreme 'Black Swan' Events? A Case Study of the Pike River Mine Disaster, New Zealand. *Systems*, 12(1). <https://doi.org/10.3390/systems12010034>
- Lord Robens, A., Beeby, G., Pike, M., Robinson, S., Shaw, A., Windeyer, B., & Wood, J. (1972). *Safety and Health at Work: Report of the Committee, 1970-72* [Report Cmnd 5034]. HMSO, London <http://www.mineaccidents.com.au/uploads/robens-report-original.pdf>
- Luxon, C., & Seymour, D. (2023). *Coalition Agreement: New Zealand National Party & ACT New Zealand* [Coalition Agreement]. Wellington
- Macfie, R. (2021). *Tragedy at Pike River mine: how and why 29 men died* (2nd ed.). Awa Press.
- Makin, A. M., & Winder, C. (2008). A new conceptual framework to improve the application of occupational health and safety management systems. *Safety Science*, 46(6), 935-948. <https://doi.org/10.1016/j.ssci.2007.11.011w>

- Matthews, L., Johnstone, R., Quinlan, M., Rawlings-Way, O., & Bohle, P. (2019). Work fatalities, bereaved families and the enforcement of OHS legislation. *Journal of industrial relations*, 61(5), 637-656. <https://doi.org/10.1177/0022185619829181>
- MBIE. (2013). *Working Safer: A blueprint for health and safety at work* [Report]. Ministry of Business, Innovation and Employment, Wellington <http://www.mbie.govt.nz/>
- MBIE. (2015). *Working Safer: Reducing work-related fatalities and serious injury by 2020: Progress toward the target* [Policy]. Ministry of Business, Innovation and Employment, Wellington <http://www.mbie.govt.nz/>
- Meadows, D. H., & Wright, D. (2009). *Thinking in systems: a primer*. Earthscan.
- MHSWR. (2000). *Management of Health and Safety at Work Regulations 1999* [Approved code of practice L21]. HSE Books, Sudbury www.hsebooks.co.uk
- Mitchell, C. (1994). *The law of subrogation*. Clarendon Press.
- Mitchell, C., Watterson, S., Fenton, A., Legge, H., & Mitchell, C. (2007). *Subrogation: Law and Practice*. Oxford University Press.
- Model Work Health and Safety Bill (2011). <http://www.safeworkaustralia.gov.au/>
- MoT. (2021). *The social cost of road crashes and injuries: June 2021 update*. Author, Wellington <https://www.transport.govt.nz/area-of-interest/safety/social-cost-of-road-crashes-and-injuries/>
- MoT. (2023). *The social cost of road crashes and injuries: Methodology and user guide*. Author, Wellington <https://www.transport.govt.nz/>
- Munkman, J. (1975). *Employer's liability at common law* (8th ed.). Butterworths.
- Neal, A., & Wright, F. (2005). *A survey of the use and effectiveness of the Company Directors Disqualification Act 1986 as a legal sanction against directors convicted of health and safety offences* [Research Report RR0597]. Health and Safety Executive, Sudbury <https://www.hse.gov.uk/research/publish.htm>
- NZISM. (2024). *Health and Safety Reform: survey overview* [Report]. New Zealand Institute of Safety Management Inc, Auckland
- Panckhurst, G., Bell, S., & Henry, D. (2012). *Royal Commission on the Pike River Coal Mine Tragedy*. Wellington www.pikeriver.royalcommission.govt.nz
- Peace, C., Lamm, F., Dearsly, G., & Parkes, H. (2019). The evolution of the OHS profession in New Zealand. *Safety Science*, 120, 254-262. <https://doi.org/10.1016/j.ssci.2019.07.005>
- Peace, C., Mabin, V., & Cordery, C. (2017). Due diligence: a panacea for health and safety risk governance? *Policy and Practice in Health and Safety*, 15(1), 19-37. <https://doi.org/10.1080/14773996.2016.1275497>
- Peters, T., & Waterman, R. (1982). *In Search of Excellence: lessons from America's best-run companies*. Harper & Row.
- Proceeds of Crime Act (1991).
- Rooney, J., Heenan, B., Rendle, R., Mercer, M., & Maitland, M. (2024). *Directors Beware: Landmark Ports of Auckland health and safety case concludes*. Lexology. <https://www.lexology.com/>
- Selinger, M. (2018). *Reckless safety breaches under the spotlight*. Lexology. Retrieved 24 May 2018 from <https://www.lexology.com/>
- Selinger, M., & Hamer, C. (2024). *Update: Industrial manslaughter offences across Australia*. Holding Redlich. Retrieved 3 July 2024 from <https://www.holdingredlich.com/update-industrial-manslaughter-offences-across-australia>
- Sentencing Act (2002). <http://www.legislation.govt.nz/>
- Shortall, S., Ferrier, M., & Hardacre, J. (2024). *Court of Appeal weighs in on novel proceeds of crime action*. MinterEllison. Retrieved 3 April 2024 from <https://www.minterellison.co.nz/insights/court-of-appeal-weighs-in-on-novel-proceeds-of-crime-action-commissioner-must-cover-commercial-bus>

- Spencer, D. (2024, 1 August). The missing pieces of the Health and Safety at Work Act *IOSH Magazine*. <https://www.ioshmagazine.com/2024/07/03/missing-pieces-health-and-safety-work-act>
- Strategic Policy Unit. (2003). *Health and Safety Reporting in the Annual Reports of New Zealand's 100 Largest Companies*. Department of Labour, Wellington
<http://www.osh.dol.govt.nz/publications/research>
- Van Velden, B. (2024). *Major health and safety consultation begins* [Press Release]. New Zealand Government, Wellington <https://www.beehive.govt.nz/release/major-health-and-safety-consultation-begins>
- Warburton, N. (2022, 1 July). Senior managers at food waste plant jailed and family business fined £2m over two fatalities. *IOSH Magazine*. <https://www.ioshmagazine.com/2022/07/01/senior-managers-food-waste-plant-jailed-and-family-business-fined-ps2m-over-two>
- WorkSafe New Zealand Act (2013). <http://www.legislation.govt.nz/>
- Zanini, S., & Bennett, Simon. (2024). The Whakaari/White Island disaster. An analysis informed by sociological theories of risk. *New Zealand Journal of Health and Safety Practice*, 1(1).
<https://doi.org/10.26686/nzjhsp.v1i1.9074>