New Zealand Journal of Health and Safety Practice; Vol 1, Ed 3, November 2024

The role of effective strategic leadership in transforming New Zealand's work health and safety system

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DOI: 10.26686/nzjhsp.v1i3.9620

Introduction

The purpose of this paper is to generate new insights that challenge the orthodox thinking that underpins the current and failing approach to improving the effectiveness of New Zealand's work health and safety system ("WHS system"), and to suggest a new pathway towards transformation. In achieving its purpose, this paper builds on the 2013 work completed by the Independent Taskforce on Workplace Health & Safety ("the Independent Taskforce") and the 2024 work completed by the Health and Safety Systems Taskforce established by the Business Leaders' Health and Safety Forum ("the Forum's Taskforce").

In this paper I posit that the underlying reason for the underperformance of the WHS system is the fundamental gap in the provision of effective strategic leadership that is accountable for the overall performance of the WHS system in meeting set harm prevention targets. I then explore the concept of effective strategic leadership and frame the argument that the first step towards revolutionising the approach to improving the effectiveness of the WHS system, will require the closing of the fundamental gap in the provision of effective strategic leadership.

I then suggest that closing that fundamental gap will require two catalytic decisions from within the Government as the principal influencer of national health and safety outcomes. First, the Minister who is for the time being responsible for the administration of the Health and Safety at Work Act 2015 ("HSWA") must accept accountability for the overall performance of the WHS system in meeting set harm prevention targets, or be held accountable by the Prime Minister. Second, to have any chance of upholding that accountability, the Minister's top strategic advisers must make the conscious decision to acquire new insights generated from new thinking, theories, and models for aiding harm prevention, such as my Chain of Interventions Model and my Risk Management Compliance Continuum Model.

A leader cannot deliver effective strategic leadership if the leader lacks the requisite insight needed to be able to clearly see, not just the future destination, but the way of getting to that destination in the most timely and cost-effective manner. The delivery of such leadership is the forerunner to taking transformative action. Taking transformative action is the forerunner to transforming the WHS system to one recognised internationally as a standout performer on the world stage.

What's wrong with these two pictures?

In 2013 the Independent Taskforce reported that "… New Zealand was identified as having a high rate of deaths compared with many OECD (Organisation for Economic Co-operation and Development) countries", and that "[t]he data indicated that we perform particularly poorly compared with Western countries like Australia and the UK, which have similar market economies and Robens-based regulatory systems" (Jager et al., 2013, p. 8). In reviewing the WHS system, the Independent Taskforce found "… a number of significant weaknesses across the full range of system components …" (p. 20). This had contributed to the creation of what the Independent Taskforce described as "… a combination of failings and circumstances that have resulted in preventable injuries, fatalities and disasters" (p. 20).

In 2024 the Forum's Taskforce reported on New Zealand's repeated health and safety failures (Business Leaders' Health and Safety Forum., 2024). They found that "[a] worker is almost twice as likely to be killed at work in New Zealand than if they were working in Australia" (p. 3). They also found that:

> *New Zealand's lagging performance is also not a recent trend – our workplace fatality rates have barely shifted in the last decade whilst comparators like Australia and the UK have continued to improve their performance. Our failure to learn is stark – the 2013 Independent Taskforce's report on Workplace Health and Safety could have been written today. (p. 4)*

The Independent Taskforce found that "… there is no single critical factor behind New Zealand's poor workplace health and safety record" (Jager et al., 2013, p. 20). However, when I examine with a critical eye the big picture painted by the Independent Taskforce in 2013, and the big picture painted by the Forum's Taskforce over a decade later, it becomes glaringly obvious to me that the single critical factor behind New Zealand's poor workplace health and safety record is the fundamental gap in the provision of effective strategic leadership that is accountable for the overall performance of the WHS system in meeting set harm prevention targets. Everything else that is wrong with the WHS system is merely a by-product of that single critical factor.

The lack of effective strategic leadership from the Government is a notion that I have been pressing for over a decade. In 2014 I red-flagged this notion to the Independent Forestry Safety Review when I explained (Koia, 2014):

> *Therefore, the analytical thinker would hit the nail on the head and posit that the reason why there is a high number of forestry deaths and serious injuries is because successive governments have failed to provide effective strategic leadership in forestry work health and safety leading to long-standing and fundamental government failings in risk mitigation.*
>
> *So there is your answer. It is a critical answer, because it feeds into the right solution that will stop the killings in forestry – effective strategic leadership from the top. Effective strategic leadership from the top will require a step change in thinking that starts from the very top. The Prime Minister was reported to have ruled out a government inquiry into the forestry industry saying he doesn't believe "it would do much" (3 News, 2014). You can't really blame the Prime Minister for making a statement like that, you can only blame his advisers. But the Prime Minister's statement is indicative of a more general government ignorance of the fundamental problems and complexities associated with forestry's appalling safety record, and how oblivious the government is to the fact that it is a major cause of the problem. (p. 66)*

A decade later, the Forum's Taskforce highlighted that "[t]he absence of national level ownership by Ministers and the relevant government agencies for ongoing health and safety improvements is a fundamental flaw in New Zealand's approach" (Business Leaders' Health and Safety Forum, 2024, p. 22).

Where does accountability lie?

The law stops short of holding someone accountable for the overall performance of the WHS system in meeting set harm prevention targets. Although the HSWA confers specified duties on defined persons, its express provisions are silent on this point. Section 195(1) HSWA confers a statutory obligation on the Minister (who is for the time being responsible for the administration of the HSWA) to "… publish a strategy, called the Health and Safety at Work Strategy, that sets out the Government's overall direction in improving the health and safety of workers".

In the (then) Minister's foreword to the Government's Health and Safety at Work Strategy 2018 – 2028, the Minister stated that "[t]he Government is determined to provide leadership on workplace health and safety" (New Zealand Government., n.d.). However, nowhere in the document does it state who within the Government is accountable for the overall performance of the WHS system. A highly functional system requires clear lines of accountability leading right to the top, so that everyone working within the system knows who is accountable for what, and who is answerable to who. Where there is a lack of clear accountability across the system, the functionality of the whole system is compromised.

By virtue of section 9(1) of the WorkSafe New Zealand Act 2013, "WorkSafe New Zealand's main objective is to promote and contribute to a balanced framework for securing the health and safety of workers and workplaces." Section 10 of its enabling statute prescribes WorkSafe New Zealand's statutory functions. None of those statutory functions bestows accountability on WorkSafe New Zealand for the overall performance of the WHS system in meeting set harm prevention targets.

The first step in closing the fundamental gap in the provision of effective strategic leadership is to make someone within the Government accountable for the overall performance of the WHS system in meeting set harm prevention targets. I posit that the most appropriate person within the Government to be made accountable is the Minister who is for the time being responsible for the administration of the HSWA. The rationale being that the said Minister (currently the Minister for Workplace Relations and Safety) is in the best position to influence Cabinet which is "… the central decision-making body

of executive government" (Department of the Prime Minister and Cabinet, n.d.-a). The Minister should be answerable to the Prime Minister as Ministers are appointed by the Governor General on the advice of the Prime Minister (Department of the Prime Minister and Cabinet, n.d.-b).

What is effective strategic leadership?

In 2013 the Independent Taskforce reported (Jager et al., 2013):

> *Irrespective of these data issues, the Taskforce is strongly of the view that all injuries and deaths in New Zealand workplaces are preventable, and any death in a workplace is unacceptable. Regardless of the emergent official toll, what is certain is that the number of people dying in New Zealand workplaces each year is a shameful tragedy. (p. 9)*

Over a decade later the Forum's Taskforce reported that "… our workplace fatality rates have barely shifted in the last decade …" (Business Leaders' Health and Safety Forum, 2024, p. 4). They objectively quantified the cost of New Zealand's workplace harm at $4.4 billion for 2022 (p. 4) noting that "[t]hese economic costs do not include the many indirect costs to lost productivity, social impacts and burden on our health system" (p. 20). They calculated that "[l]ifting our standards to that of Australia would save New Zealand $1 billion per annum" (p. 4) before concluding that "[t]he quantifiable financial argument for safety improvements is irrefutable" (p. 4).

New Zealand cannot afford to stay the present work health and safety course of being accepting of the unacceptable. The whole strategic approach to improving the effectiveness of the WHS system is in urgent need of review and correction. Lives depend on it! This does not necessarily mean that the WHS system itself needs an overhaul. The central component of the WHS system is health and safety law. On examining whether the HSWA was fit for purpose, Peace (2024) concluded that "[t]he Act seems to be fit for purpose from the point of view of large PCBUs, trades unions, lawyers, and health and safety practitioners" (p. 8).

The beating heart of the HSWA is its section 30 which requires all duty holders under the HSWA "to eliminate risks to health and safety, so far as is reasonably practicable" and "if it is not reasonably practicable to eliminate risks to health and safety, to minimise those risks so far as is reasonably practicable". Peace (2024) also found that "[w]hat is missing in the overall WHS system is sector- or business-specific guidance" (p. 8). Now we can connect the dots. Correcting the approach to improving the effectiveness of the WHS system requires revolutionary strategic change to the way the Government educates, incentivises, and enables duty holders to comply with section 30 HSWA. The effectiveness of how duty holders under the HSWA go about the daily business of managing risks to health and safety ultimately determines the effectiveness of the entire WHS system.

The key then is to revolutionise the strategic approach to improving the effectiveness of a WHS system that is already fit for purpose, by targeting duty holder risk management compliance. This will inevitably involve revolutionary strategic change, and revolutionary strategic change needs to be lead.

I define effective strategic leadership as leadership that is effective in achieving strategic outcomes and outputs. Effective strategic leadership is not a one off, front end, set and forget function. Effective strategic leadership requires the ongoing provision of high-level strategic oversight from vision setting to vision attainment. In the national work health and safety context, effective strategic leadership is concerned with moving New Zealand's health and safety performance towards a clearly defined future destination over the long-term, but with a focus on short-term and medium-term high-impact low-cost interventions. This future destination can be articulated in the form of a vision statement. As strategy follows vision, effective strategic leadership extends across the whole spectrum of strategic functions including high-level oversight of the strategy's formulation and execution.

Know the terrain: Seeing the big picture through the Chain of Interventions Model

To be effective in leading revolutionary strategic change, the Minister's top strategic advisers must make the conscious decision to acquire many new insights generated from new thinking, theories, and models for aiding harm prevention. One such model is my Chain of Interventions Model.

The Forum's Taskforce concluded that "[w]e need intervention to redress this shameful performance, keep workers safer, and reduce avoidable confusion for employers" (Business Leaders' Health and Safety Forum, 2024, p. 4).

While that may seem obvious, implementing the right interventions, let alone in the right manner, is somewhat problematic. The Independent Taskforce observed that (Jager et al., 2013):

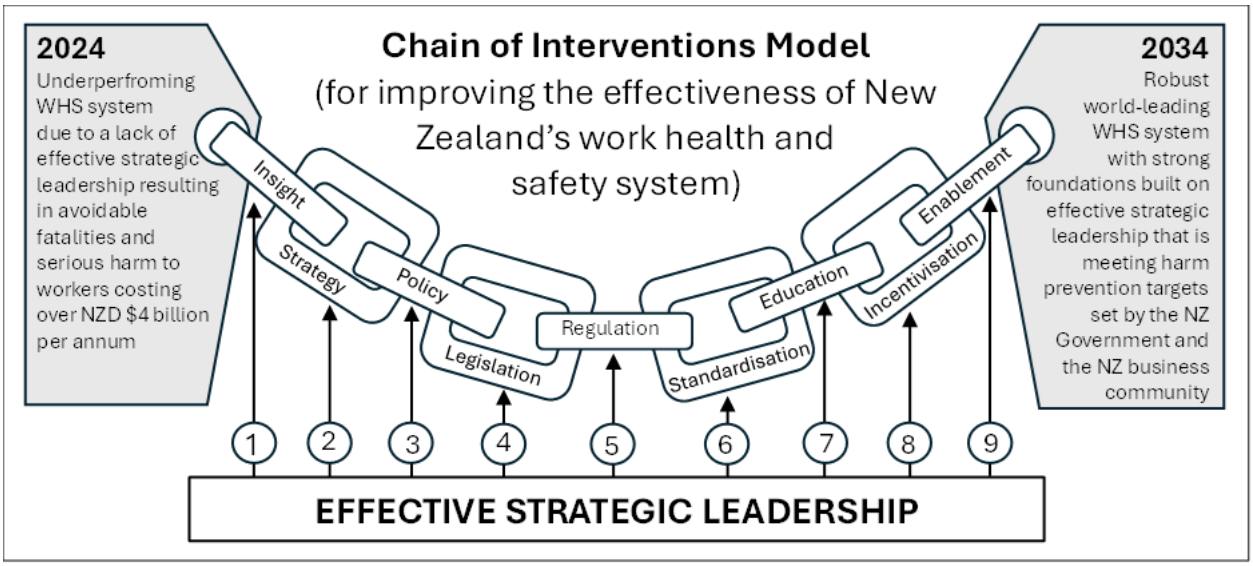
> *As previously indicated, New Zealand has unreliable data on workplace fatalities. More broadly, we also have poor information and intelligence on health and safety risk concentrations, causes of workplace injuries and illnesses, and the effectiveness of interventions to improve health and safety outcomes. As a result, we don't know the full extent of the issues or what to target. Further, while we may have a sense of who gets hurt and where, we often don't know why. There is insufficient detail to target effective interventions. (p. 30)*

How then should the Government intervene in a strategic way that will have the biggest impact on reducing New Zealand's workplace fatality rate, for the least cost, in the shortest time? – is the burning question. To help answer that question, a good place to start is to look at the big picture of what effective strategic interventions are available to the Government. My chain of interventions theory can help paint that big picture by explaining how the combining and sequencing of different interventions can be synergised to deliver superior health and safety outcomes across the WHS system.

My chain of interventions theory is based on the supposition that the best approach to improving the effectiveness of the WHS system is to take a strategic holistic approach to implementing the right combination and sequencing of interventions to create synergies for harm prevention.

There is a wide array of interventions that the Government can choose from. My theory supposes that this wide array of interventions can be organised under nine categories. Each category is an essential component to the strategic holistic approach, in the sense that if any one of the nine categories of interventions is weak, then the integrity of the whole approach is compromised. The nine categories of interventions are like links in a chain that connects the present state to a desired future state, and each link must be kept strong through effective strategic leadership. My chain of interventions model appears in **Figure 1** as a simplified representation of my theory.

Figure 1



The **first** category of interventions is **insight** which is primarily concerned with knowledge management. These interventions include activities related to the ongoing capture, analysis, interpretation, sharing, and storage of data and information to help identify and understand the critical issues and weaknesses across the WHS system. Quality insight helps ensure the right combinations of interventions are effectively sequenced, implemented, measured, and controlled to create synergies for harm prevention.

The **second** category of interventions is **strategy** which is primarily concerned with improving the health and safety of workers and others. I define strategy as an intended course of action to achieve the realisation of a desired future state (for example, the desired future state of having the lowest fatality rate of all OECD countries by 2034). Harm prevention must set the strategic direction for interventions falling under this category.

The **third** category of interventions is **policy** which is primarily concerned with ensuring the Government's work health and safety policy settings support and enable strategy execution.

The **fourth** category of interventions is **legislation** which is primarily concerned with ensuring the HSWA (as the primary source of law relating to work health and safety in New Zealand) remains fit for purpose and aligned with the Government's work health and safety policy settings.

The **fifth** category of interventions is **regulation** which is primarily concerned with prescribing the manner in which duty holders across the WHS system must legally discharge their duties conferred by the HSWA.

The **sixth** category of interventions is **standardisation** which is primarily concerned with standardising good practice through codified rules and standards such as approved codes of practice and safe work instruments to support duty holders across the WHS system comply with their legal duties conferred by the HSWA and its supporting regulations. Standardisation interventions can be targeted towards specific high-risk industries (for example, forestry) or specific hazards that give rise to critical risks to health and safety (for example, working at height).

The **seventh** category of interventions is **education** which is primarily concerned with ensuring duty holders across the WHS system have the health and safety competences required to comply with their duties conferred by law (*I know what's legally required of me as a duty holder*).

The **eighth** category of interventions is **incentivisation** which is primarily concerned with ensuring duty holders across the WHS system are willing to comply with their duties conferred by law (I know what's legally required of me as a duty holder *and I'm willing to comply with my duties*).

The **ninth** category of interventions is **enablement** which is primarily concerned with ensuring duty holders across the WHS system are able to comply with their duties conferred by law (I know what's legally required of me as a duty holder and I'm willing *and able* to comply with my duties).

When developing interventions, lead and lag indicators will also need to be developed (including the methods for (1) establishing baseline measures; and (2) impact evaluation) so that the effectiveness of the interventions can be measured and tracked over time.

Identify the target: Zooming in to see the little picture

In this paper's previous section, I discussed my chain of interventions theory to help paint the big picture of what strategic interventions are available to the Government. Seeing that big picture can help answer the burning question – how should the Government intervene in a strategic way that will have the biggest impact on reducing New Zealand's workplace fatality rate, for the least cost, in the shortest time? What can also help answer the burning question, is to zoom in and look at the little picture. In formulating a sound strategic holistic approach to implementing the right combination and sequencing of interventions for high-impact low-cost harm prevention over the short-to-medium-term, it helps when the big picture and the little picture are seen together. Connecting the dots between the big picture and the little picture can help reveal the hidden pathway towards realising the degree of revolutionary change needed to transform the WHS system. There is a pathway, but it is not easy to see. If it were easy to see, then New Zealand would have the lowest fatality rate of all the OECD member countries.

The common denominator in every workplace fatality and serious harm occurrence is the failure to effectively manage the risks associated with exposure to a workplace hazard. It follows that one of the best ways to protect workers and others from work-related harm is to ensure that workers exposed to hazards have the means, motive, and opportunity to participate meaningfully in the effective management of the risks to their health and safety arising from that exposure. The trick though is not to focus on workers. The trick is to focus on who has control or influence over workers, workplaces, and resources. That person is the person conducting a business or undertaking ("PCBU").

The legal framework is already in place requiring a PCBU to ensure, so far as is reasonably practicable, that workers under the control of the PCBU who are exposed to hazards have the means, motive, and opportunity to participate meaningfully in the effective management of the risks to health and safety arising from that exposure – if that is the objective.

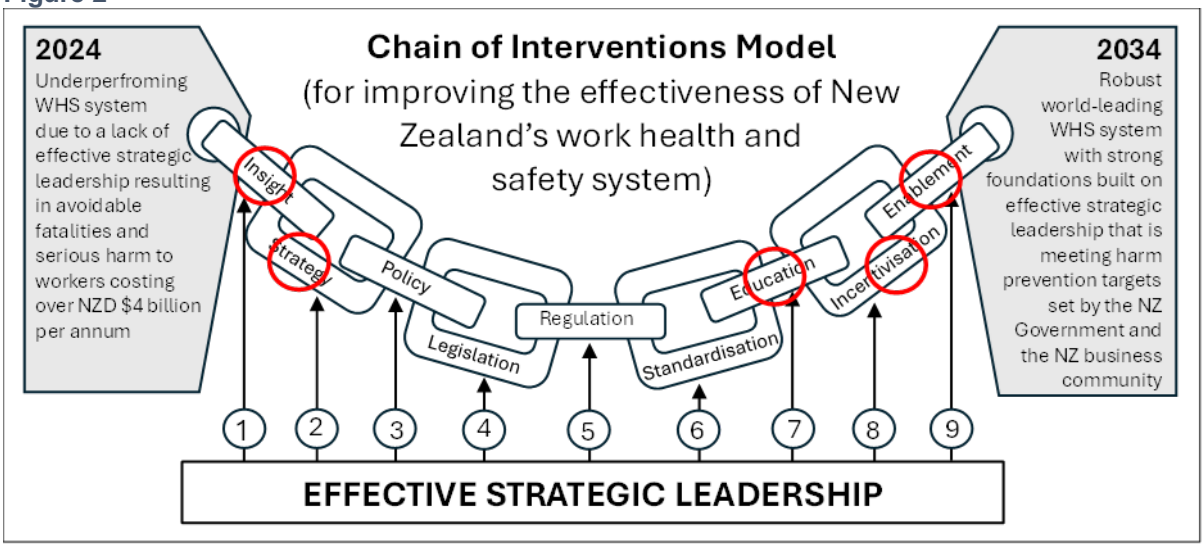
For instance, section 30 HSWA confers a duty on a PCBU to manage risks. In managing risks, regulations 5 – 8 of the Health and Safety at Work (General Risk and Workplace Management) Regulations 2016 ("HSWGR Regs") prescribes the mandatory "[r]isk management process to be followed by [a] PCBU in specified circumstances". By virtue of section 36(3)(f) HSWA, in discharging

the primary duty of care, "… a PCBU must ensure, so far as is reasonably practicable, … the provision of any … training … that is necessary to protect all persons from risks to their health and safety …". Clearly then, the scope of training necessary to protect workers from risks to their health and safety includes quality foundation risk management training and refresher training. Supporting section 36(3)(f) HSWA is regulation 9 HSWGR Regs which confers a duty on a PCBU to ensure, so far as is reasonably practicable, that training provided to a worker is "… suitable and adequate …" and "… is readily understandable to any person to whom it is provided". And, finally, section 61 HSWA confers duties on a PCBU regarding worker participation in managing risks. So the legal framework is already in place – meaning that the achievement of the objective does not require statutory reform (in the shape of legislation or regulation targeted interventions).

So then, if the objective is to ensure workers exposed to hazards have the means, motive, and opportunity to participate meaningfully in the effective management of the risks to health and safety arising from that exposure, and the legal framework necessary to achieve that objective is already in place, then PCBU compliance with the following duties of a PCBU becomes the target:

- The duty to manage risks effectively; and
- The duty to train workers to manage risks effectively; and
- The duty to provide reasonable opportunities for workers to participate effectively in managing risks.

Figure 2



Considering that insight, as indicated by the red circles in **Figure 2**, my Chain of Interventions Model can assist in determining what combination and sequencing of interventions should be targeted to achieve the objective of ensuring workers exposed to hazards have the means, motive, and opportunity to participate meaningfully in the effective management of the risks to health and safety arising from that exposure.

The framework of interventions to achieve that objective might look something like the following framework shown in **Table 1**.

Table 1

Intervention 1
Insight Intervention (develop lag indicators): Gather and collate data and information from the four industries with the highest fatality rates (the "target industry group"): (1) Necessary to establish a baseline measure for each industry of: a. fatality rates b. hospitalisation injury rates c. lost time injury rates. (2) Necessary to establish a good sense of the typical hazards involved in each industry's:

a. Fatalities
b. Hospitalisations
c. lost time injuries.

Intervention 2

Insight Intervention (develop lead indicators): Capture (from across the target industry group), analyse, and interpret data and information:

(1) Necessary to establish a baseline measure of:

a. **what workers know** – how knowledgeable are workers of:

i. worker duties
ii. PCBU duties (particularly the duties to (1) manage risks effectively (2) train workers to manage risks effectively; and (3) provide reasonable opportunities for workers to participate effectively in managing risks)
iii. officer of a PCBU duties (particularly the duty to take reasonable steps to ensure the PCBU has, and implements, processes for complying with the duties of a PCBU)
iv. the potential consequences for duty holders (including workers) arising from the failure to comply with a duty
v. the statutory risk management process to be followed by PCBUs (outlined in the HSWGR Regs).

b. **what training workers are getting** – what is the proportion of workers (within each industry of the target industry group):

i. who have received training about duty holders (training about who has a duty to do what under health and safety law and why, and the consequences for duty holders for getting it wrong)
ii. who have received foundation risk management training
iii. who have received competent-to-role training and assessment (for roles performing hazardous work)
iv. who receive ongoing refresher foundation risk management training

c. **the quality of worker training provided** – within each industry of the target industry group regarding:

i. duty holders
ii. the statutory risk management process to be followed by PCBUs
iii. worker participation in managing risks
iv. competent-to-role training and assessment (for roles performing hazardous work).

d. **the level of worker participation in managing risks** – (within each industry of the target industry group).

(2) Necessary to establish a baseline measure of:

a. **what officers of a PCBU know** – what is the proportion of officers of a PCBU who are knowledgeable of:

i. the duties of a PCBU to manage risks effectively, train workers to manage risks effectively, and provide reasonable opportunities for workers to participate effectively in managing risks
ii. the duty of an officer of a PCBU to take reasonable steps to ensure the PCBU has, and implements, processes for complying with the duties of a PCBU

iii. the legal consequences for the PCBU for failing to comply with the duties of a PCBU
iv. the legal consequences for an officer of a PCBU for failing to comply with the duty of an officer of a PCBU to take reasonable steps to ensure the PCBU has, and implements, processes for complying with the duties of a PCBU.

b. **Prosecutions of officers** – how many officers of a PCBU have been:

i. charged with failing to comply with the duty of an officer of a PCBU to take reasonable steps to ensure the PCBU has, and implements, processes for complying with the duties of a PCBU
ii. convicted of that charge.

c. **PCBU compliance** – what is the proportion of PCBUs that are compliant with:

i. the duty of a PCBU to manage risks effectively
ii. the duty of a PCBU to train workers to manage risks effectively; and
iii. the duty of a PCBU to provide reasonable opportunities for workers to participate effectively in managing risks.

Intervention 3

Strategy Intervention: Consider the insight gained from insight interventions 1 and 2 (above) and formulate a Managing Risks to Health and Safety Strategy (the "sub-strategy") as a sub-strategy that feeds into the Government's Health and Safety at Work Strategy 2018 – 2028 and links to that strategy's vision of 'Work is healthy and safe for everyone in New Zealand'. The sub-strategy should focus on interventions that target four key objectives:

(1) officers of a PCBU are incentivised to commit to taking reasonable steps to ensure the PCBU has, and implements, processes for complying with the following duties of a PCBU:

a. the duty to manage risks effectively
b. the duty to train workers to manage risks effectively; and
c. the duty to provide reasonable opportunities for workers to participate effectively in managing risks.

(2) PCBUs are enabled to implement new systems, or align existing systems, to the statutory risk management process to be followed by a PCBU.
(3) PCBUs are enabled to train workers to manage risks effectively; and
(4) PCBUs are enabled to implement practices that provide reasonable opportunities for workers to participate effectively in managing risks.

In the pursuit of the above four objectives, the sub-strategy should encompass the combining and sequencing of **education**, **incentivisation**, and **enablement** interventions as well as define lead and lag indicators to measure the effectiveness of each intervention and the synergies created for harm prevention. The framework for these (**education**, **incentivisation**, and **enablement**) interventions falling within the scope of the sub-strategy might look something like the following framework:

(1) **Education**: Deliver training to officers of a PCBU (not workers!) across the target industry group in respect of:

a. the link between the statutory risk management process to be followed by a PCBU, and protecting workers and others from work related harm
b. the duties of a PCBU to manage risks effectively, train workers to manage risks effectively, and provide reasonable opportunities for workers to participate effectively in managing risks
c. the statutory risk management process to be followed by a PCBU in specified circumstances

d. case studies of effective risk management compliance systems and effective worker participation practices
e. the potential legal consequences for a PCBU for failing to comply with the duties of a PCBU
f. the duty of an officer of a PCBU to take reasonable steps to ensure the PCBU has, and implements, processes for complying with the duties of a PCBU
g. the potential legal consequences for an officer of a PCBU for failing to comply with the duty of an officer of a PCBU.

(2) **Incentivisation:** Incentivise officers of a PCBU through innovative incentivisation programmes and schemes (both rewards based and punitive based) to comply with the duty of an officer of a PCBU to ensure the PCBU has, and implements, processes for complying with the duties of a PCBU.

(3) **Enablement:** Enable PCBUs to comply with the duties of a PCBU to have, and implement, processes to comply with the duties of a PCBU to manage risks effectively, train workers to manage risk effectively, and provide opportunities for workers to participate effectively in managing risks, by giving PCBUs access to compliance enabling tools and resources such as:

a. risk management compliance gap analysis tools
b. foundation hazards and risks management training modules
c. risk management compliance systems, processes, and procedures
d. guidance material on implementing effective worker participation practices.

Intervention 4

Insight intervention (measuring the sub-strategy's effectiveness): Periodically measure over time the effectiveness of the education, incentivisation, and enablement interventions falling within the scope of the sub-strategy against the baseline measures for both lead and lag indicators. The results can then be analysed and used to inform evidence-based strategic, policy, or statutory reform.

Squeeze the trigger: Nailing compliance through the Risk Management Compliance Continuum Model

Prioritising PCBU duty holder compliance with New Zealand health and safety at work legislation is important for reasons other than for achieving the objective of ensuring workers exposed to hazards have the means, motive, and opportunity to participate meaningfully in the effective management of the risks to health and safety arising from that exposure.

For instance, by virtue of its section 3, the main purpose of the HSWA is to provide for a balanced framework to secure the health and safety of workers and workplaces through a range of means, including by eliminating or minimising risks to health and safety arising from work. It follows that the best way to secure the health and safety of workers and workplaces is for duty holders to comply with law designed for that express purpose.

In addition, New Zealand PCBUs and their officers can commit a range of offences by failing to comply with their legal duties. For example, a company PCBU commits an offence against regulation 14 HSWGR Regs for non-compliance with its duty to prepare, maintain, and implement an emergency plan, and is liable on conviction to a fine not exceeding $50,000. Furthermore, by virtue of section 49 HSWA, an officer of a company PCBU (for example, the company's directors and CEO) who fails to comply with an officer's duty under section 44(4)(e) HSWA to take reasonable steps to ensure the PCBU has, and implements, processes for complying with any duty of a PCBU under the HSWA, commits an offence and is personally liable on conviction to a fine not exceeding $100,000.

Now we can connect the dots. Targeting interventions towards duty holder compliance is an important strategic consideration because full compliance by duty holders is the most effective way to manage health and safety risk while mitigating both PCBU financial risk and officer personal criminal liability risk.

My risk management compliance continuum theory explains how a PCBU's performance in complying with the duties of a PCBU to manage risks effectively, train workers to manage risks effectively, and provide reasonable opportunities for workers to participate effectively in managing risks, can be measured at any given point in time, and that there are variables and factors that can be manipulated to improve a PCBU's compliance performance. Measurement is an important means of detecting compliance gaps. The effective manipulation of the variables and factors that affect compliance performance, is an important means of closing those gaps.

My theory is based on the supposition that a continuum exists between non-compliance at one end of the continuum, and full compliance at the other end, and that every PCBU sits somewhere on the compliance continuum at any given point in time. My Risk Management Compliance Continuum Model appears in **Figure 3** as a simplified representation of my theory.

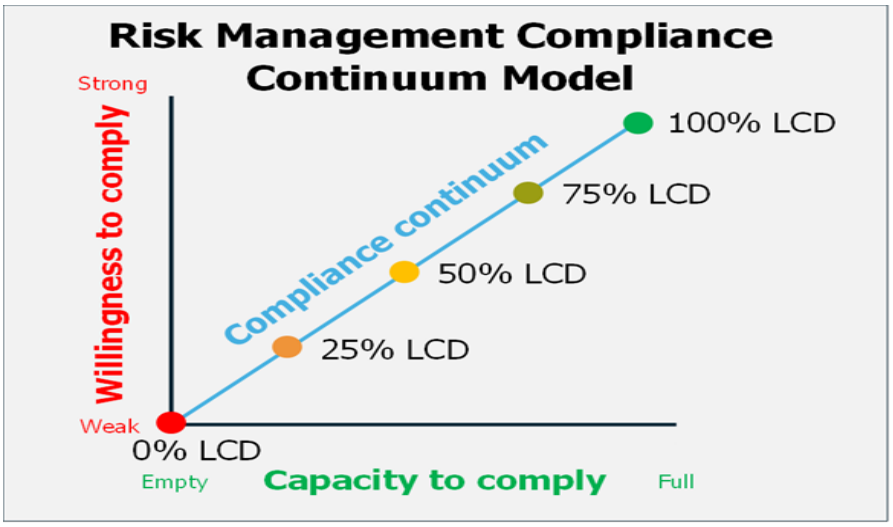


Figure 3

I identify two placement variables that determine a PCBU's positioning on the compliance continuum. The first placement variable is a PCBU's willingness to comply. Influencing factors that impact a PCBU's willingness to comply includes compliance leadership (the exertion of influence to achieve compliance); a culture of safety compliance (around here we do things by the book); and the Government's policy settings regarding compliance enablement and enforcement.

The second placement variable is the PCBU's capacity to comply. Influencing factors that impact a PCBU's capacity to comply includes the health and safety competences and resources that are readily available to the PCBU for immediate disposal at any given point in time. Health and safety competences includes knowledge about how to manage risks in accordance with the law. Resources includes the things the PCBU needs to manage risks in accordance with the law such as an effective compliance management system; safe, well-maintained machinery and equipment; effective safe operating procedures consistent with relevant industry good practice standards and guidelines; worker training modules and resources; alert, well trained workers deemed competent-to-role or under documented training and competent supervision; and the provision and use of suitable personal protective equipment.

'Legal compliance demonstrated' (LCD) is the test I apply to determine a PCBU's placement on the compliance continuum at any given point in time. The yardstick I have chosen to measure 100% LCD is compliance with regulations 5 to 8 HSWGR Regs (PCBU duty to follow the risk management process); compliance with section 36 HSWA & regulation 9 HSWGR Regs (PCBU duty to train workers to manage risks effectively); and section 61(1) HSWA (PCBU duty to provide reasonable opportunities for workers to participate effectively in managing risks).

I have developed an LCD Rating Tool[1] to enable PCBUs to self-assess where they sit on the compliance continuum at any given point in time. The assessment result will assist officers of a PCBU

[1] The LCD Rating Tool is publicly available at no cost for downloading and use from the website www.ezhr.co.nz

identify areas for improvement and what needs to be done to move the PCBU up to 100% LCD on the compliance continuum, where every PCBU should be sitting.

Conclusion

The current approach to improving the effectiveness of the WHS system is in urgent need of review and correction. Lives depend on it! The pathway to transforming the WHS system is via revolutionary strategic change. Revolutionary strategic change must be driven by effective strategic leadership that is accountable for the overall performance of the WHS system in meeting set harm prevention targets. To be an effective agent of revolutionary strategic change, the leader must draw from many new insights generated from new thinking, theories, and models for aiding harm prevention. In conclusion, effective strategic leadership has a critical role to play in transforming the WHS system. Who amongst us will lead the way?

Funding and declaration

Funding: Self-funded by the author

Declaration of interest: I have no conflicts of interest that are known to me. However, I do declare that the website www.ezhr.co.nz from which my LCD Rating Tool is publicly accessible at no cost also promotes a market product that I hold a commercial stake in.

References

Business Leaders' Health and Safety Forum. (2024). Been there. Done that. A report into New Zealand's repeated health and safety failings. https://www.forum.org.nz/resources/a-report-into-new-zealands-repeated-health-and-safety-failings/

Department of the Prime Minister and Cabinet. (n.d.-a). What are Cabinet and Cabinet committees https://www.dpmc.govt.nz/publications/what-are-cabinet-and-cabinet-committees#:~:text=Cabinet%20is%20the%20central%20decision,is%20in%20the%20Ministerial%20List.

Department of the Prime Minister and Cabinet. (n.d.-b). Ministers. https://www.dpmc.govt.nz/our-business-units/cabinet-office/supporting-work-cabinet/cabinet-manual/2-ministers-crown-appointment-role-and-conduct/ministers

Health and Safety at Work Act 2015 https://www.legislation.govt.nz/act/public/2015/0070/latest/DLM5976660.html

Health and Safety at Work (General Risk and Workplace Management) Regulations 2016 https://www.legislation.govt.nz/regulation/public/2016/0013/latest/DLM6727572.html

Jager, R., Cosman, M., Mackay, P., Mullins, M., Rose, P., & Rosenberg, W. (2013). Independent Taskforce on Workplace Health & Safety. Wellington

Koia, H. (2014). Submission to the Independent Forestry Safety Review https://931cffa0-55bc-4b66-91dd-ef185ecfa33b.filesusr.com/ugd/b9ddf8_ea959e9f2c13431481fd0d8fad55b57b.pdf

New Zealand Government. (n.d.). Health and Safety at Work Strategy 2018 – 2028. Wellington https://www.mbie.govt.nz/assets/69361d5a98/health-safety-at-work-strategy-2018-2028.pdf

Peace, C. (2024). What's missing in the New Zealand workplace health and safety system?. New Zealand Journal of Health and Safety Practice, 1(2). https://doi.org/10.26686/nzjhsp.v1i2.9550

WorkSafe New Zealand Act 2013 https://www.legislation.govt.nz/act/public/2013/0094/latest/DLM5302019.html