

You and the HSW Act

Health and Safety at Work Act 2015

Let's be clear right off: I'm not a lawyer and this is not a legal opinion. Furthermore, there are no test cases. Nevertheless, the HSW Act is not rocket science, so here goes.

In a nutshell

Despite the usual over-excitement around new legislation, it's probably best to see the HSW Act as clarifying responsibilities rather than introducing many new responsibilities.

In a nutshell, what is clear for guides and instructors is:

- You have duties under the new Act – a self-employed contractor is a business entity (the Act calls it a PCBU); a chief executive is an Officer; and other staff are Workers
- Workers must take reasonable care to keep themselves and others safe
- Your employer must provide a safe place for you to work, eg training, safe systems, and protective clothing and equipment (unless you genuinely prefer your own, eg parka, helmet, harness, rope, crampons, ice axe, and PFD)
- Wherever you guide or instruct will be deemed to be a workplace for the time you're there, which removes any doubt stemming from the 2007 Rangitikei rafting incident
- There is a [risk focus](#) (what really bad stuff could happen?)
- Incident reporting to the health and safety regulator extends to [some near misses](#)
- You must 'consult, co-operate and co-ordinate' when there are overlapping business entities, eg when an instructor contracts with a school, you share responsibilities and need to be clear on who is responsible for what
- You can expect to see Officers of your PCBU (directors, board members, chief executive) visiting your workplace to better understand the operation
- The regulator can prosecute up to 12 months after finding out about an incident, or up to six months after a coroner reports

Why a new Act then?

The 2010 Pike River tragedy led to a major review, which brought to our attention that NZ workplace fatalities were about double those of Australia and three times those of the UK (although comparing apples to apples internationally has its challenges). The review argued that these accident rates reflect the different safety cultures of our societies.

'Health and safety culture differs depending on where you were born' was the observation of the prominent lawyer Mai Chen when comparing NZ and Vietnam workplaces. She meant that NZ work practices are built on our safety culture, which differs from that of Vietnam, eg picture towering bamboo scaffolding. But NZ safety culture also differs from that of Australia and the UK.

The government realised that NZ society has accepted incidents too readily ('shit happens'), along with the financial and social costs. The HSW Act is one attempt to change that by clarifying responsibilities and increasing penalties for reckless behaviour.

That commercial pressure

Rebecca Macfie, in her book *Tragedy at Pike River Mine*, often writes about the commercial pressure, eg *The push was on to start hydro mining; dealing with the gas issues had taken a lower priority than getting coal out.*

Obviously, organisations can't survive unless they provide quality products or services and keep money coming in. The outdoor sector is no different, and guides and instructors go out of their way to provide quality experiences, even when conditions are poor.

Instructors feel pressure to achieve course goals even when it's raining or the sea is rough, eg the 2008 Mangatepopo canyoning incident and the 2012 Paritutu rock scrambling incident; and guides sometimes strive to pull off trips when the snow's unstable, eg the 2009 Canterbury Ragged Range heli-skiing incident.

Clearly, it's critical to review the environmental operating range for each activity you provide. This could be river levels for boating, canyoning, and caving; swell levels for coasteering, sea kayaking, wind surfing, sailing, and coastal rock climbing; wind levels for activities in trees; and the snow stability for snow travel.

An activity review must consider whether the operator's standard operating procedures or activity management procedures align with [good practice](#), particularly the [Activity Safety Guidelines](#).

However, the HSW Act doesn't say that exactly. What it does say is that you need to take all reasonably practicable steps.

All reasonably practicable steps

Arguably, the HSW Act raises the bar to '...the highest level of protection against workplace hazards as is reasonably practicable...'

WorkSafe is charged with regulating workplace safety (along with Maritime NZ and the Civil Aviation Authority) and they've been given more resources to do the job, eg more inspectors. They have a stronger mandate than previous regulators, and they're more active enforcing the law.

In 2015, 45 organisations were sentenced for health and safety breaches across 31 industries. Recent outdoor sector prosecutions involved a Christian camp in 2015 ([a supervision deficit](#) on their ropes course) and a kayak rental company (2016 – proceeding). Importantly, when all reasonably practicable steps were taken, WorkSafe didn't prosecute a heli-ski company after a 2015 incident in Otago.

Organisations should review their safety management system with 'all reasonably practicable steps' in mind. In particular, the activity procedures that spell out how an activity will be provided are documents that guides and instructors should have strong input into, ensuring they align with good practice.

Workers' responsibilities

You must take reasonable care to keep yourself (and others) safe, eg you should use a personal safety system when you're working above a drop, just as you wear a PFD when kayak guiding or instructing. Furthermore, you must engage on safety matters, follow any reasonable instructions, and follow your organisation's procedures.

These procedures include reporting incidents, something the sector is getting better at, although reporting near misses is surely under reported. The HSW Act requires some near misses to be reported to the regulator, which sharpens the focus on these free lessons.

But filling in an incident form is just one step in a learning process. Guides and instructors should insist that managers 'respond in a timely manner', unlike at Pike River where Rebecca Macfie reported a miner's frustration: *What should happen if there's an incident is that ...there ought to be a detailed explanation of what happened, how to avoid it next time, and what to look out for.* In light of the explosion in the mine, check out one of his incident reports below.

SECTION 4: Identify the Potential Root Causes			
Immediate Causes (tick and describe)		Basic Causes (tick and describe)	
Substandard practices <input type="checkbox"/> Operating equipment without authority <input type="checkbox"/> Unaware of hazard <input type="checkbox"/> Failure to secure <input type="checkbox"/> Operating at improper speed <input type="checkbox"/> Not following procedure <input type="checkbox"/> Removing safety devices <input type="checkbox"/> Using defective equipment <input type="checkbox"/> Failing to use PPE <input type="checkbox"/> Improper loading <input type="checkbox"/> Improper placement <input type="checkbox"/> Improper lifting <input type="checkbox"/> Improper position for task <input type="checkbox"/> Servicing equipment in operation <input type="checkbox"/> Horseplay <input type="checkbox"/> Under influence of alcohol/drugs <input type="checkbox"/> Making safety devices inoperable	Substandard conditions <input checked="" type="checkbox"/> Inadequate guards or barriers <input type="checkbox"/> Inadequate protective equipment <input type="checkbox"/> Defective tools, equipment or materials <input type="checkbox"/> Congestion/restricted action <input type="checkbox"/> Inadequate warning system <input checked="" type="checkbox"/> Fire & explosion hazards <input type="checkbox"/> Poor housekeeping, disorder <input type="checkbox"/> Noise exposure <input type="checkbox"/> Radiation exposure <input type="checkbox"/> High or low temperature exposure <input type="checkbox"/> Inadequate or excess illumination <input checked="" type="checkbox"/> Inadequate ventilation <input type="checkbox"/> Weather	Personal factors <input type="checkbox"/> Lack of knowledge/training <input type="checkbox"/> Lack of skill/inexperience <input type="checkbox"/> Lack of concentration <input type="checkbox"/> Stress <input type="checkbox"/> Misconduct <input type="checkbox"/> Language difficulties <input type="checkbox"/> Inadequate capability <input type="checkbox"/> Improper motivation	Job factors <input checked="" type="checkbox"/> Inadequate leadership/ supervision <input checked="" type="checkbox"/> Inadequate engineering <input type="checkbox"/> Inadequate purchasing <input checked="" type="checkbox"/> Inadequate maintenance <input type="checkbox"/> Inadequate tools, equipment, materials <input checked="" type="checkbox"/> Inadequate work standards <input type="checkbox"/> Abuse <input type="checkbox"/> Wear and tear <input checked="" type="checkbox"/> Inadequate procedure <input checked="" type="checkbox"/> Safety rules not enforced <input type="checkbox"/> Insufficient staff numbers <input checked="" type="checkbox"/> Sub standard/no training <input checked="" type="checkbox"/> Substandard work practice
What was the ROOT CAUSE of this event? VERY INADEQUATE VENTILATION, POOR STOPPING S. POOR VENTILATION MANAGEMENT. VENTILATION LEAKAGE HIGH PERCENTAGE			
SECTION 5: Remedial Actions Recommended, Including Any Injury Prevention & Training if Required			
Follow up of Event: What investigation/action has or will be taken to prevent a recurrence			
VENTILATION ENGINEER REQUIRED		By Whom	By When
CONSTRUCT PERMAMENT STOPPING ETC TO CONTROL VENTILATION			
THIS			
REQUIRE IMMEDIATE FEED BACK WITHIN 4 DAYS - OR I WILL WRITE A FORMAL LETTER TO			
New Hazard identified - has this been added into the Hazard Register?		THE MINES INSPECTOR	No <input type="checkbox"/>
New Controls implemented - Have these been recorded in the Hazard Register?			Yes <input type="checkbox"/> No <input type="checkbox"/>

Overlapping responsibilities

Often guides and instructors contract to provide activities for a school or other entity under their own safety plan. In these cases, two overlapping entities must discuss who is responsible for what and how they will do it, eg when a teacher accompanies a group you've contracted to instruct, are both parties clear on what the teacher's role is?

In 2002, an investigation into a kayaking incident on the Buller raised questions around different entities' responsibilities. Those questions are more pointed under the HSW Act, which explicitly requires parties to 'consult, co-operate and co-ordinate'.

So, what does the HSW Act mean for you?

Guides and instructors need to:

- Contribute to a strong safety culture, eg discuss safety with other guides and instructors, raise safety concerns, and follow up on incident reports
- Contribute to reviews of activity procedures against good practice, and work according to the organisation's activity procedures
- Discuss who is responsible for what and how it will be done
- Check conditions before and during an activity, and halt an activity if you think it's unsafe
- Preserve an accident site, eg belay ropes, abseil ropes, and anchors

Isn't that what you've always done?

To more fully understand what the HSW Act 2015 means for you, I suggest you read Matt Bennett's article in NZOIA's November 2015 Quarterly, and WorkSafe's [guidance document](#), which introduces the Act in plain English. Well organised guides and operators shouldn't find much to keep them awake at night.

Stu Allan is the Tourism Industry Aotearoa Adventure and Outdoor Project Leader and an NZOIA Board member. He wishes to thank Rachael Moore, Matt Bennett, and WorkSafe for their comments on this article.