Independent Taskforce
on Workplace Health and Safety

Strategic Review of the Workplace Health and Safety System

Submission template

This template can be used to make a submission to the Independent Taskforce on Workplace Health and Safety. The template does not limit the length of your answers, and you can attach documents to supplement your answers if you wish. Alternatively, you can use the on-line questionnaire to make a submission, which can be found at www.hstaskforce.govt.nz . The on-line questionnaire restricts the length of your answers to about 300 words per question.

Please refer to the taskforce's consultation document, *Safer Workplaces* before completing this template. The consultation document can be found at www.hstaskforce.govt.nz

About you

* *Indicates mandatory questions*

1. *Your full name:

Irene King

2. *Is this submission on behalf of an individual or an organisation?

❑ Individual ◪ Organisation

Name of organisation: Aviation Industry Association

3. *Region

◪ Northland ◪ Whangarei ◪ Auckland
◪ Waikato ◪ Bay of Plenty ◪ Gisborne
◪ Hawke's Bay ◪ Taranaki ◪ Manawatu-Whanganui
◪ Wellington ◪ Marlborough ◪ Nelson
◪ West Coast ◪ Canterbury ◪ Otago
◪ Southland ❑ Overseas

4. *Respondent category

❑ Employer
❑ Manager
❑ Employee
❑ Self-employed
❑ Employee representative
❑ Not in paid employment
❑ Occupational health nurse
❑ Health and safety practitioner
❑ Other:

Industry Association represent

5. *Which type of industry do you manage, own a business in, or work in?

❑ Agriculture
❑ Forestry
❑ Fishing
❑ Mining
❑ Manufacturing
❑ Electricity, Gas, Water and Waste Services
❑ Construction
❑ Wholesale Trade
❑ Retail Trade
❑ Accommodation and Food Services
◪ Transport, Postal and Warehousing
❑ Information Media and Telecommunications
❑ Financial and Insurance Services
❑ Rental, Hiring and Real Estate Services
❑ Professional, Scientific and Technical Services
❑ Administrative and Support Services
❑ Public Administration and Safety
❑ Education and Training
❑ Health Care and Social Assistance
❑ Arts and Recreation Services
❑ Other Services

6. *Size of business that you own / manage or work for?

❑ Self employed
❑ 1–5 employees
❑ 6–9 employees
❑ 10–19 employees
❑ 20–49 employees
❑ 50–99 employees
◪ 100+ employees

7. Gender

❑ Male ◪ Female ❑ Other

8. Age

❑ 15–24

❑ 25–34

❑ 35–44

❑ 45–54

◪ 55–64

❑ 65+

9. Ethnicity

❑ NZ Maori

◪ European

❑ Pacific Island

❑ Other European

❑ Asian

❑ Middle Eastern/Latin American/African

❑ Other ethnic group

❑ Do not wish to indicate

10. Your contact details

Phone number(s)

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Email address:

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Please tick the boxes below as appropriate

◪ I consent to my submission being placed on the Independent Taskforce on Workplace Health and Safety website

❑ I would like my name withheld from publication (submissions from individuals only)

Please note that your name and contact information, including any personal information, is being collected so that the Independent Taskforce on Workplace Health and Safety can publish the names of people and organisations who or that made submissions, follow up with a respondent if any submission needs clarification, and for the general purposes of the Strategic Review of the Workplace Health and Safety System. The Independent Taskforce on Workplace Health and Safety is the intended recipient and holder of the information and can be contacted at PO Box 3705, Wellington, New Zealand. In accordance with Privacy Principle 7, you have the right to access and correct any personal information you provide.

Submission template questions

Please answer the following questions and feel free to attach any supporting documents.

If you are completing the template on paper, please feel free to add other pages but make clear which questions your answers refer to. ***If you are completing the template electronically*** and need more space for any of your answers, please write the rest of your answer into another document, making clear which question your answer refers to, and attach it when you send your completed submission template to us. The answer fields below hold approximately 430 words.

Who gets hurt, killed or suffers from ill-health or disease as a result of work?

1. What do you think is driving the differences in health and safety outcomes for different demographic groups?

In our industry we would say:

Young inexperienced - its is simply lack of familiarity with the operating environment. For the older and experienced it is too much familiarity with the operating environment combined with a history or practice which unknowingly or unwittingly result in a propensity to injury or fatally harm themselves.

Research into the general aviation sector in the early 2000's showed two distinct peaks of injury - those who had more than 500 hours flight time but less than 1000 and those who has masses of flight time ie 10-20,000 hours. This pattern is broadly similar to other civil aviation jurisdictions around the world and says reflects changes in risk taking behaviours. Low flight hours combined with good basic training creates an environment in which the safety envelop is not pushed. However between 500 and 1000 hours some experience and knowledge proves potentially quite dangerous. Accident rates then dropped substantially until considerable levels of experience were amassed. At this point it was thought to be a combination of unknowingly or unwittingly developing practices which could ultimately result in injury or fatality. With this knowledge the industry commenced a process of education by putting the facts in front of the pilot along with giving the community more tools which assisted with mitigating the risk. This process coupled with a changed regulatory setting has seen general commercial aviation's performance dramatically improve as evident in the CAA statistics refer . http://www.caa.govt.nz/safety_info/safety_reports.htm

Although the workforce is predominantly male and of European descent there is no demographic difference detectable with other ethnicities or our female workforce. The pattern is the pattern described above.

For a highly hazardous industry the accident rate for aviation operations in the air is very low. Employees are trained from day one to understand the hazards. They are constantly examined, refreshed, subject to peer assessments and review. There is only one system of safety in the air and it applies to all on board aircraft ie it does not distinguish with one is ab employee or a passenger. The same duty of care applies. For ground based activities there are two systems of safety - one under the jurisdiction of the Civil Aviation Authority in so far as the activity impacts on safety and another where the activity is within the jurisdiction of the HSE Act.

2. What changes are needed to the workplace health and safety framework to improve outcomes for demographic groups with higher than average rates of injury and illness?

The issue from our perspective is not demographics but experience levels. Arguably at both points (ie the 500 hour but less than 1000 hours flight time and the 10,000 hour plus flight time) its about both groups understanding that these are particularly important points at which they can harm or fatally injury themselves. At its essence it is to do with experience one thinking they have the experience to push the safety envelope and the other having as set of experience constructed in a work practice framework which unknowingly or unwittingly may be fatally flawed.

Again we make these comments in the context of businesses and a workforce that is highly focused on ensuring the safety of operations all day every day.

It is easy to attribute higher than average rates of injury or illness to demographics but as we have found it is more to do with the psychology of the individual worker than demographics. Risk taking leading to injury and or illness can emerge for a variety or reasons and drilling down to the underlying causative factors is more important than a top down broad brush approach. We would submit that it is important to get to the underlying trends that put in place remedial actions which may only address the problem superficially. We do not consider addressing the health and safety of employees and those who are exposed to the same hazards, in the case of aviation our passengers, should be a matter of superficial analysis or stop gap measures - this has the potential to gloss over the fundamental causative factors and it is understanding those underlying factors which will enhance safety performance.

Regulatory framework

3. What do you think the challenges are with the current health and safety regulatory framework?

In the aviation industry it stems from the top - having two frameworks which can be potentially be both confusing and conflicting. For example, the aviation framework is prescriptive but developing and emerging within a risk based context. However this framework is now being intertwined with the less prescriptive but performance based framework of the Health and Safety legislation. The effect of this is to start to establish a pathway for a conflict of two jurisdictional frameworks

The aviation safety culture and it systems are driven by one basic understanding that it is not acceptable to harm or kill anyone. This extends well beyond the duty of care it is simply a duty of every employee irrespective of role in the company. This is accompanied by a duty to report circumstances in which hazards may be merging or safety compromised. To do otherwise is unthinkable. In turn such reports are logged, investigated and rectified. The setting is non punitive except where there is wilful or deliberate action to compromise safety.

The Health and Safety in Employment legislation is largely "no hands" and the point of final resort punitive irrespective of whether there was any deliberate act of negligence. There is very little if any guidance material for small to medium sized businesses who must seek out information from whatever source is available. As we have found even though the source of the guidance material may be highly credible a serious accident invariably finds that the duty of care was not properly exercised. In the context of our aviation industry a finding of this nature invariably leads to serious questions being asked as to what is actually intended - a safety system which learns from an inadvertent accident as in our civil aviation system or one which is designed to penalise even the most safety conscious of work places.

While presenting some of the comparators between the aviation industry's system of safety and the health and safety regulatory framework we do so simply to highlight the point that the taskforce should look to some of the highly safety sensitive sectors and learn from those sectors what drives their safety performance.

4. How do you think the health and safety regulatory framework could be improved?

1. Recognition of specialist industry safety regulators - there should be one and not two standards for safety in the work. Specialist safety regulators should be given responsibility for exercising full jurisdictional control over all aspects of their industry. Presently it is confusing and in our view undermines safety gains when there are two systems to regulate safety as is presently the case for aviation. In the instance of civil aviation the CAA should be responsible for all aspects of safety and that includes safety in the air and on the ground. The performance of the CAA, working in conjunction with key stakeholders, has much greater potential to create the right environment to protect all persons engaged in including our customers than two jurisdictions.

2. In the alternative the present jurisdictional arrangements should remain unchanged. We think this is a suboptimal solution from a safety perspective and clearly less efficient than one agency being charged with all aspects of aviation safety. In the aviation environment, for the safety management system to be optimally effective it needs to collect robust data and information on a comprehensive basis. Presently there are reporting costs imposed and information potentially incorrectly considered as we have two definitions for example of serious harm. Employers are reporting the same accident from two very different definitional perspectives. The importance of this is that it impedes the analysis of the accident from a preventative view point as the analysis must be conducted from the perspective of very different first principle tests. At essence with aviation the system of analysis is conducted from the perspective of prevention and investigations are conducted from a "no blame" perspective. The perception with failure (ie an accident) in the Health and Safety in Employment environment is the investigation is about whether or not "all practicable steps" were applied to prevent the accident. The very different regulatory systems and philosophies have and do produce very different safety outcomes. To develop alignment we suggest as a first step that the concept of ALARP ie as low as reasonably practicable be adopted in both sets of legislation. This introduces the concept of risk and from that point forward the risk management principles and practices in ISO 3100:2009 can be developed and applied

3. The HSE Act is of very limited assistance to SME's in terms of providing a methodology to address and evaluate risk in the work place. Referencing ISO 3100:2009 in the Act at the very least provides a methodology and a way of thinking about risk. In our industry this has lead to the development of the "safety case" as one of the most important tools for dealing with hazards in a highly challenging and changing environment.

4. The HSE Act fails to address the matter of effective compliance and the value of audit. In aviation audit is seen as an effective tool for increasing awareness and performance. For example in the voluntary setting - this Association operates "AIRCARE" to improve safety (on the ground and in the air) and environmental assurance. In the compulsory setting the Civil Aviation Authority regularly audits conformance and compliance. There appears to be no equivalent mechanisms in the HSE environment. We do not advocate or favour multiple agencies becoming involved in audit but see a turn key audit akin to "AIRCARE" as a solution to enhancing sector performance from a number of perspectives. Delivering quality HSE outcomes is about delivery quality outcomes within a businesses - we are strong advocates of having highly integrated business systems which look at and measure all aspects of performance of a business. This can be done from the small one person business to the large multinationals most of whom have embraced such systems some time ago. Our experience is that delivering one integrated platform does not need to be a massive business expense.

Regulators' roles and responsibilities

5. How effective are the regulators in influencing workplace health and safety outcomes?

1. As stated we see the matter of dual jurisdiction over safety in the air and on the ground as suboptimal. There should be only one duty and that is not to fatally harm anyone in or at a place of work and that all firms should strive to achieve a standard of "ALARP". In our environment the Civil Aviation Authority exercises clear jurisdiction over all matters in the air. Their effectiveness is measured by international benchmarking to ICAO and the regular publication of both globally (eg Air Transport News 2012 safety reports zero fatalities in the airline sector in Australasia) and locally (aviation sector safety performance). Few other safety regulators in New Zealand are measured in such a public manner.

2. However because of the split jurisdiction aviation is not benefiting from the knowledge of the specialist safety regulator when it comes to safety in ground based aviation workplaces. Because the Department of Labour neither has the specialist resources nor the aviation knowledge to competently regulate ground based activities we are frustrated from optimising safety outcomes. Having the split jurisdiction leads to a potential undermining of the development of an attentive and informed safety culture.

3. Influencing safety outcomes is a complex issue. Informed Regulators have a critical role in leading the change process along with all inspirational leaders from industry who "walk the talk". On their own neither industry nor regulators can effect the quantum improvements in safety sought.

4. Inconsistent messages can cause a major undermining of the safety culture. We have today the classic problem of the DoL inspectors perceived as being very punitive whereas in fact the statistics say otherwise with very few cases prosecuted. A perception of a punitive investigatory process leads to "optimum positioning" of the facts whereas an investigation without blame leads to in most circumstance the facts being fully investigated and the causes of the accident being more likely to be identified.

5. Aviation would not contemplate a safety system which did not clearly quarantine a safety investigation away from an investigation for the purposes of prosecution however we understand that there is no such quarantine in the HSE environment. We cannot see how in this environment the causative factors can be fully captured, assessed and evaluated as you will always be mindful that you may be prosecuted.

6. How could the regulators' roles and responsibilities be changed to improve their effectiveness in influencing workplace health and safety outcomes?

1. For Aviation the Civil Aviation Authority to exercise jurisdiction over all safety matters.

2. A specialist accident investigation team separate from the prosecution arm of the DoL

3. Education - there must be much greater use of formalised risk assessment process in conjunction with the collection of data and a culture which encourages reporting and free and frank exchange of safety information.

4. Regulators need to embrace the concepts of a just safety culture. If this culture doesn't exist then we will continue to have accidents because people will be reluctant to "fess up" to errors or mistakes. Companies similarly have to encourage "just culture" and accept that accidents happen generally in the absence of any negligent or wilful behaviours.

5. Learn from the best industries and the best sectors - what do they do that is different to the norm.

6. The HSE cannot be all things to all people. For SME's it is a confusing piece of legislation particularly after they have had an accident. The Act doesn't provide strong enough guidance that there is an expectation of being proactive and seek out best practice. The non prescriptive environment for many small businesses places prohibitive costs on them and they simply do not know where to go to seek advice and guidance on best practice. With some of our enterprises who have sought out best practice and who have had subsequently had an accident they have found out in Court that "best practice" wasn't in effect "best practice".

New Zealand’s changing workforce and work arrangements

7. What impacts are New Zealand’s changing workforce and work arrangements having on health and safety outcomes?

As industries we know that the workforce is changing and the objective must be to pro actively manage those changes and address any emergent risks. In aviation the retirement age for pilots has been lifted from 55 to no retirement age limit within Australasia. This change has been effected without any change in the operational risk profile of the sector ie the level of pilot incapacitation today is about the same as it was prior to the retirement age being lifted. The combined strategies of effective health monitoring combined with operational monitoring generally in simulators has ensured that pilots can continue working longer with no or an acceptable level of risk elevation. With an aging workforce it is a matter of determining through objective analysis how workplace health and safety outcomes will be delivered at acceptable levels. The important point is that there needs to be objective and not subjective analysis.

Similarly issues surrounding fatigue in this sector have been addressed through objective analysis of the issue and acceptance that fatigue is one of the causal factors of injury and harm.

8. What changes to the health and safety framework, if any, are needed as a result of the changing workforce and work arrangements?

We see movement to a risk based framework would automatically identify these as matters in some sectors which can cause potential harm and enable participants in the business or industry to look for realistic solutions. In this area there is no "One size" fits all solutions.

Worker participation and engagement

9. How effective do you think worker participation is in improving workplace health and safety in New Zealand?

Critical - a safety system which over looks or ignores those in the work place is doomed to failure. No one person holds all of the keys to ensuring a workplace environment free from harm. However a workplace that encourages every participant to openly and freely engage in discussion around keeping the work place safe supported by a culture of reporting without recrimination and high quality safety investigations will lead to a better outcome for all.

In our industry we say "safety is expensive until you've had an accident" by that we mean an accident does immeasurable damage to business reputation not simply from a HSE perspective but it lifts insurance loadings on equipment and assets; can discourage high quality personnel from joining the company and invariably leads to a loss of customer and ultimately loss of business.

The employees are the "eyes" of the business. They see and or experience the hazards. They know when conditions are changed and they generally can tell you, unfortunately for many after the event. we quite frequently hear the comment "that was an accident waiting to happen".

However again they must be given clear and systematic tools to identify hazards and generally they must be very simple to use. Everyone must accept that their duty is not to see fellow workers harmed. Being safe comes from the heart and it must be part of the culture.

10. What improvements can be made to worker participation in workplace health and safety so as to get better workplace health and safety outcomes?

The biggest investment this sector has made of recent times is to impress on everyone the importance of understanding how the hazard management part of the risk management process works.

We suggest that workers should become much more versed in the application of ISO 3100:2000 as this gives both methodology and authority to change if required in a non confrontational and collegial way. Everyone understands what the issues are and works from the "same" information sets.

We also think this is a very useful way for employers to deal with some of the more difficult and challenging issues.

The importance for safety is that the issues are dealt with in a non confrontational and non adversarial way. Sometimes the practices of both management and unions when dealing with such matters can become confrontational. Our experience is that in dealing with HSE matters that must be evaluated in an objective way to get in place the best solution.

Leadership and governance

11. To what extent do directors and other senior leaders provide effective leadership and governance of workplace health and safety?

The safety of all persons who are employed by the company or use the companies products and services must be a matter that is addressed by all from directors to those who are the organisation's front line.

Our experience is that directors of aviation companies, as they also tend to be operational, understand very clearly the importance of keeping all safe and free from harm. In larger organisation's where there are professional directors, there tends to be an established Board sub committee that addresses the safety performance of the company. Establishing appropriate reporting mechanisms and metrics is the key. In the past many aviation organisation's had safety officers who could by-pass the normal chain of control. We do not think this appropriate as its important that information relating to the safety performance of the company is a shared responsibility and all must be integrally engaged in its development.

We agree however that it is important to have an individual who is accountable for the operational integrity and safety performance of the company. This is a more analytical role and supports data gathering and the exchange of meaningful information both to directors and staff.

The safety performance of an organisation should be a measurable KPI for senior managers and integral to their roles not an adjunct. A clear articulation of the Board's vision of the organisation in respect of safety should be built into all senior managers job descriptions. Being safe and not harming employees and or customers is key to the financial performance of the business. Repeated accidents and injuries damages a businesses reputation - these are messages that must be instilled by leaders of the work places.

Within the aviation environment there are clear lines of accountability to ensure that senior managers have the resources and funding to do the task appropriately. The corollary is that Directors, in accepting governance over ensuring a safe operating environmen,t must make the funding available to ensure senior managers can discharge their responsibilities appropriately.

12. What improvements can be made to directors' and other leaders' participation in workplace health and safety, so as to get better workplace health and safety outcomes?

The Civil Aviation Act does not require any specific performance standards of Directors however it does ensure that Operators have the appropriate resources and funding. This piece of legislation is quite prescriptive. For the wider New Zealand work place community however such prescription is probably unnecessary but some best practice guidelines from companies who have excellent safety performance would be beneficial information for all.

See comments above for some of the improvements we believe would improve the performance of directors and leaders.

It would also be useful if some common measurement metrics were available and could be readily adopted by Boards and organisation's that don't have these. Specific metrics could be developed by sector or interest groups. Measurement is important for trend analysis and it is the trends which are equally as important as high quality investigation of the specific events to drive improvements.

Capacity and capability of the workplace health and safety system

13. To what extent do firms have the capacity and capability to effectively manage workplace health and safety issues (including through accessing external resources)?

Again we can only speak about the aviation. This is an environment in which customers and employees can be assured that resource and capability are carefully managed according to quite prescriptive rules.

As we have said we have reservations regarding the split jurisdiction and our ability to provide independent assurance that the same level of capacity and capability is provided on the ground however where ground activities are integral to flight safety there are expositions which address such matters. In addition for the international flight community there is an International Airline Safety Audit which addresses comprehensively safety systems and for the General Aviation community in New Zealand we operate AIRCARE which comprehensively integrates Health and Safety in Employment into our basis safety and environmental assurance programme.

14. What options are there for improving firm level capacity and capability to deliver better health and safety outcomes?

We are unaware of the extent to which non aviation businesses have systematic reporting mechanisms. As we know from our own experiences incident data for example can be a good predictor of potentially more catastrophic events. In this sector there are rules prescribed for events and occurrences which must be reported. In many respects this is no different to HSE. Where however we differ is that most businesses run reporting systems which record all occurrences no matter how minor or on their own insignificant. The larger enterprises employed skilled investigators who can analyse the data and search for trends. This has helped to prevent more catastrophic events.

Incentives

15. How effective are existing financial and non-financial incentives in improving workplace health and safety outcomes?

The biggest incentive for any business is prevention of reputational damage. We know from our experiences of the past that very few SME's can survive a catastrophic accident. For the self employed this is even more reason why they should invest in ensuring their businesses are "safe"

Third parties are important in that they can establish contractual arrangements which articulate zero harm and punitive provisions should the accident rate become unacceptably high.

High quality data is more important than any financial or non financial incentives. We fundamentally believe that nobody accepts that its OK for an employee or colleague to be killed or seriously harmed at work however quite often managers don't have the visibility needed over high risk accident or incident areas.

16. How could incentives be better used to improve workplace health and safety outcomes?

In our view a punitive or penalty based culture ultimately undermines improved performance. Its a balance between ensuring companies, SME's and the self employed work to reduce accident rates and dealing with those recidivist employers who repeatedly hurt employees.

Influencing health and safety outcomes beyond one's own workplace

17. How successful are government, industry, corporate or other potentially influential bodies in influencing health and safety outcomes beyond their own workplaces (for example through influencing their suppliers, counterparts, and competitors)?

One of the most challenging issues is to obtain agreement from persons who let bulk contracts and tenders to industry to provide some audit assurance requirements within those tenders. This is particularly important within the context of Health and Safety in Employment. Many automatically assume companies are in compliance however some of the highly hazard conscious sectors such as the resources and infrastructure providers actually require independent evidence to be submitted that clients are meeting the highest standards of safety (including the safety and health of employees) while discharging contracts.

Most government agencies do not require independent verification and where they do they seem to endorse contestable assurance mechanisms which in our view defeats the purpose of ensuring best practice is followed. There appears to be a genuine absence of understanding about assurance and effective assurance mechanisms. For example some agencies appear to place much weight on self assessment. This self assessment when conducted in specialised areas has at times left gaps in actual appraisal of the present situation. Other agencies have no independent verification whereas other's absolutely insist on such verification prior to a tender being issues. We think government needs to be consistent in its practices. It is audit consistency and intensity which has lifted the performance of the international airline community. There is clear evidence that carriers who participate in the IOSA (IATA Operational Safety Audit) mechanism have a 52% better safety record (ie avoidance of fatality) than carriers who do not (reference Air Transport News 2012 SAFETY).

In Aviation, our International Association, has developed a six point safety programme. Similarly the UK Civil Aviation Authority has established a seven point plan for safety. Both of these organisations/agencies, based on high quality analytical data have a "most wanted list" of safety issues to be addressed. We know from previous initiatives of this nature that this focus on the most wanted list drives safety gains. New Zealand tends not to have such high profile focus on initiatives and where we do we don't seem to be consistent in driving safety gains. This is one of the reasons why we are strong advocates of having specialists regulators in safety sensitive industries which comprehensively cover all aspects of safety.

The Resources Sector (Oil and Petroleum producers, mining etc) have adopted the BARS Basic Aviation Risk Standard as the basic for improving safety to improve safety in operations involving remote and hazardous environment. the programme has four key components :

A new risk based international Aviation standard
A new auditing programme tailored to the new Standard
A range of aviation safety training programmes
A global safety and data analysis programme

Refer http://www.google.co.nz BARS+programme+aviation&oq=BARS+programme

18. What could be done to get government, industry, corporate or other potentially influential bodies to exert greater influence on improving workplace health and safety outcomes beyond their own workplaces?

In the New Zealand context we have AIRCARE. Its objective is to bring together a number of different legislative compliance regimes onto one integrated safety management platform. The scheme is voluntary and applicable to general aviation only. Multiple government agencies use aircraft and they rely on the CAA providing assurance however at the present time CAA do not conduct integrated system audits but rather focus on operational safety only. AIRCARE addresses this gap and extends into other areas of environmental management such as the application of chemicals, baits etc. The assurance process is about lifting the performance of the whole sector across a wide range of activities which present specific hazards within the operating environment.

Like BARS it has a number of codes of practice, training programmes etc but does not collect safety data.

It does recognise outstanding safety performance through the issue of safety awards.

For more information on AIRCARE go to http://www.aia.org.nz/AIRCARE.html

Major hazards

19. How strong is New Zealand’s current approach to regulating major hazards?

In the aviation environment where it directly impacts on flight safety of the travelling public very strong. However when it comes to matters of addressing hazards on the ground there is a mish mash of regulators involved from local and regional councils to HSE, EPA.

20. What improvements to the regulation of major hazards would lead to better health and safety outcomes?

We would prefer one Safety regulator dealing with all aspects of safety in the air and on the ground. In this way there is focus on improving the performance of the sector in all of its aspects.

Health and hazardous substances

21. What are the most significant challenges to managing occupational health risks and exposure to hazardous substances?

Knowledge of the health risk.

Pro actively understanding the risks and consequences of exposure to hazardous substances

Education, education eduction - how do we get to authoratative sources of.

We trust that the Regulators know what the effects are of exposure to hazardous substances and assume we are in compliance

Some of the health risks become evident later in a persons career - if they had been known at the time we are sure they would be mitigated

Ensuring the right protective clothing is worn and proper equipment used all of the time

22. What changes could be made to the existing health and safety framework to reduce the harm caused by occupational disease and ill-health?

Making more information readily available when issues are identified and ensuring the information is factual and backed by substantive evidence. The role of the regulator in education cannot be understated.

We understand that ACC, for example, has some data on occupational diseases however in general this information is not shared with sectors or across occupations where there is exposure to common hazards. We think in these circumstances sharing of data would be beneficial.

In general there is not a significant amount of research undertaken on occupational diseases specific to the aviation sector. At times there is discussion about the effects of cosmic radiation however where there has been high quality research such in the areas of fatigue we have been able to introduce mitigations - some quite inexpensive mitigations such as ensuring an appropriate in take of fluids has improved safety performance. Other mitigations have resulted in changed rosters. This has been done from a scientific view point and not on the basis of subjectivity.

Often workplaces do not know whether an employee's disease is due to the workplace. However where occupational disease is linked to hazards chemicals or toxins and the like this information needs to be readily accessible and made available in a transparent way.

Small to medium-sized enterprises

23. What workplace health and safety challenges are specific to the self-employed and small-to-medium enterprises?

1. The non prescriptive environment makes it very difficult to understand whether "all practicable" steps have been applied to any particular set of circumstances. In our environment we use field safety advisors to communicate and convey best practice

2. Complex compliance frameworks do not work as they consume too much time effort and money when there are other competing objectives

3. SME's need a hand up and not another big stick - simple tools which can improve performance are always welcome

4. Access to affordable and quality advice. The networks for some SME businesses can be limited and they tend to be time pour. they don't have the financial robustness to employ a raft of advisors.

5. Remoteness and isolation. Quite a number of aviation industry SME's operate in remote and isolated locations. They simply may not have ready access to best practice.

6. In general they want to know they are doing the right things in a simple and understandable way.

24. What improvements could be made to the workplace health and safety framework, and its implementation, to ensure that it's effective for self-employed and small-to-medium sized enterprises?

1. More accessible tools to provide assurance they are in fact doing the right thing

2. Dealing with one regulator across the spectrum of matters under the HSE Act. Aviation is close to achieving this but not quite.

3. Good practical tools for mapping hazards and identifying risks

4. Information sharing - we find stories about practical encounters with the HSE Act have produced an excellent learning environment. Nobody want to see their employees harmed and if this can be avoided through learning from the experiences of others this should be encouraged.

Measurement and data

25. To what extent are New Zealand's workplace injury and occupational disease data collection mechanisms conducive to robust monitoring, investigation and comparative analysis?

As we have stated in our submission its important to have high quality data supported by robust non punitive investigations. We would also support the printing of comparative data across sectors provided there was a clear understanding of the parameters being reported against.

In the context of aviation we think this should be undertaken by the specialist aviation regulator as it builds up a robust picture of safety across the enterprise. Categorising accident and incidents into HSE accident/incidents and CAA accident/incidents destroys the picture and it is the full picture which leads to major safety gains.

Presently we are forced to report against two definitions of serious harm. The first definition is the specialist aviation definition applied throughout the international civil aviation jurisdictions and then quite possibly report the same accident against a different definition applied in the HSE environment. To our way of thinking its a serious harm accident which requires high quality accident investigation to ensure it does not happen again. That is the essence of the issue.

26. What opportunities are there for improving data collection, integration and reporting?

In our sector the best way of improving data collection, integration and reporting is to provide for one jurisdiction providing control over all aspects of aviation safety. With two jurisdictions the quality of the analysis will always be sub optimal. No one regulator has the "full picture" however in a sector like aviation it would be relatively easy to define CAA's coverage in a way that optimises the safety management systems.

Our national culture and societal expectations

27. Do you think New Zealand culture influences our workplace health and safety outcomes?

No it is not the New Zealand culture. We don't think for one moment New Zealanders have ever said or believe its "ok" to kill our people. Our personal hazard ID register is not as well educated as the likes of Australia or the UK. We do take more risks and in some areas such as adventure tourism this has encouraged a new industry which creates jobs and wealth for New Zealand.

However this does not mean that we should not endeavour to treat and mitigate the risks, it simply means that we have to all become very proficient managers of risk in everything we do.

Culture is "the way we do things around here" . Instilled in the way we do things is an absolute expectation we have a right to expect that we will go home at the end of the working day to our families and loved ones. In aviation most of our businesses get that but it has been a long path over many years. If we look to our Agricultural aviation sector the improvement in its safety performance has been remarkable. In our view this would be an excellent sector to study in terms of its "turnaround strategies".

28. What might we do to improve our culture relating to workplace health and safety?

Tell the story of those who have turned their HSE performance a round.

Use best risk management practice and have these practices fully integrated into all aspects of the business.

Educaition, Education Education - its important to get our leaders talking about health and safety from government right through Associations such as ours to CEO's in businesses to the shop floor. Ensuring we are safe all day every day needs to become part of the way we do businesses

Other factors

29. Are there any other factors (not already covered) that influence workplace health and safety outcomes in New Zealand?

30. Do you have any other suggestions for how to improve workplace health and safety outcomes in New Zealand?

Other comments

31. Are there any other comments that you would like to make?

We have placed the cost of having split jurisdiction's exercising control over Health and Safety of our people at many thousands of dollars for what real safety gain.

The Royal commission into Pike River comments on the criticality of "specialist" safety regulators. We see that in the aviation environment the same logic and the same arguments apply. We can only have one system of safety and that is keeping everyone safe all the time every day.

Thank you for the opportunity to make this submission.

Please send your completed submission to secretariat@hstaskforce.govt.nz (preferred) or post it to: Submissions, Independent Taskforce on Workplace Health and Safety, PO Box 3705, Wellington 6140. We would appreciate it if you could get your submission to us as early as possible, but at the latest, you must get your submission to us by **5pm, Friday 16 November 2012**. If you are sending your submission to us by mail, you should put it into the post by 5pm, Wednesday 14 November 2012.