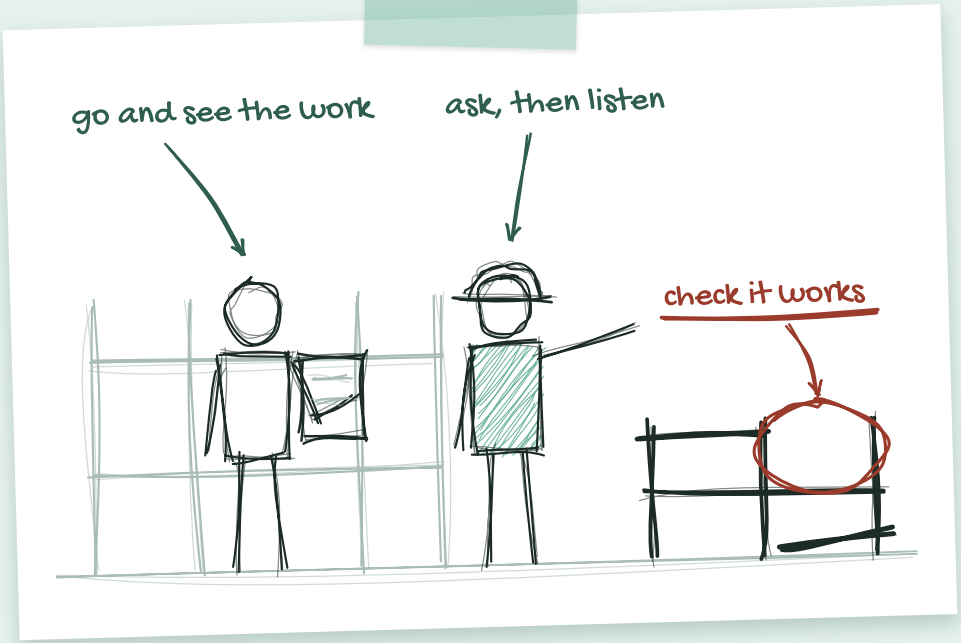
vimes consulting

Field guide 1



Leading health and safety

The ideas behind this series: what the law asks of you, what good leaders do, and how to change your approach as the work changes.

For middle managers and senior leaders in Aotearoa New Zealand

Health and safety field guide 1
Edition 2.3
Published 27 October 2026

A night on the wharf

In the early hours of 30 August 2020, a port worker was lashing containers on a ship at Ports of Auckland.

A crane was lifting two containers at once. One twist lock had not been undone, so a third container beneath came up at one corner. It came loose and fell on him. He died.

Maritime New Zealand charged the port company. It also charged the port's chief executive, Mr Gibson, in person. In November 2024 a judge found him guilty of failing in his duty as an officer. The High Court upheld that verdict in March 2026. The law expects leaders to know the serious risks, and to check that the controls really work.

What the wharf shows

The people who set budgets, systems and priorities shape what happens on a ship in the middle of the night.

Why this guide starts here

Much of what keeps people safe is decided far from the work: what you buy, how you staff, what you measure and what you check.

This guide sets out the ideas behind all 14 field guides. Page 18 tells what the courts found in Mr Gibson's case.

A note from Mick

Kia ora! I hope you find these field guides useful. The idea of a pocket sized reference book was inspired by combining two ideas from my early working life. The first is something called a Zeus book, which every engineer had as a reference, and the second was my apprentice log book. The first was a tiny technical encyclopedia of data tables, and my log book was a badly illustrated record of my work. I hope this series sparks curiosity and starts conversations. Enjoy!

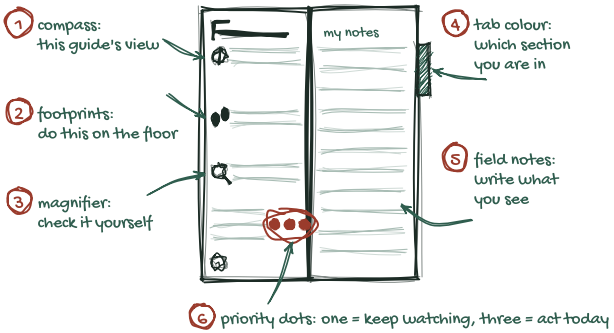
Mick, Vimes Consulting

A death at work is never only about the last few seconds. It is also about the months of decisions before them.

Sources *Gibson v Maritime New Zealand* [2026] NZHC 813 at [2], [4], [32] to [36].

How to use the field guides

These guides are built like a naturalist's field guide: short, practical, and made to be carried, used and written in. There are 14. This one explains the ideas the other 13 build on.



Who it is for

Senior leaders who shape how the organisation is run, and **middle managers** who turn plans into work.

How to use it

Read it at your own pace and use it as a reference. Take the walk on page 13 and the card on page 28 onto the floor. Key words are explained on page 29.

Finding your way

Before you start	2
The duty	5
Managing risk	11
Good practice	15
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Key words and sources	29

About this guide "The Act" means the Health and Safety at Work Act 2015, "s" means section and "ss" means sections. "Risk Regulations" means the Health and Safety at Work (General Risk and Workplace Management) Regulations 2016. "The Amendment Act" means the Health and Safety at Work Amendment Act 2026 (2026 No 38). This guide gives general information, not legal advice. Check the current law at legislation.govt.nz before you rely on it. Written to the plain language standard in the Plain Language Act 2022 (s 5).

What leading health and safety means

Leading health and safety is less about rules, and more about the decisions you make every day.

The strongest protections come from choices about design, buying, layout, contracts, staffing and targets. Leaders make those choices, not frontline workers. So some of the most important safety work happens in a meeting room.

The ideas below run through all 14 guides. Page 31 maps the series, so you can see which guide to read when.

Eight ideas behind this series

1. **Know who holds which duty.** Many people hold more than one. Page 5.
2. **Do what is reasonably practicable,** not what is convenient. Page 7.
3. **Remove the risk first.** Rules and protective gear come last. Page 11.
4. **Put critical risks first:** the ones that could kill someone. Page 12.
5. **Listen to the people doing the work.** Page 15.
6. **Check that controls work.** Don't assume. Page 16.
7. **Learn when things go wrong,** without looking for someone to blame. Page 17.
8. **Change your approach as the work changes.** Page 19.

Start from respect

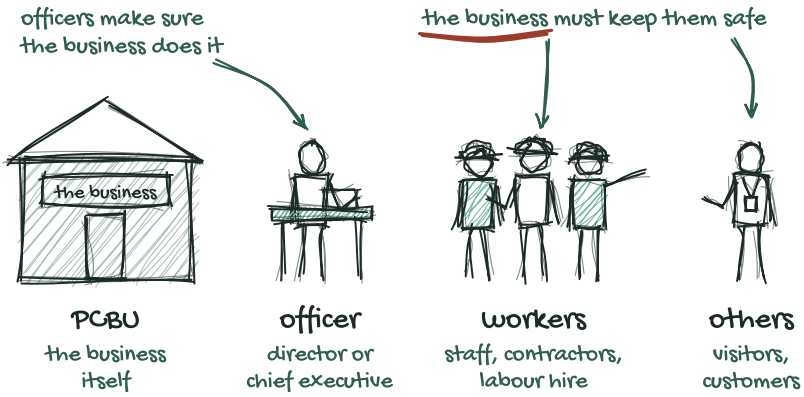
Workers are not a problem to be fixed. They usually see a risk first, and often know the best fix. People want to go home safe, and want their workmates to as well. Good leaders make that easier.

Reading these pages

- A taped card with footprints: something to try at work
- A small compass: the sentence or point after it is this guide's view
- A pink box with a red edge: what changes from 1 April 2027
- The foot strip: sources. Untinted tables, sketches and checklists are this guide's own
- A hatched edge with a compass: this guide's own view
- A tinted box: the law, WorkSafe guidance or court facts
- A dark box: this guide's lessons from a court case
- Priority dots (this guide's rating): one means watch, three means act today

One workplace, many duties

The Act gives duties to roles, not job titles.



The business, which the law calls a PCBU (s 17), carries the main duty. Officers, such as directors, make sure it does (s 18). Workers, including contractors (s 19), and others at the workplace take reasonable care.

Duties overlap: several people can hold the same duty, and each must meet it (s 33). No one can hand their duty to someone else (s 31).

If you share a site with other businesses, you must consult, cooperate and coordinate with them (s 34). Field guide 3 covers this.

If you are a middle manager

You are usually a worker, not an officer. But the organisation meets its duty through you: you plan, staff and supervise the work, and often hear first when something is wrong.

If you are a senior leader

If you can strongly influence how the business is run, you are probably an officer, with a personal duty of due diligence. The Act names chief executives as an example.

Sources the Act, ss 17 to 19, 31, 33, 34, 36, 44 to 46.

The organisation's main duty

The organisation must keep its workers healthy and safe while they work, so far as is reasonably practicable. This includes workers it influences or directs, such as contractors. Its work must not put other people at risk either.

s 36(1) to (2)

So far as is reasonably practicable, the organisation must provide s 36(3)

a a work environment without risks to health and safety

b safe plant and structures

c safe systems of work

d safe use, handling and storage of plant, substances and structures

e adequate welfare facilities for workers, such as toilets, drinking water and first aid, and access to them

f the information, training, instruction and supervision people need to stay safe

g monitoring of workers' health and workplace conditions, to prevent injury and illness

Three points leaders often miss

- **Treat health as seriously as safety.** In the Act, health means physical and mental health. **s 16**
- **Count influence, not just employment.** The duty covers contractors and labour hire whose work you influence or direct. **s 36(1)(b)**
- **Keep the duty yourself.** You cannot hand it to someone else. Several organisations can hold the same duty at once, and each must meet it. **ss 31, 33**

> **From 1 April 2027**
>
> Critical risks come first. Page 10 explains the change.

Sources the Act, ss 16, 31, 33, 36.

What "reasonably practicable" means

Most duties in the Act include the words "so far as is reasonably practicable". This does not mean "whatever is convenient". It means what you can reasonably do once you have weighed up everything that matters. **s 22**

The law asks you to weigh five things

What the Act says to consider	The question to ask
How likely the hazard or risk is to happen	How often could this happen here?
How much harm it could cause	If it happens, how bad could it be?
What you know, or should reasonably know, about the hazard and how to remove or reduce it	What would a well-informed leader in our industry know?
What ways exist to remove or reduce the risk, and whether they suit the work	What controls are there, and do they fit our work?
Only after weighing those: the cost, and whether it is grossly out of proportion to the risk	Is the cost clearly far greater than the risk justifies?

How to read the test

- **Look at cost last.** Weigh cost only after you understand the risk and the controls available.
- **Find out what you should know.** Not knowing is no defence if a reasonable person in your role would have found out. WorkSafe expects you to look at industry standards, its own guidance and what others in your industry do. But common practice is not automatically enough.
- **Do more when the harm could be worse.** In WorkSafe's words, "the greater the potential harm, the greater the action required".

Sources the Act, s 22; WorkSafe, *Reasonably practicable* (updated July 2025).

Officers: due diligence

Officers must take reasonable steps to make sure the organisation meets its duties. They must take the care a reasonable officer would take in the same position. **s 44(1) to (2)** The duty is personal. An officer can be convicted whether or not the organisation is. **s 50**

Today: reasonable steps include s 44(4)	**From 1 April 2027: reasonable steps new s 44(5)**
(a) to learn about, and keep up to date on, work health and safety	**(a) Understand** and keep up to date with: how the organisation operates the hazards and risks of that work health and safety as it applies to the organisation
(b) to understand how the organisation operates, and its hazards and risks	
(c) to make sure the right resources and processes are available and used to remove or reduce risks	**(b) Resource:** make sure the organisation has and uses the right resources and processes can receive, consider and respond in time to information about incidents, hazards and risks has and uses processes to meet its duties
(d) to make sure there are processes to receive and consider information about incidents, hazards and risks, and to respond quickly	
(e) to make sure there are processes to meet the organisation's duties, and that they are used	
(f) to **check** that the resources and processes in (c) to (e) are provided and used	**(c) Check** that those resources and processes are provided and used

What changes for officers

- Most of the ground stays, grouped as understand, resource and check. But (a) narrows from health and safety in general to health and safety as it applies to your organisation.
- If an officer also does another job in the business, the officer duty covers only the officer role. The reasonable officer standard in s 44(2) stays.

Sources the Act, ss 44, 45, 50; Health and Safety at Work Amendment Act 2026 (new s 44(5)); WorkSafe, *Understanding the changes to health and safety law* (July 2026). The right-hand column follows the Amendment Act, new s 44(5).

Other duties every organisation has

Duty	What you must do	Where
Involve workers	Share information with workers and give them a fair chance to have their say before you make decisions that affect their health and safety	**ss 58 to 60**
Let workers take part	Have ongoing ways for workers to help improve health and safety	**s 61**
Work with other organisations	Consult, cooperate and coordinate with every other organisation that shares a duty with you	**s 34**
Report serious events	Tell WorkSafe or the relevant regulator as soon as possible after a death, a notifiable injury or illness, or a notifiable incident	**ss 23 to 25, 56**
Leave the scene alone	Don't disturb the site until an inspector says you can. You may still help an injured person, make the site safe, or act as police or an inspector direct	**s 55**
Keep records	Keep a record of each notifiable event for at least five years from when you told the regulator	**s 57**

If a duty is broken: offences and maximum fines

Offence	Organisation	Officer, or self-employed person	Other individual, such as a worker
Reckless conduct that exposes someone to risk of death or serious injury or illness **s 47**	$3 million	$600,000, 5 years' prison, or both	$300,000, 5 years' prison, or both
Failing a duty in a way that exposes someone to risk of death or serious injury or illness **s 48**	$1.5 million	$300,000	$150,000
Failing a duty **s 49**	$500,000	$100,000	$50,000

Sources maximum penalties set in the Act, ss 47 to 49, as summarised in WorkSafe's fact sheet *Offences and penalties under the Health and Safety at Work Act 2015*.

Note You cannot insure against a fine. **s 29** Courts can also order costs, adverse publicity, restoration, a health and safety project, or training. **ss 152 to 158**

The law from 1 April 2027

The Amendment Act starts on 1 April 2027. It became law on 9 July 2026. Until then, the Act applies as it is.

Critical risks come first

The Act's main purpose becomes managing critical risks first. A critical risk is linked to a hazard listed in new Schedule 1A, such as working at height, asbestos or cranes. Or it is linked to a hazard likely to cause death, a notifiable injury, illness or incident, or a listed occupational disease (new s 22A).

Large and small businesses

A small PCBU has fewer than 20 workers. If numbers go up and down, such as seasonal work, it is small if it expects fewer than 20 in at least nine months of the year (new s 17(3) to (5)). Its main duties then apply only to critical risks, but it must still provide welfare facilities such as toilets and first aid, and put critical risks first in everything else (new s 25A). Larger organisations must manage all risks, with critical risks first.

Officers: understand, resource, check

Due diligence is grouped into three steps. Page 8 sets out both versions side by side.

Getting ready

- [ ] List the work in your organisation that could kill someone.
- [ ] For each item, name the control that matters most, and who checks it.
- [ ] Count your workers, so you know whether you are a small or large PCBU.
- [ ] Brief your board or owners on the three-step officer duty.

Sources Amendment Act 2026 (new ss 17(3) to (5), 22A, 25A, 44(5) and Schedule 1A); WorkSafe, *What is a critical risk?*, *Am I a small or large PCBU?* and *Managing critical risks for small PCBUs* (September 2026).

See also Field guide 6 covers critical risks in full.

Remove the risk first

First, remove the risk if that is reasonably practicable. If you can't, reduce it as far as is reasonably practicable. **s 30** The Risk Regulations set the order to try controls in. **reg 6**



Steps 3 and 4 rely on people getting it right every time. You still need them, but on their own they are the weakest.

Why leaders own this

The strongest controls come from decisions about design, buying, layout, contracts and staffing. If every control on a serious risk is a rule or protective gear, a leader chose that, whether they meant to or not.

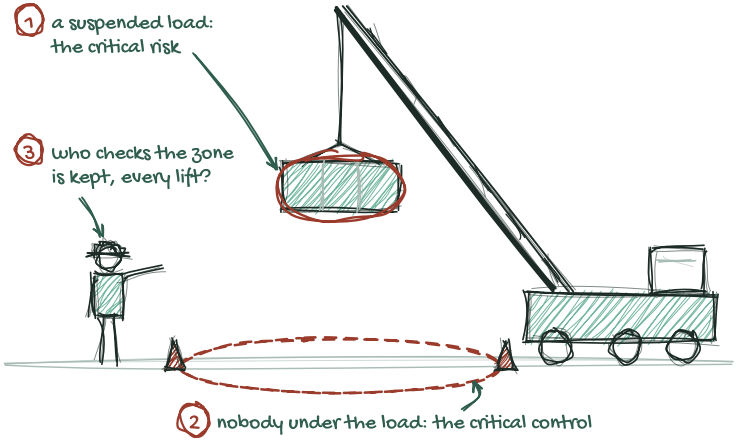
Ask about any serious risk

- [ ] Have we really looked at removing it? Did we record why we can't?
- [ ] How much of our control relies on people following rules perfectly?

Sources the Act, s 30; Risk Regulations, reg 6.

Critical risks and critical controls

Give most of your attention to the few risks that could kill someone. In the *Gibson* case, a suspended load was the critical risk.



Critical risk

From 1 April 2027, the law defines it. A critical risk is linked to a hazard listed in Schedule 1A, or to a hazard likely to cause death or other serious harm (new s 22A). Cranes and lifting are on the list.

Critical control

The law does not define it. This series uses the meaning from ICMM, a mining industry body. It is a control for a fatal hazard that is "crucial to directly preventing an unwanted event or mitigating the consequences of the event".

A test for any critical control

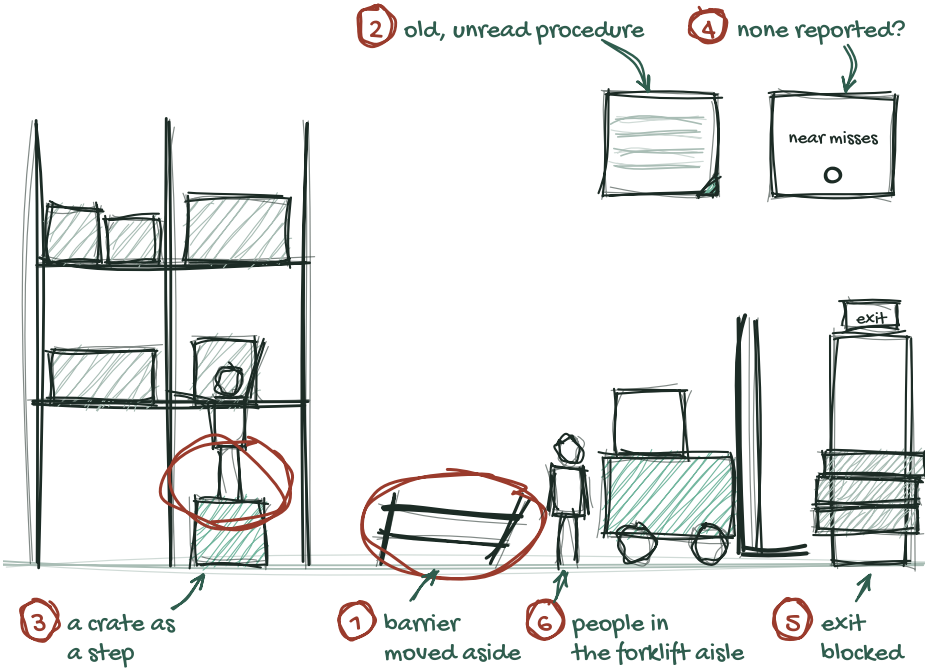
If this control failed tonight, would anyone notice before someone got hurt? If not, find a way to check it.

Sources Amendment Act 2026, new s 22A and Schedule 1A; ICMM, *Critical Control Management Good Practice Guide* (2026), p 6; [2026] NZHC 813 at [73].

See also Field guide 6 covers this in full.

What to look and listen for

You don't need to be an expert to see the gap between the plan and the work. You need to look, ask and listen.



The same habits work on a farm, a building site or in an office. The numbers match the table on the next page.

Listen for

"We've always done it this way." "Just this once." These can mean the work has drifted. So can silence when a manager walks in.

walk it with this page open

Six things to notice

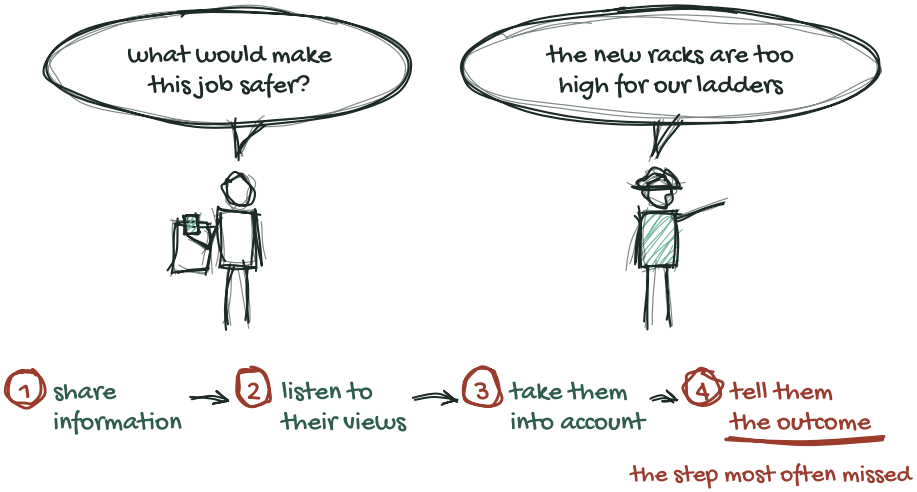
	What it looks like	Why it matters, and what to do	Priority
1	A barrier or guard moved aside.	Someone found it in the way. Put it back first, then ask why and fix the reason.	●●●
2	An old procedure on the wall that nobody reads.	The written way and the real way may have drifted apart. Ask someone to show you how the job is really done.	●●○
3	A crate, chair or pallet used as a step.	The right gear is missing, too far away or too slow to get. Ask what would make the safe way the easy way.	●●●
4	A near-miss board that shows none.	Silence is not safety. Reporting may feel pointless, or people may fear blame. Thank the next person who reports one.	●●○
5	A fire exit blocked by stock or pallets.	A small thing until there is a fire. Clear it now. Then ask who checks the exits.	●●●
6	People walking where forklifts drive.	Where people and moving vehicles mix, one mistake can kill. Check walkways are marked and used. Field guide 7 covers this.	●●●

Try it this week

Walk one area for ten minutes with this page. Find what matches. Then ask the person who works there what they would fix first. They usually know something you missed.

Listen to the people doing the work

The people doing the work see the risks first. Involving them is the law, and it is also the best source of safety ideas you have.



So far as is reasonably practicable, you must engage with workers on health and safety matters that affect them (s **58**). Engaging means four things. Share information in good time. Give people a fair chance to have their say and help decide. Take their views into account. Tell them the outcome (s **59**). You must also have ongoing ways for workers to take part (s **61**).

Words to use

"What would make this job safer?" "What gets in your way?" "I can't fix that this month. Here's why, and here's what we'll do meanwhile."

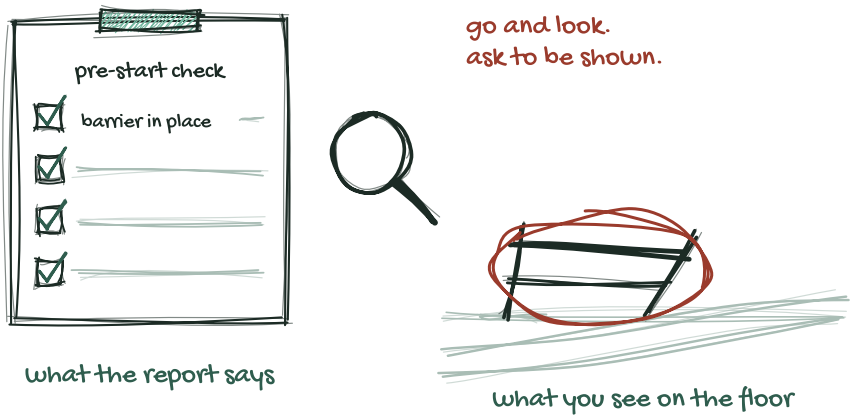
The last answer matters most. People stop speaking up when nothing comes back.

Sources the Act, ss **58**, **59**, **61**.

See also Field guide **4** covers worker voice in full.

Check, don't assume

A control on paper is not always a control on the floor. Officers must check that resources and processes are provided and used, not just trust that they are. **s 44(4)(f)**



Three ways to know

- **Read the reports,** and ask what they can't tell you.
- **Ask people to show you,** not just tell you.
- **Go and see the work,** more than once and at different times of day.

In the *Gibson* case, the court found the chief executive was on notice that the port was struggling to monitor how work was really done. **[73]**

When nobody can show you

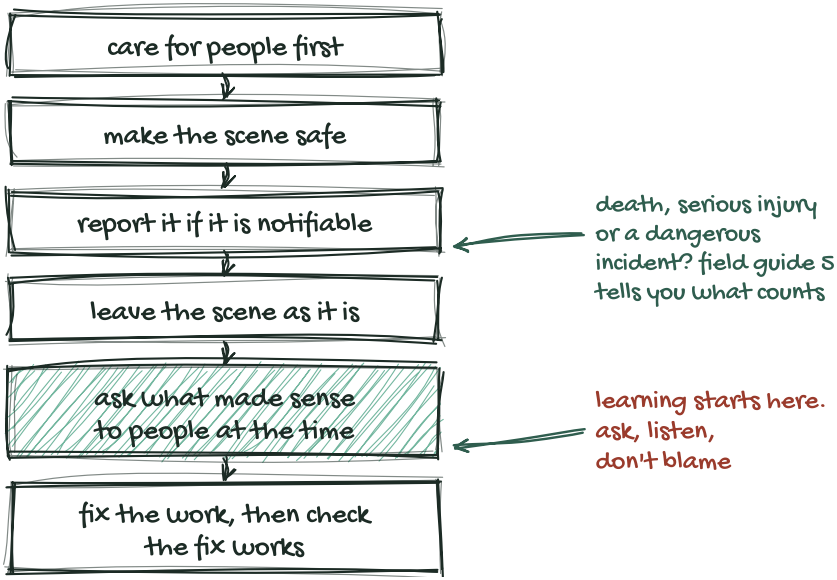
If nobody can show you the last time a critical control was checked, that is your answer.

Sources the Act, s 44(4)(f); [2026] NZHC 813 at [73].

See also Field guide 2 covers checking in full.

Learn when things go wrong

One day something will go wrong. What you do in the first hours, and in the weeks after, shows everyone what you value.



After a death or other notifiable event, tell WorkSafe or the relevant regulator as soon as possible (s 56). Leave the scene alone until an inspector says you can. You may still help someone, make the site safe, or follow police or inspector directions (s 55). Keep a record for at least five years (s 57).

Ask what made sense

Start from the view that people did what made sense to them at the time, with the tools, time and information they had. Find out what that was. Then change the work, so the next person is not set up to fail.

Sources the Act, ss 23 to 25, 55 to 57.

See also Field guide 5 covers incidents in full.

Lessons from *Gibson v Maritime NZ*

Mr Gibson was the port's chief executive when the worker on page 2 died.



30 August 2020
A port worker is killed on a ship at Ports of Auckland.

November 2024
A judge finds Mr Gibson guilty of failing to exercise due diligence as an officer (ss **44** and **48**).

February 2025
He is fined $130,000 and ordered to pay $60,000 in costs.

31 March 2026
The High Court dismisses his appeals against conviction and sentence.

What the court found

- A chief executive need not be across every operational policy, and can reasonably rely on others. But "reasonable conduct for the most part does not excuse unreasonable conduct in another part". **[95], [100], [157]**
- He was "fully aware of the critical risk of handling suspended loads". He knew the port relied on "behavioural controls", but "failed to turn his mind" to direct, physical ones. **[73]**
- The test is whether a reasonable officer in the same position would have taken further steps. "Reasonable" does not mean perfect. **[157] to [158]**

“failed to turn his mind”

[2026] NZHC 813 at [73]

Five lessons for leaders

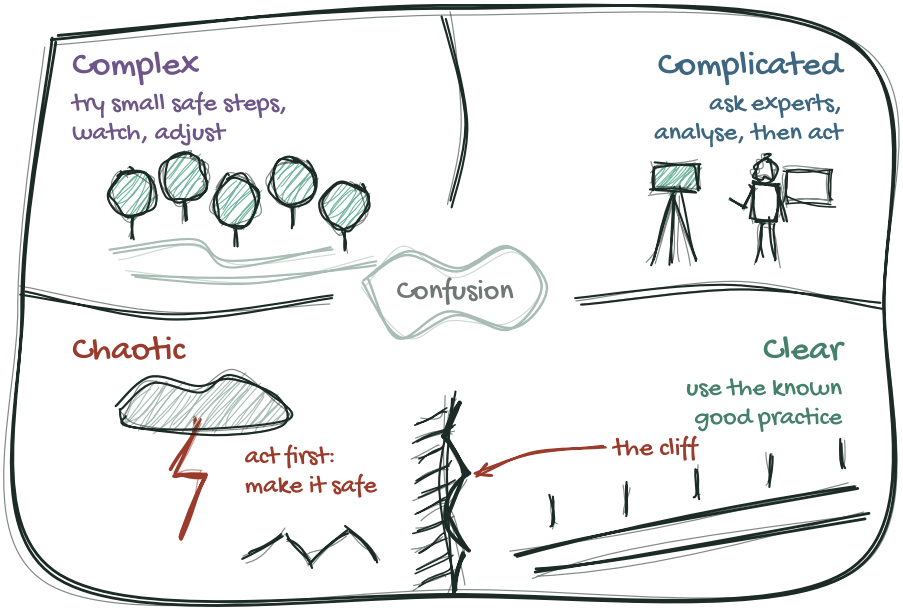
- **Know your critical risks** and every part of how they are controlled.
- **Test what you rely on,** especially things you don't fully understand.
- **Watch how work is really done,** not only how it is written down.
- **Act on warning signs,** and follow actions through. A delay is a decision.
- **Don't let good work elsewhere hide a gap** in a critical risk.

Sources *Gibson v Maritime New Zealand* [2026] NZHC 813. Numbers in square brackets are paragraphs of the judgment.

Same duty, different work

The law asks what is reasonably practicable in the circumstances. Part of the circumstances is how well anyone understands the work.

Cynefin (say "kuh-NEV-in", Welsh for "habitat") is a way to make sense of a situation. It sorts situations by how clearly you can link cause and effect. This series uses it to help you match your approach to the work.



No situation is better than another. Trouble starts when you use the wrong approach. Think of a checklist for work that is really Complex, or a long analysis in the middle of an emergency.

Sources Snowden and Boone (2007); Snowden and Friends (2021).

Note "Clear" was once called "Simple", then "Obvious". "Confusion" is also called "Disorder".

Meeting the duty in each situation

Situation	What the work looks like	How leaders meet the duty	The trap
Clear	Routine, stable, well understood. Same plant, same crew, same conditions.	Standardise. Make the safe way the easy way. Check procedures match how work is really done.	Assuming people follow a procedure because it exists.
Complicated	Technical work where experts can find the answer, such as plant design or electrical work.	Use competent experts. Follow the order of controls. Weigh the five matters in s 22 and record your reasons.	Endless analysis, or experts who don't listen to frontline workers.
Complex	Many parts that affect each other: several contractors, changing sites, fatigue, new technology.	Keep critical controls fixed. Try small, safe changes with workers. Watch what happens, then do more of what works. Involve workers closely (ss 58 to 61).	Writing yet another procedure for a problem procedures can't fix.
Chaotic	An emergency or crisis, such as a serious incident, fire, collapse or natural disaster.	Act to stabilise: stop work, make it safe, help people, call for help. Then report the event (s 56) and leave the scene alone (s 55).	Holding a meeting before acting, or staying in command mode afterwards.
Confusion	You don't know which situation you are in, or people disagree.	Break the problem into parts and place each part in a situation. Ask the people doing the work.	Falling back on your favourite approach.

The s 22 test asks what you know, or should reasonably know. Officers must make sure the business has ways to take in information about incidents, hazards and risks, and to respond in good time. **ss 22, 44(4)(d)**

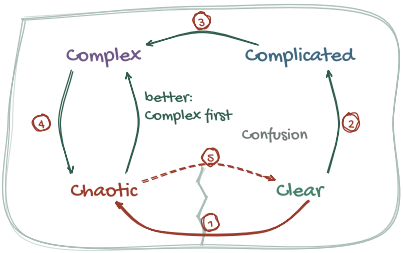
Why this matters

In Clear work, good practice is known and published, so we read the standard as high and specific. In Complex work, less can be known in advance. So "reasonable" leans more on **watching closely, learning fast and responding quickly**.

Sources Snowden and Boone (2007); the Act, ss 22, 44, 55, 56, 58 to 61.

The edges: where harm happens

Snowden describes the boundaries between situations as thresholds you cross, not gentle slopes. Harm comes when the work crosses one and the way it is managed stays the same.



1 Clear to Chaotic: the cliff

Snowden and Boone warn that "success has bred complacency", and that this shift "can bring about catastrophic failure". Small changes to how work is done slowly become normal. Nobody notices, because nothing has gone wrong. Safety researcher Jens Rasmussen called this a "systematic migration of organisational behaviour toward accident".

2 Clear to Complicated: the job has quietly changed

New plant, a new site or a new crew. The old procedure no longer fits.

3 Complicated to Complex: analysis stops working

Expert fixes cause side effects. A control works on one site and fails on another.

4 Complex to Chaotic: losing control

Fatigue, short staffing or a failed critical control. Events pile up faster than people can think.

5 Chaotic to Clear: the wrong way out

Strict new rules can push problems out of sight. Move to Complex first and learn. Then standardise what is stable.

Sources Snowden and Boone (2007), p 3; Snowden (2017); Rasmussen (1997).

Signs worth a closer look

Changes rarely announce themselves. They show up as small signs, usually to the people closest to the work. None of these proves a problem. Each is worth a question.

What you might see or hear	Possible shift	What to do	Priority
Work often differs from the procedure. Audits look perfect, but few near misses are reported.	Clear toward Chaotic	Go and see the work. Treat differences from the procedure as information about the work.	●●●
More "one-offs". New plant, site, client or product.	Clear to Complicated	Bring in the right expertise. Reassess the risk before work carries on.	●●○
Experts disagree. Fixes cause new problems. Results differ between crews.	Complicated to Complex	Hold critical controls steady. Try small changes with workers and watch closely.	●●○
Fatigue and overtime rising. Critical controls not in place "just this once".	Complex to Chaotic	Pause the work. Restore critical controls and resources. Escalate now.	Act now
People argue about what kind of problem it is.	Confusion	Split the problem into parts. Ask which parts are known, which need experts, and which are uncertain.	●○○

The surprise test

At your next site visit, ask: "What surprised you this week?" If nobody has an answer, either nothing changed, or nobody is telling you. Both are worth knowing.

Leading on an ordinary Tuesday

It is Tuesday morning. A delivery is late, two people are off sick, and a contractor you haven't met is waiting at the gate. Nothing is on fire. This is when leading happens.

Before work starts

- [ ] Ask "What has changed since yesterday?" and listen to the small answers.
- [ ] Check the critical controls for today's work are in place.
- [ ] Brief new people and contractors before they start.

While work is happening

- [ ] Walk the work. Look for the gap between the plan and what people do.
- [ ] Back anyone who stops a job because it doesn't feel right.
- [ ] Notice when the pace or the pressure changes.

Afterwards

- [ ] Thank people for bad news. Early warnings are the most useful thing you can get.
- [ ] Tell people what happened to the concerns they raised.
- [ ] Pass up anything you can't fix, clearly enough for someone to act on.

What to say

"If something doesn't feel right, stop the job and tell me. You won't get in trouble for it." Say it often, and back people when they do.

Going further: learning to read the work

You don't need a framework to lead well. But leaders who can read the situation in front of them make better calls.

Practise this month

- [ ] **Sort five jobs.** Pick five jobs in your area. Which situation is each one in today? Ask the crew where they would put them. Talk about any differences.
- [ ] **Keep a surprise log.** Each week, write down one thing that surprised you at work. After a month, look for patterns. Surprises are often the first sign the work has changed.
- [ ] **Watch for a threshold.** Before a change in plant, crew, site or workload, ask: "Will the way we manage this still fit afterwards?"
- [ ] **Try one small, safe experiment.** In Complex work, try one small change with the people doing it. Agree what you will watch for, and when you will stop.

To read more

- **Snowden and Boone (2007).** "A leader's framework for decision making". A short, readable introduction to the situations, written for managers.
- **Snowden and Friends (2021).** *Cynefin: Weaving sense-making into the fabric of our world*. The current names, and how people use the framework.
- **Rasmussen (1997).** Why work drifts toward the edge of safe performance, one sensible adjustment at a time.
- **Kurtz and Snowden (2003).** The original academic paper behind the framework.

One way among several

Cynefin is one way to think about context. Others look at the gap between work as planned and work as done, or at how work drifts over time. Use whichever helps you and your people see the work more clearly.

See also Full details of each reading are on page 30.

Take these to your next meeting

Senior leaders and officers

- [ ] Can I name our critical risks, and the critical controls for each?
- [ ] How do I know those controls work, not just that they are written down?
- [ ] What do I hear about incidents and near misses? How quickly do we act?
- [ ] Are restructures, budgets or contracts quietly cutting health and safety resources?
- [ ] Where do I rely on others? Have I tested that?
- [ ] Which parts of our work are Complex rather than Clear? Do we manage them that way?
- [ ] Are we ready for the changes on 1 April 2027?

Middle managers

- [ ] Is work in my area done the way our procedures say? Where is it different, and why?
- [ ] What has changed lately: people, plant, sites, contractors or workload?
- [ ] Can workers raise concerns, and stop unsafe work, without getting in trouble?
- [ ] Which other organisations share duties for this work? How do we coordinate?
- [ ] What warning signs am I seeing that senior leaders are not?
- [ ] When I pass a problem up, is it clear enough to act on?
- [ ] Would everyone know what to do first after a serious incident?

Which of our critical controls have I seen working with my own eyes this month?

Field notes

ideas for this page:

- one thing you saw that surprised you
- a gap between the plan and the work
- something a worker told you
- which situation is this work in?
- what you will check next time

→ write it down here

Field notes

Back of your pocket card (page 28)

My critical risks here:	Who to call:

Pocket card

Cut out and fold in half.

On a site walk

1. What has changed?
2. What here could kill someone?
3. What stops that happening? Show me.
4. What gets in your way?
5. What would you fix first?

Thank people for bad news.

Which situation?

1. **Clear:** use the known good practice.
2. **Complicated:** ask experts, then act.
3. **Complex:** try small safe steps, and watch.
4. **Chaotic:** act first. Make it safe.
5. **Confusion:** break it into parts.

Watch the cliff from Clear to Chaotic.

Sources Card text from pages 12 to 15 and 20 to 23. Field guide 1, Vimes Consulting.

Key words

The words this series uses most, in plain English.

Word	What it means
PCBU	A "person conducting a business or undertaking". Usually the organisation itself, such as a company, council or trust. s 17
Officer	A director, partner, or anyone with significant influence over how the business is run, such as a chief executive. s 18
Worker	Anyone who works for a PCBU: employees, contractors, labour hire, apprentices and volunteer workers. s 19
Health	Physical and mental health. s 16
Hazard and risk	A hazard is something that could cause harm. The risk is how likely that harm is, and how bad it could be.
Control	Something that removes or reduces a risk, such as a guard, a barrier or a safe way of working.
Reasonably practicable	What you can reasonably do, once you weigh up the risk, what you know, and the controls that exist. s 22
Due diligence	The reasonable steps an officer must take to make sure the PCBU meets its duties. s 44
Critical risk	From 1 April 2027, a risk linked to a hazard the law lists, or to one likely to cause death or other serious harm. Page 12.
Critical control	The control that matters most for a risk that could kill. Not a legal term. Page 12.
Notifiable event	A death, a notifiable injury or illness, or a notifiable incident. You must tell the regulator. ss 23 to 25
Cynefin	A way to make sense of a situation. Say "kuh-NEV-in". Pages 19 to 24.

Sources the Act, ss 16 to 19, 22 to 25, 44; Amendment Act 2026, new s 22A.

Check it yourself

How this guide was checked

Every statement of law or fact in this guide was checked against a primary source before printing: the Act or regulations, the Amendment Act 2026 as passed, WorkSafe guidance, or the court judgment. Each check is recorded in a claims register, with the source and date checked. Statements that could not be checked were removed. Facts checked on 11, 22, 23 and 24 October 2026.

Law and court decisions

1. Health and Safety at Work Act 2015, ss 16 to 19, 22 to 25, 29 to 31, 33, 34, 36, 44 to 50, 55 to 61, 152 to 158. legislation.govt.nz
2. Health and Safety at Work (General Risk and Workplace Management) Regulations 2016, reg 6.
3. Health and Safety at Work Amendment Act 2026 (became law on 9 July 2026): new ss 17(3) to (5), 22A, 25A, 44(5) and Schedule 1A.
4. Plain Language Act 2022, s 5.
5. *Gibson v Maritime New Zealand* [2026] NZHC 813 (31 March 2026). courtsofnz.govt.nz

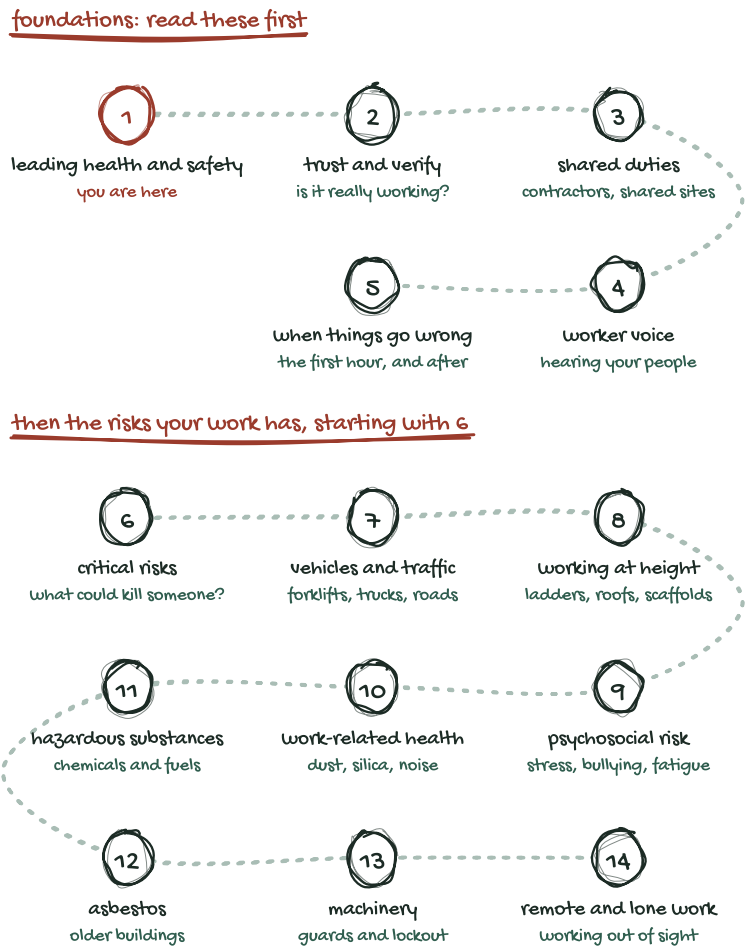
Guidance

6. WorkSafe. *Reasonably practicable* (July 2025); *Offences and penalties under the Health and Safety at Work Act 2015* (fact sheet); *Understanding the changes to health and safety law*, *What is a critical risk?*, *Am I a small or large PCBU?* and *Managing critical risks for small PCBUs* (July to September 2026). worksafe.govt.nz
7. ICMM (2026). *Critical Control Management Good Practice Guide*, p 6. icmm.com

Research

8. Snowden, D. J., and Boone, M. E. (2007). A leader's framework for decision making. *Harvard Business Review*, 85(11), 68 to 76.
9. Kurtz, C. F., and Snowden, D. J. (2003). The new dynamics of strategy. *IBM Systems Journal*, 42(3), 462 to 483.
10. Snowden, D. (2017). *Liminal Cynefin*. thecynefin.co
11. Snowden, D., and Friends (2021). *Cynefin: Weaving sense-making into the fabric of our world*. Cognitive Edge, The Cynefin Co.
12. Rasmussen, J. (1997). Risk management in a dynamic society: a modelling problem. *Safety Science*, 27(2 to 3), 183 to 213.

Which guide to read when



1 Leading health and safety · 2 Trust and verify · 3 Shared duties · 4 Worker voice · 5 When things go wrong · 6 Critical risks and critical controls · 7 Vehicles, mobile plant and traffic · 8 Working at height · 9 Psychosocial risk and mental health · 10 Work-related health · 11 Hazardous substances · 12 Asbestos · 13 Machinery, plant and energy isolation · 14 Remote, isolated and lone work

Sources

Leading health and safety in one minute

- Duties follow roles, not job titles. Many people hold more than one.
- Do what is reasonably practicable. Cost comes last.
- Remove the risk first. Rules and protective gear come last.
- Put critical risks first, and check their controls really work.
- Listen to the people doing the work. Always get back to them with an answer, even if it is no.
- Change your approach as the work changes. Watch the edges.

The field guides

1	**Leading health and safety**	8	Working at height
2	Trust and verify	9	Psychosocial risk and mental health
3	Shared duties	10	Work-related health
4	Worker voice	11	Hazardous substances
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Field guide 1, edition 2.3
Published 27 October 2026

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