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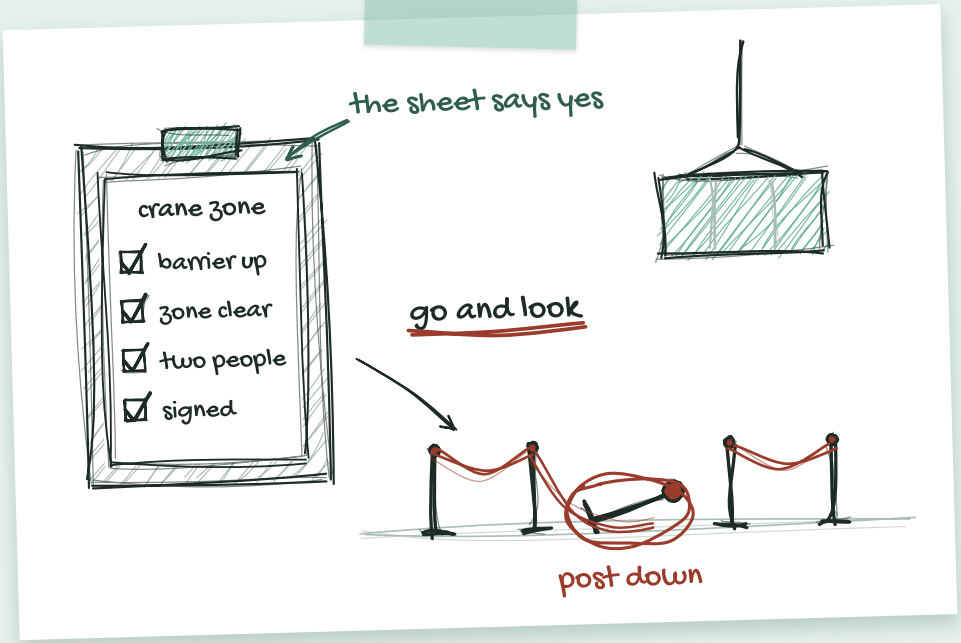
Field guide 2



Trust and verify

How leaders know their health and safety controls really work, and how to check the work people really do.

For middle managers and senior leaders in Aotearoa New Zealand

Health and safety field guide 2
Edition 2.3
Published 27 October 2026

A system on paper

In September 2016, a worker at PBT Transport was unloading freight from a cage lifted on a forklift's forks.

The cage was not correctly attached to the forklift, and it did not meet industry standards. It fell about three metres from the forks, with the worker in it. He suffered back injuries.

PBT Transport had documented safety systems. WorkSafe found they were not applied in day-to-day work. Similar incidents had already happened at other PBT sites, in 2009 and about a month before.

What the story shows

On paper, this risk was managed. On the floor, the system was not in use, and the warnings from earlier incidents had not changed the work. Only someone looking at the work could have seen the gap between the two.

Why this guide starts here

WorkSafe's Simon Humphries said: "If you have a system in place – use it and when things go wrong – learn from your mistakes before another life is put at risk."

This guide is about knowing whether your system is in use: seeing the work, not just the paperwork. The Auckland District Court fined the company $250,000 and ordered $20,000 reparation.

> **A rule that nobody checks on the job is a hope, not a control.**

Sources WorkSafe media release, Forklift incident a reminder for companies to learn from their mistakes (6 December 2018); the Act, ss 36, 48.

About this guide

Who it is for

Senior leaders who need to know, not assume, that the controls on their worst risks work.

Middle managers who do many of the checks, and who see first when the work and the procedure part ways.

How to use it

Read pages 2 to 10 at your own pace. Take the spotting pages (11 and 12) and the pocket card (page 19) on your next site visit. Write what you find on page 18. Key words are explained on page 21.

Field guide 1 explains the ideas behind the series. This guide builds on it.

Finding your way

Before you start	2
The duty	4
The duty in court	6
What good looks like	7
Spotting the gaps	11
Running the checks	13
Questions and notes	18
Key words and sources	21

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

About this guide In this guide, "the Act" means the Health and Safety at Work Act 2015, "s" means section and "ss" means sections. This guide gives general information. It is not legal advice. Written to the plain language standard in the Plain Language Act 2022 (s 5).

The duty to check

The law asks officers, such as directors and chief executives (s 18), to do more than set up a system. They must check that the system is there, and that people use it.

Who	What the law asks
Officers **s 44(4)(c), (e)**	Take reasonable steps to make sure the business has the right resources and processes to manage risk, and uses them.
Officers **s 44(4)(f)**	Take reasonable steps to verify that those resources and processes are there and in use.
Workers **s 45(d)**	Co-operate with reasonable health and safety policies and procedures the business has told them about.

An officer's duty under s 44 is called due diligence: the care an officer must take so the business meets its health and safety duties.

You can rely on others, within reason

The High Court said senior managers "may rely on others where it is reasonable to do so". It also cited Maritime NZ's guidance for officers. Directors and chief executives "need to obtain credible information and follow up and challenge the information they are given where necessary".

If you are a senior leader

Checking is part of your own duty if you are an officer. You need a way to test what you are told, not just to receive it.

If you are a middle manager

Many checks happen through you. Your honest reports are what leaders rely on, so record what you really found.

Sources the Act, ss 44(4), 45(d); *Gibson v Maritime New Zealand* [2026] NZHC 813 at [100] and [162].

Checking in the new law

From 1 April 2027 the officer duty reads more simply, and checking stays at its heart. The Amendment Act became law on 9 July 2026.

The officer duty in three steps

WorkSafe sums up the new officer duty in three steps. Understand the risks. Make sure the business has resources and processes to manage them. Verify that the business uses them. The verify step keeps its wording: "to verify the provision and the use of the resources and processes".

The officer role only

WorkSafe says officer duties "are separate from what an officer does in their role as a worker".

Critical risks first

The law will define critical risk (new s 22A): a risk the law lists, or one likely to cause death or serious injury or illness. Small PCBUs (a PCBU is a "person conducting a business or undertaking", usually an organisation, s 17), with fewer than 20 workers (new s 17(3) to (5)), must manage their critical risks and put them first (new s 25A). So every business needs to know its critical controls work: the controls crucial to stopping a serious event, or to limiting its harm.

Getting ready

- [ ] For each critical risk, write down its main control and what "working" looks like.
- [ ] Name who checks each control, how often, and where the results go.
- [ ] Ask for board papers that show what checks found, not just how many were done.

Sources Health and Safety at Work Amendment Act 2026 (new ss 17(3) to (5), 22A, 25A, 44(5)); WorkSafe, Understanding the changes to health and safety law (July 2026).

The port: what the courts found

In August 2020, a lasher died at the Ports of Auckland when a container fell during a crane lift. Field guide 1 tells the story in full. Maritime NZ charged the port company and its chief executive, Tony Gibson. The charge against him was failing in his due diligence duty as an officer (ss 44 and 48).



August 2020
A lasher dies.

26 November 2024
The District Court finds Mr Gibson guilty.

21 February 2025
Fine $130,000, costs $60,000.

31 March 2026
Conviction and sentence upheld.

The company, Ports of Auckland, pleaded guilty. It accepted it could have avoided letting lashers work near a working crane.

What the High Court said about checking

- As Maritime NZ argued, "verification is essentially assessing whether the processes/system are working".
- His role included reasonable steps to "implement and monitor (and improve where necessary)" the port's processes.
- He should have "verified (monitored and measured) 'work as done' to detect non-compliance, including with the three-container width rule".
- Supervisors did checks each shift, but "it was accepted these checks were not effective".

“it was accepted these checks were not effective”

[2026] NZHC 813 at [127]

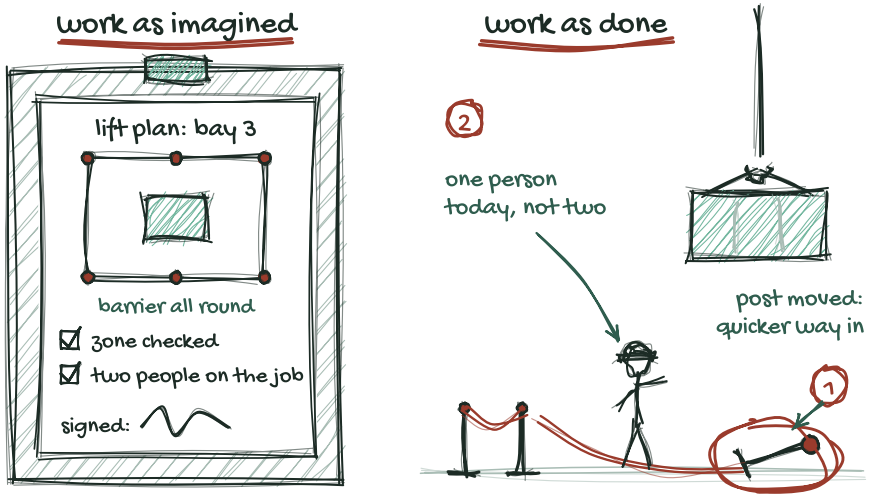
The lesson for leaders

Checks happened, and someone recorded them. They still did not show that people were working alone inside the crane zone. A check that never looks at the work tells you about the form, not the control.

Sources *Gibson v Maritime New Zealand* [2026] NZHC 813 at [1], [4], [6], [37], [38], [40], [127], [161], [164], [165]; Courts of New Zealand case summary (31 March 2026); the Act, ss 44, 48. Numbers in square brackets are paragraphs of the judgment.

Work as imagined, work as done

Safety researcher Erik Hollnagel separates two versions of every job. Checking is about finding the gap between them.



same job, same morning. both are real.

Work as imagined is "the various assumptions, explicit or implicit, that people have about how their or others' work should be done". **Work as done** is "how something is actually done, either in a specific case or routinely".

The two never match exactly. People adjust to real conditions, and much of that keeps work safe. The Institute of Directors (IoD) asks leaders to judge each difference. Is it "helpful and innovative", or "drift that may be unintentionally increasing risk"?

- **Look at the control, not only the form.** A signed plan shows someone filled it in. It does not show the barrier stayed up.
- **Ask why the work differs.** The answer is often a resource, design or planning problem.

Sources Hollnagel, E. (2017), Can we ever imagine how work is done? *HindSight* 25; IoD, Health and Safety Governance (2024), pp 34 to 35.

Start with critical controls

Start with the controls that stand between your people and death or serious harm.

What a critical control is

The International Council on Mining and Metals (ICMM) says a critical control is "crucial to directly preventing an unwanted event" or "mitigating the consequences of the event". If it is missing or fails, the chance or severity of harm rises sharply, "despite the existence of other controls".

A control is not the same as a support activity

Control	Support activity
A physical object or human action that directly prevents the event or limits its harm. You can specify, measure and check it.	Something that helps a control work: procedures, risk assessments, training, maintenance, monitoring.
Example: a physical barrier that keeps people out of a crane's lifting zone.	Example: training on exclusion zones. ICMM says training is "a support activity not the control".

Choosing which controls are critical

- **Ask how much you rely on it.** It may be the only control, or the main one.
- **Ask how reliably it works.** ICMM prefers controls that rely less on people remembering to act.

A quick test

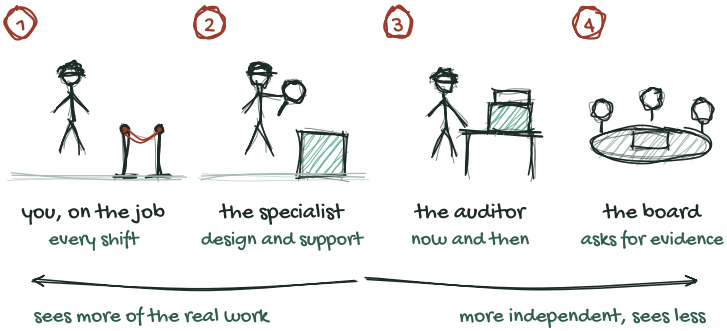
Point to the control. If you can only point to a document, a course or a sign, you have found a support activity. Keep looking for the control it supports.

Sources ICMM (2026), *Health and Safety Critical Control Management Good Practice Guide*, pp 6, 26 to 33.

This guide's view The ICMM method was written for mining and metals, but it suits any critical risk.

Who checks what

Good checking comes from more than one direction. Each checker sees something the others miss. Boards and audit committees often use the Three Lines Model for this.



Who	What they check	Example
You and your team leaders First line	That the control is in place, at the job, while work happens.	A supervisor walks the crane zone at the start of each shift.
The specialist Second line	That the control is well designed, and that its support activities work.	An adviser or engineer reviews the zone layout each quarter.
The auditor Third line: internal audit	That checks happen, find real problems, and lead to fixes.	An audit samples check sheets and visits the zone.
The board Governing body	That the whole system works, using evidence.	Directors ask what checks found, then go and see.

Where one person holds several roles, ICMM says someone else should still check.

Close and far both matter

The further a check sits from the work, the more independent it is, but the less of the real work it sees. Use each for what it does best.

Sources ICMM (2026), pp 38 to 46; The Institute of Internal Auditors, *The IIA's Three Lines Model* (July 2020).

Checking one control, start to finish

ICMM sets out the parts of a good check. Here they are for one control: the barrier round a crane's lifting zone.

Set this up	The question it answers	For the crane-zone barrier
Performance requirement	What does "working" look like?	Barrier all round the zone before any lift. Nobody inside while the crane works.
Verification activity	How, and how often, do we check?	The supervisor walks the zone at the start of each shift and once during it.
Owners	Who is responsible, by name?	The shift supervisor owns the daily check. The operations manager owns the control.
Triggers	What result means we act at once?	Barrier down, or anyone inside: stop lifting until it is fixed.
Response to gaps	What happens when a check fails?	Fix it, record it, find out why it happened, and tell the owner.
Evaluation and reporting	Is the control getting better or worse?	Each month, report what the checks found, not just how many were done.

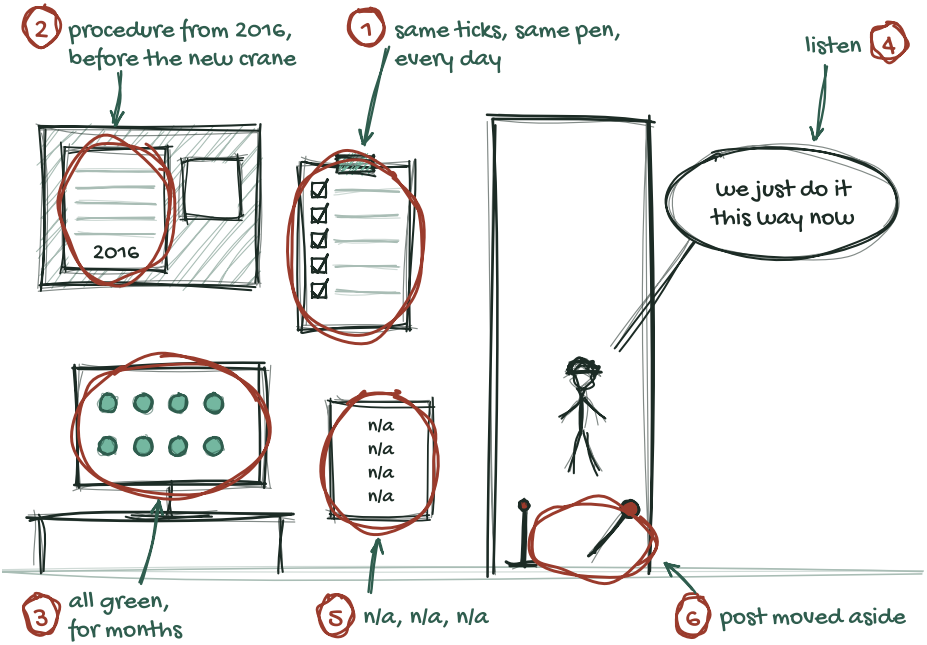
Two kinds of check

- **In-field checks** confirm the control is in place. Any leader can do them, including frontline staff. They happen often, based on risk.
- **System checks** look at design and support activities. They suit control owners and specialists. ICMM gives quarterly, six-monthly or yearly as examples.

Sources ICMM (2026), steps 5 to 9, pp 35 to 53.

What to look and listen for

The gap between the form and the work leaves marks you can see and hear.



None of these proves a problem. Each one is a reason to ask a question.

The numbers match the table on the next page. The scene is a site office, but the same six signs turn up in a warehouse, a ward or a workshop.

Six signs to spot

	What it looks like	Why it matters, and what to do	Priority
1	A check sheet with the same ticks, in the same pen, every day.	The sheet may be filled in away from the control, not at it. Go and look at the control with the person who signs the sheet.	●●○
2	A procedure older than a change in plant, layout or crew.	The checks may test the old job. Ask whether the procedure still fits the work, and update the checks with it.	●●○
3	Indicators that have been green for months.	Green may mean the check looks at the wrong thing. Ask what would turn it red, and when that last happened.	●●○
4	"We just do it this way now."	The work has moved away from the procedure. Ask why, and whether the new way is safer or riskier. Thank the person for telling you.	●●○
5	Lots of "n/a" or "other" on a check sheet.	The check no longer fits the work. Review it with the people who use it.	●○○
6	A barrier, guard or other critical control moved aside while work goes on.	The control is not working right now. Stop the work and put it back. Then ask why it moved.	●●●

Try it on your next visit

Look for each of the six signs, and note where you looked. Then ask the crew which sign they would add.

Reports that tell you the truth

Much of what leaders know about health and safety arrives in a report. A tidy report can hide an untidy job.



The IoD guide warns that injury rates "can be random, non-predictive and not helpful". It asks boards for "narrative as well as numbers", and to "be wary when receiving only positive reports".

Instead of only	Also ask for
Number of lost-time injuries	Critical control checks done on time, and what they found
Number of audits completed	Audit findings on critical risks, and whether the fixes are done
"All actions closed"	Whether the action fixed the problem, checked on the job
Near-miss count	What near misses taught you, and what changed

Sources IoD guide (2024), pp 9, 10, 36.

Go and see the work

Reports tell you about work as imagined. Going to see the work is the most direct way to learn about work as done.

The IoD guide suggests officers visit sites regularly to learn how work normally happens. It suggests one or two officers at a time, so workers see a chance to talk, not an inspection. It also names curiosity as a skill for officers: probing beyond reports, and staying sceptical when reports are always positive.

Making a visit count

- [ ] **Pick one critical risk before you go.** Ask to see its critical control in place.
- [ ] **Ask "show me" rather than "do you".** Let people walk you through the task.
- [ ] **Ask what makes the job hard,** such as time pressure, missing tools or unclear plans.
- [ ] **Ask what would go wrong first** if today went badly.
- [ ] **Hold back your own opinions.** The point is to learn, not to judge.
- [ ] **Go back and report.** Tell people what you did with what they told you.

A New Zealand example: three tiers of checks

Fletcher Building tags each performance requirement by the kind of check it needs. Most are "simple, visible" checks that leaders can do on site at any time (Tier 1). Others are audit-style (Tier 2) or need experts (Tier 3). These happen less often, often at a desk.

Sources IoD, Health and Safety Governance (2024), pp 29, 39 to 41; Fletcher Building, Critical Risks Handbook, version 2.0 (October 2023), p 14.

When the work changes

The same control needs a different kind of check as the work changes. Field guide 1 explains why.

What is happening	How to check
Routine work, settled crew Clear	Simple, frequent checks at the control. Someone else spot-checks now and then.
New plant, new site or a new design Complicated	Get an expert to review the control design. Rewrite the performance requirement and the check.
Many crews or contractors, and results vary Complex	Talk to people. Look for patterns in stories and near misses, not just numbers. Keep checking critical controls as fixed.
A critical control has failed, or someone is hurt Chaotic	Stop the work and make it safe. Confirm the critical controls are back before restarting. Then report and learn (field guide 5).
People disagree about what a check result means Confusion	Go and see together. Agree what "working" looks like for that control.

Clear to Chaotic: the green dashboard

Every indicator has been green for months. The checks confirm the form, not the control. Then something fails that no check was looking at.

Clear to Complicated: checking the old job

New plant or a new layout changes the work, but the checklist still describes the old job. Checks pass because they test the wrong things.

Sources The situation names in colour come from the Cynefin framework (Snowden and Boone, 2007, who called Clear "Simple" and Confusion "Disorder"; current names from Snowden and Friends, 2021).

Note Any of these can be serious. The priority depends on the risk, not the situation.

See also Field guide 1 explains them.

Signs worth a closer look

Check results are also an early warning. Patterns in them can show the work changing before anyone gets hurt.

What you see in the results	What to do	Priority
Checks missed or late because people are too busy.	A missed check is a result too. Treat a missed critical control check as a trigger. Find out what is crowding it out.	●●●
Failed checks with no follow-up, or actions closed without anyone looking.	Act on every failed critical control check. Name who owns the fix, and check it on the job.	●●●
Results differ widely between sites, shifts or crews doing the "same" work.	Ask each crew what is different. Look at how people, plant and contractors interact.	●●○
The same problem comes back after someone closed the action.	The fix treated a symptom. Look for the cause in design, resources or planning.	●●○
Reports arrive weeks after the work.	Problems show up late. Add a quick check on the job that reports within days.	●○○

The same-day test

Take today's check sheet for one critical control. Walk to that control the same day, with the person who signed it. Compare what the sheet says with what you both see. If they match, say so. If they don't, ask what made the sheet easier than the check.

Checking at the front line

It is 6.45 am. The crane-zone check sheet is already ticked for the whole week. You walk over, and one barrier post is lying on the ground. What you do next shows your crew what checking is for.

Do

- [ ] Check the control itself, where the work happens.
- [ ] Vary when you check, so you see the work as it normally is.
- [ ] Record what you really found, including "not checked" and why.
- [ ] Ask workers what makes the control hard to use.
- [ ] Act on a failed critical control check straight away. Then pass it up.
- [ ] Follow up actions on the job, not just in the system.

Avoid

- [ ] Ticking boxes from the office.
- [ ] Rounding results up to look better.
- [ ] Treating a gap as a worker's fault. Look first at design, resources and planning.

Passing bad news up

Say what you found, what you did and what you need. A clear, early warning beats a tidy report.

Field notes

Back of your pocket card (page 19)

My critical risks here:	Who to call:

ideas for this page:

- one control you saw working
- where the form and the job differed
- a number to ask about
- checks missed, and why
- who you thanked for bad news

→ write it down here

Pocket card

Cut out and fold in half.

Checking one control

1. Name the control and what "working" looks like.
2. Go to where the work happens.
3. Ask "show me", not "do you".
4. Look at the control itself, not the form.
5. Record what you found, and what you couldn't check.

A missed check is a result too.

Testing a report

1. Where did this number come from?
2. How was it checked, and by whom?
3. What does it not show?
4. Does it match what I saw on my last visit?

Always green? Ask what would turn it red.

Note Card text from pages 10 to 14. Field guide 2, Vimes Consulting.

Take these to your next meeting

Senior leaders and officers

- [ ] For each critical risk, what is the critical control, and what does "working" look like?
- [ ] How do I know it works on the job, not just on paper?
- [ ] Who checks, how often, and who checks the checkers?
- [ ] Are our indicators always green? If so, why do I believe them?
- [ ] What story sits behind the numbers I see?
- [ ] Do our audits look at critical risks, and are the fixes done?

Middle managers

- [ ] Do my checks test the control, or the paperwork?
- [ ] Do I know the performance requirement for each critical control in my area?
- [ ] Which checks were missed this month, and why?
- [ ] Where does the work differ from the procedure? Is that helpful, or drift?
- [ ] What would I want my manager to know that our reports don't show?
- [ ] Do failed checks lead to action, every time?

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

Notes

Key words

The words people use about checking, in plain English.

Word	What it means
Verify	Check for yourself that something is in place and working. Officers must take reasonable steps to "verify the provision and use" of resources and processes. s 44(4)(f)
Officer	A director or partner, or anyone with significant influence over how the business is managed, such as a chief executive. People who only advise are not officers. s 18
Due diligence	The care an officer must take so the business meets its health and safety duties. s 44
PCBU	A "person conducting a business or undertaking". Usually an organisation. s 17
Critical risk	From 1 April 2027, a risk the law lists, or one likely to cause death or serious injury or illness. new s 22A
Critical control	A control that is crucial to stopping a serious event, or to limiting its harm. If it fails, harm becomes much more likely or much worse.
Support activity	Something that helps a control work, such as training, a procedure or maintenance. It is not the control itself.
Performance requirement	What "working" looks like for a control, written down so anyone can check it.
Work as imagined	The job as the procedure, the plan and the training describe it.
Work as done	The job as people really do it, on the day.

Sources the Act, ss 17, 18, 44; Amendment Act 2026, new s 22A; ICMM (2026), pp 6, 26 to 35; Hollnagel (2017).

See also Field guide 6 explains critical risk in full.

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, the Amendment Act 2026 as passed, the court judgment, or the published guidance itself. 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, 17, 22, 23 and 24 October 2026.

Law and court decisions

1. Health and Safety at Work Act 2015, ss 17, 18, 44, 45, 48. legislation.govt.nz
2. Health and Safety at Work Amendment Act 2026 (became law on 9 July 2026): new ss 17(3) to (5), 22A, 25A, 44(5).
3. Plain Language Act 2022, s 5.
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11. Snowden, D. J., and Boone, M. E. (2007). A leader's framework for decision making. *Harvard Business Review*, 85(11), 68 to 76. The source of the situation names on page 15.
12. Snowden, D., and Friends (2021). *Cynefin: Weaving sense-making into the fabric of our world*. Cognitive Edge, The Cynefin Co. The current situation names.

Where next

Other guides that help

Checking touches every guide in the series.

Guide	Read it for
1	Leading health and safety: who has which duty, and why the same task needs a different approach in different situations.
3	Shared duties: how to check the controls a contractor runs on your site.
4	Worker voice: the people doing the job will tell you what your checks miss, if you ask well.
5	When things go wrong: what to do when a critical control fails, and how to learn from it.
6	Critical risks and critical controls, in full.

The whole series

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

Trust and verify in one minute

- A rule on paper is not a control in place. Go and look.
- Start with critical controls, and know what "working" looks like for each.
- Check the control itself, at the job, while the work happens.
- Treat a missed or failed check as a result, and act on it.
- Ask for the story behind the numbers, especially when everything is green.
- Officers must verify, now and from 1 April 2027 (s 44).

The field guides

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
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