When things go wrong, in one minute

- People first. Then make it safe. Then keep the scene.
- A death: phone WorkSafe now on 0800 030 040, any hour.
- Nobody hurt can still be notifiable. If in doubt, report it.
- Photograph before anything moves. Keep records for five years.
- Ask what made sense at the time, not who is to blame.
- A fix you can't find on site is a lesson not yet learned.

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
5	**When things go wrong**	12	Asbestos
6	Critical risks and critical controls	13	Machinery, plant and energy isolation
7	Vehicles, mobile plant and traffic	14	Remote, isolated and lone work

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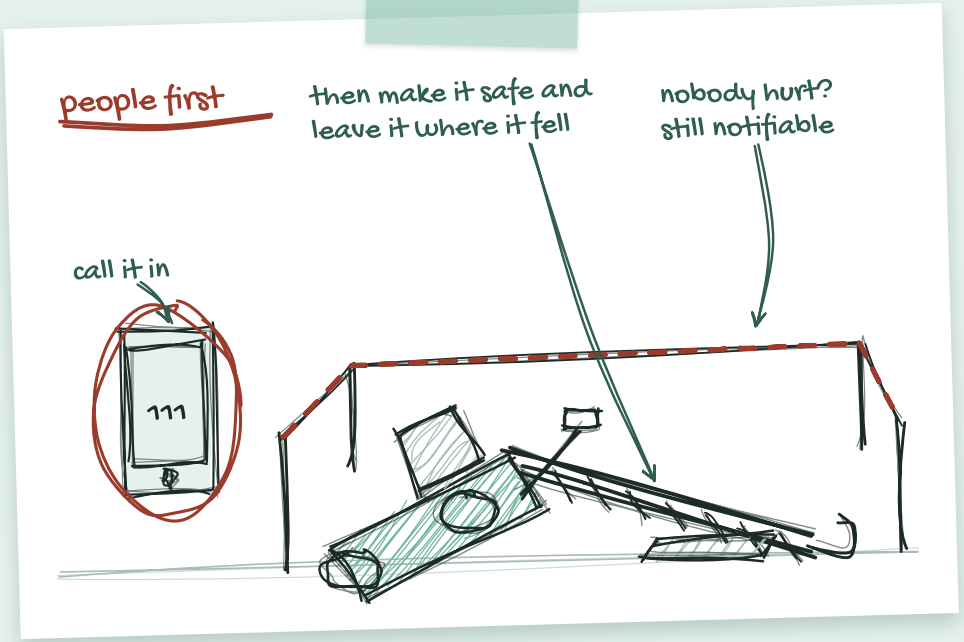
Field guide 5



When things go wrong

What to do in the first hour after an incident, when to tell WorkSafe, and how to learn from what happened.

vimesconsulting.com
Field guide 5, edition 2.3
Published 27 October 2026

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For middle managers and senior leaders in Aotearoa New Zealand

Health and safety field guide 5
Edition 2.3
Published 27 October 2026

Nobody was hurt

In September 2018, a mini crane lifting panels on an Auckland building site collapsed. The workers nearby were lucky. Nobody was hurt.

The company, KNCC Limited, had the crane taken off site and replaced. Work could carry on. It did not tell WorkSafe. A member of the public did.

WorkSafe's chief inspector said: "When the crane collapsed the workers were at risk of being seriously injured". The company was prosecuted for not reporting the collapse, and for not keeping the site as it was. A collapse that hurts nobody can still be notifiable.

What the story shows

The urge to tidy up and get going is strong, and very human. But the scene is the evidence everyone needs to learn from.

Why this guide starts here

What happens after an incident is often decided in the first hour, by a manager who has never faced one before. So this guide gives you that hour first, on page 4. Page 14 tells what the court decided.

> **The first hour after an incident decides how much you can learn from it.**

Sources WorkSafe media release, Repeat health and safety offender fined (3 June 2020).

Other guides that help

What you learn after an incident feeds the whole series. These guides help most alongside this one.

Guide	Read it for
1	The ideas behind the series, including why the same event needs a different response in different situations.
2	Trust and verify. Checking that the fixes from a review are in place and working.
3	Shared duties. Who reports, and who keeps the site, when several businesses share it.
4	Worker voice. Making it safe for people to report near misses and mistakes.
6	Critical risks and critical controls. Using your notifiable events to find the risks that could kill.
9	Psychosocial risk and mental health. Looking after people after a serious event.

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

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, WorkSafe and MBIE guidance, or WorkSafe's media release on the case. 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 12, 22, 23 and 24 October 2026.

Law

1. Health and Safety at Work Act 2015, ss 23 to 25, 36 to 44, 47, 55 to 57. legislation.govt.nz
2. Health and Safety at Work Amendment Act 2026 (became law on 9 July 2026): new ss 17(3)–(5), 25A, 44(5), examples in s 23.
3. Sentencing Act 2002, s 32.
4. Plain Language Act 2022, s 5.

Government guidance

5. WorkSafe. What events need to be notified? (web page and quick guide, March 2024); Notify WorkSafe; How we investigate (May 2022).
6. WorkSafe (July 2017). Identifying, assessing and managing work risks; How to manage work risks.
7. WorkSafe. Involving everyone in learning reaps benefits (case study).
8. WorkSafe. Enforceable undertakings, and operational policy.
9. WorkSafe (3 June 2020). Repeat health and safety offender fined (media release).
10. WorkSafe (July 2026). Understanding the changes to health and safety law; MBIE (July 2026). Health and safety reform. worksafe.govt.nz, mbie.govt.nz

Research

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 first source of the situation names on page 16.
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.

About this guide

Who it is for

Senior leaders who set how the organisation responds, reports and learns.

Middle managers who are often first on the scene, and who run the follow-up.

How to use it

Read pages 4 and 5 today, before you need them. Cut out the pocket card on page 20 and keep it with your phone. Read the rest at your own pace, and use page 19 for your own notes. Key words are explained on page 21.

Field guide 1 explains the ideas behind the series. This guide applies them to the day something goes wrong.

Finding your way

Before you start	2
The first hour	4
The duty	6
Look and listen	10
What good looks like	12
The duty in court	14
On the scene	15
Questions and notes	18
Key words and sources	21

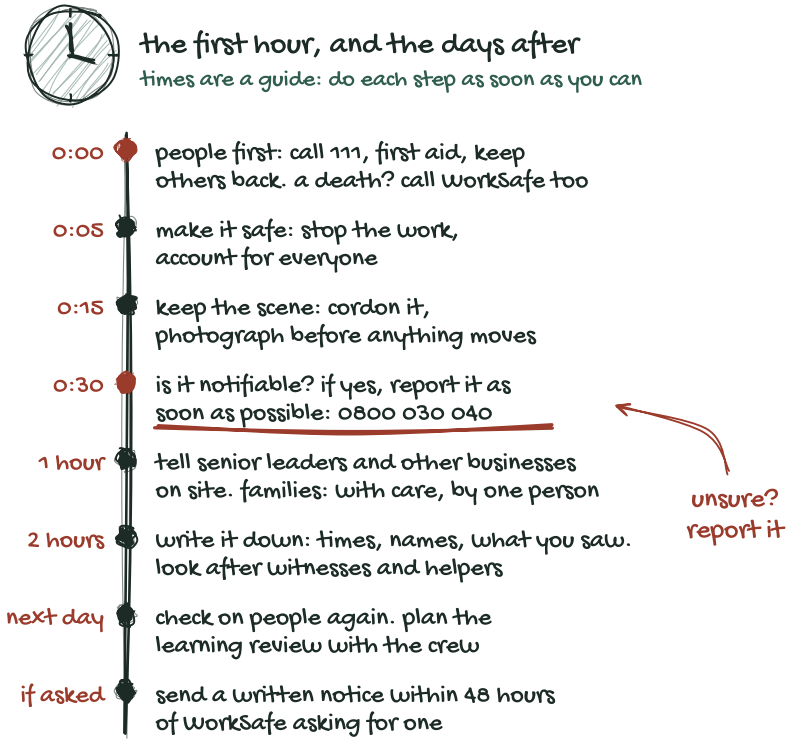
Reading these pages

- 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

In this guide, "the Act" means the Health and Safety at Work Act 2015, "s" means section and "ss" means sections. The Act says "notify the regulator". For most work that is WorkSafe. 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 first hour

When someone is hurt, nobody reads a manual. Read this page now, so the steps are already in your head.



If someone has died

WorkSafe says: "If there has been a death, call WorkSafe immediately." Phone 0800 030 040, any time of day or night. In an emergency, phone 111 first.

Sources WorkSafe, Notify WorkSafe; the Act, s 56(3).

Key words

The words people use after an incident, in plain English.

Word	What it means
PCBU	A "person conducting a business or undertaking". Usually an organisation.
Notifiable event	An event you must report to WorkSafe. It is a death, a notifiable injury or illness, or a notifiable incident, arising from work. s 25
Notifiable injury or illness	A serious injury or illness on the list in the Act. Page 6 sets it out. s 23
Notifiable incident	An unplanned or uncontrolled incident that exposes someone to a serious risk, even if nobody is hurt. s 24
Immediate treatment	WorkSafe says it is "urgent treatment", including by a doctor, registered nurse or paramedic. From 1 April 2027 the Act names a nurse practitioner, not a registered nurse (page 9).
Degloving or scalping	An injury where skin is torn away. WorkSafe describes it as "skin separating from underlying tissue where the tendons, bones, or muscles are exposed".
Keep the site	Leave the scene undisturbed until an inspector says otherwise, except to help people or make it safe. s 55
Near miss	An event that could have hurt someone, but didn't. Some near misses are notifiable incidents.
Learning team	A group that brings together the people involved to understand what happened and what to change.
Enforceable undertaking	A voluntary agreement with WorkSafe, usually instead of prosecution.
Reparation	Money a court orders an offender to pay for harm or loss caused by the offence. Sentencing Act 2002, s 32

Sources the Act, ss 23 to 25, 55; WorkSafe, What events need to be notified?; WorkSafe, Enforceable undertakings; Sentencing Act 2002, s 32.

Pocket card

Cut along the dotted lines and fold in half. Keep it with your phone or in the first aid kit.

The first hour

1. People first. Call 111. First aid.
2. Make it safe. Stop the work.
3. Keep the scene. Cordon. Photos.
4. Is it notifiable? Report it.
5. Tell leaders. Families with care.
6. Write it down. Look after people.

Someone has died? Phone WorkSafe now: 0800 030 040.

Is it notifiable?

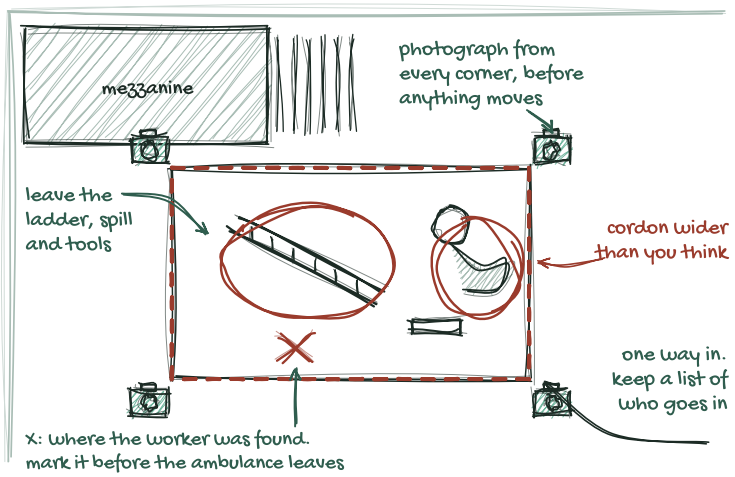
1. Did it arise from work?
2. A death? Phone now.
3. A serious injury or illness on the list, or a hospital stay?
4. An unplanned event that put someone at serious risk, even if nobody was hurt?

Any yes: notify as soon as possible. Unsure? Report it.

Card text from ss 23 to 25, 55 and 56 of the Act, WorkSafe's Notify WorkSafe page, and pages 4 to 7 of this guide. Field guide 5, Vimes Consulting.

Keep the scene

If you manage or control the workplace, take all reasonable steps to keep the site undisturbed "until authorised by an inspector". That includes any plant, substance or thing involved. **s 55**



You may still disturb the site to

- help an injured person, or remove a person who has died
- make the site safe, or reduce the risk of another event
- let the police do their job
- do anything an inspector or WorkSafe allows. **s 55(2)**

If you must move something

Photograph it first, from more than one side. Write down where it was and who moved it.

Sources the Act, s 55.

What you must report

The Act calls these "notifiable events". There are three kinds, and each must arise from work. s 25

Event	What it covers
A death s 25(a)	Any death that arises from work.
A notifiable injury or illness s 23	Any one of these: • an injury needing immediate treatment (urgent treatment, not just first aid), such as an amputation, a serious head or eye injury, a serious burn, degloving or scalping (skin torn away), a spinal injury, loss of a bodily function, or serious cuts • an injury or illness that needs admission to hospital for immediate treatment • medical treatment within 48 hours of exposure to a substance • a serious infection where work was a significant cause.
A notifiable incident s 24	An unplanned or uncontrolled incident that exposes someone to a serious risk, even if nobody is hurt. Examples include a spill or leak, a fire or explosion, an electric shock, something falling from height, or a structure or excavation collapsing.

Near misses count

A notifiable incident does not need an injury. If a crane collapses and nobody is hurt, you must still report it.

If in doubt, report it

Reporting an event that turns out not to be notifiable costs a phone call. Not reporting one that is can cost a conviction, and the chance to learn.

Sources the Act, ss 23 to 25, in plain summary; WorkSafe, What events need to be notified? Section 24 has a longer list, including plant that must be authorised, tunnels and vessels. Read the full lists at legislation.govt.nz.

Field notes

Fill in the back of your pocket card (page 20) before you cut it out.

Back of your pocket card

My critical risks here:

Who to call:

ideas for this page:

- who to call, day and night
- where the cordon tape lives
- what the crew said made sense
- fixes, owners and check dates
- people to check on again

→ write it down here

Take these to your next meeting

Senior leaders and officers

- [ ] Who decides whether an event is notifiable, at any hour?
- [ ] When did we last practise our response to a serious event?
- [ ] Do our reviews look at conditions, or stop at people?
- [ ] How do we know fixes from past events were done, and worked?
- [ ] Are we hearing about near misses, or has reporting gone quiet?
- [ ] Do we support injured workers, witnesses and helpers afterwards?
- [ ] Do our notifiable events point to critical risks we haven't named?
- [ ] As an officer, how do I check for myself that our first-hour steps are in place and used? (s **44**)

Middle managers

- [ ] Would my team know what to do in the first five minutes?
- [ ] Do I know which events must be reported?
- [ ] Could I keep a site undisturbed while helping people?
- [ ] Do my workers feel safe reporting mistakes?
- [ ] Did my team hear what we learned from the last event?
- [ ] Which fixes from past events have quietly slipped?
- [ ] Who on my team was affected and needs a follow-up?

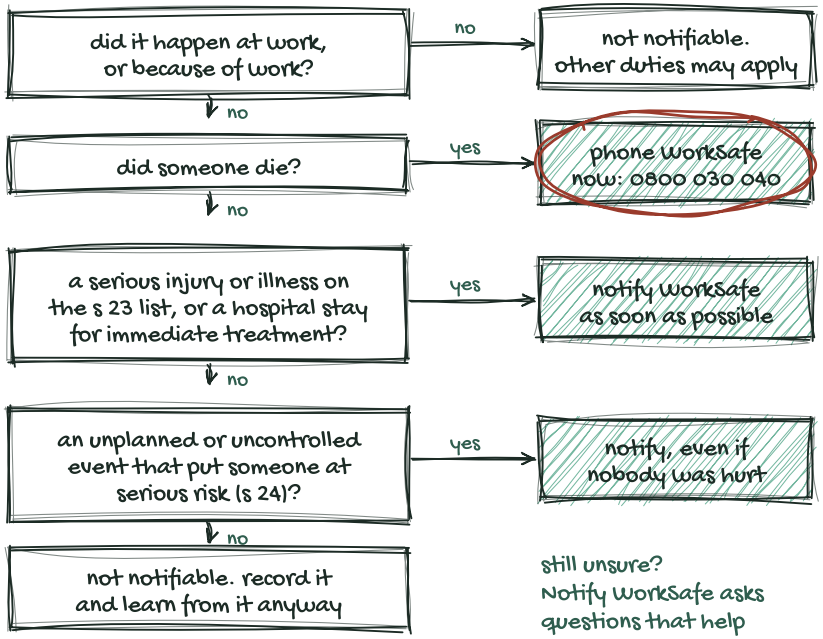
What did our last serious event teach us, and where can we see that lesson on site today?

Two measures a board can track: notifiable events reported to WorkSafe the same day; fixes from past events checked on site and closed.

Notes

Is it notifiable?

Work down the questions in order. Stop at the first yes.



Term	What WorkSafe says
Admitted to hospital	Admitted "as an inpatient for any length of time". It does not include out-patient treatment in an emergency department, or later corrective surgery.
Not notifiable	A diabetic worker slipping into a coma at work. A worker fainting from a non-work cause. Back strain or bruising. Something that only causes eye discomfort.

Sources the Act, ss 23 to 25; WorkSafe, What events need to be notified? and Notify WorkSafe.

The duty

Report, keep the site, keep records

When a notifiable event happens, three duties start at once.

1. **Report it straight away.** Make sure WorkSafe is told "as soon as possible" after you become aware of the event, by "the fastest possible means". You may phone, email or report online. If WorkSafe asks for a written notice, send it within 48 hours. **s 56**
2. **Keep the site as it was,** until an inspector says otherwise. Page 5 shows how. **s 55**
3. **Keep a record** of each notifiable event for at least five years from the date you reported it. **s 57**

Maximum fine for failing to	Individual	Organisation
Keep the site **s 55(4)**	$10,000	$50,000
Report the event **s 56(6)**	$10,000	$50,000
Keep a record **s 57(3)**	$5,000	$25,000

What happens after you report

- Every notification goes to WorkSafe's Response team, which decides what to do.
- Options include an investigation, or asking you to take part in an "assisted review" of your health and safety system.
- WorkSafe says it is "deliberate in choosing when we will, and won't, investigate".
- Work can carry on in other parts of the workplace.

> **From 1 April 2027: notifiable events help define critical risks**
>
> A critical risk includes one from a hazard "likely to result in death, a notifiable injury, illness, incident, or an occupational disease". Field guide 6 covers this.

Sources the Act, ss 55 to 57; WorkSafe, What events need to be notified? (March 2024); How we investigate (May 2022). Critical risk: Health and Safety at Work Amendment Act 2026 (new s 22A).

Signs worth a closer look

The signs that a serious event is coming, or that learning has stalled, often show up in reports and conversations first. None proves a problem. Each is worth a question.

What you might see or hear	What to do	Priority
Senior leaders hear about a serious event days later, or second-hand.	Agree who tells whom, and how fast. Test it in your next practice run.	●●○
The injured worker has not heard from anyone at work for a week.	Call them. Plan their return to work with them, not for them.	●●●
Small events clustering in one area or task.	Check the critical controls there. Talk to the crew.	●●○
"Should we really tell WorkSafe?"	Use page 7. If still unsure, report it.	●●●
Actions from past events still open, or closed without a check.	Ask to see each fix in place.	●●○
Events involving contractors never reach your reports.	Agree with each contractor to share events both ways (field guide 3).	●●○

The fix test

Take the three most recent incident reports. For each one, go and find the fix on site. A fix you can't find, or that nobody uses, is a lesson not yet learned.

When the work changes

An incident can start in any kind of situation, and the response and the learning often sit in different ones. Field guide 1 explains the situation names.

What is happening	How to respond and learn
A known event with a known cause, like a slip on a wet floor Clear	Follow the procedure. Fix the cause. Check the fix holds.
A technical failure, like a burst hydraulic hose Complicated	Bring in someone who knows the equipment. Test the cause before you act on it.
Several small things combined, with no single cause Complex	Use a learning team and many views. Try small changes and watch what happens.
The event itself: people hurt, danger still live Chaotic	Act first to make safe. Then work out what is happening. Then respond.
Nobody is sure what happened, or whether to report it Confusion	Gather the facts you have. Use page 7. If still unsure, report it.

Clear to Chaotic: the second casualty

Routine work fails without warning. In the rush to help, people step into the same danger. Make safe before you go in.

Chaotic to Clear: the quick fix

Once the emergency is over, the file closes on "human error" and "retrain". The conditions that set up the event stay. Treat the learning as Complex.

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

Law changes from 1 April 2027

The Amendment Act became law on 9 July 2026. The duties to report, keep the site and keep records stay. What changes is how clearly the law describes what to report.

Clearer examples of what to report

The government says the changes include "clarifying the types of serious injury, illness or event that require notifying the regulator". The Amendment Act adds examples to s 23, such as: **head injury**, a fractured skull, or loss of consciousness or memory; **eye injury**, an object entering the eye, or loss of vision; **burn** that needs a skin graft or a compression garment; **cuts** that are deep and damage muscle, tendon, nerve or blood vessel, or that need stitches.

It also defines "immediate treatment" as urgent treatment, including by a doctor, nurse practitioner or paramedic.

If you have fewer than 20 workers

You are a small PCBU (a "person conducting a business or undertaking") if you have fewer than 20 workers or, if numbers vary, expect fewer than 20 in at least 9 months of the financial year. **new s 17(3)–(5)** Your duties in ss 36 to 43 then cover only critical risks, except welfare facilities. The duties to report, keep the site and keep records (ss 55 to 57) still apply in full. **new s 25A**

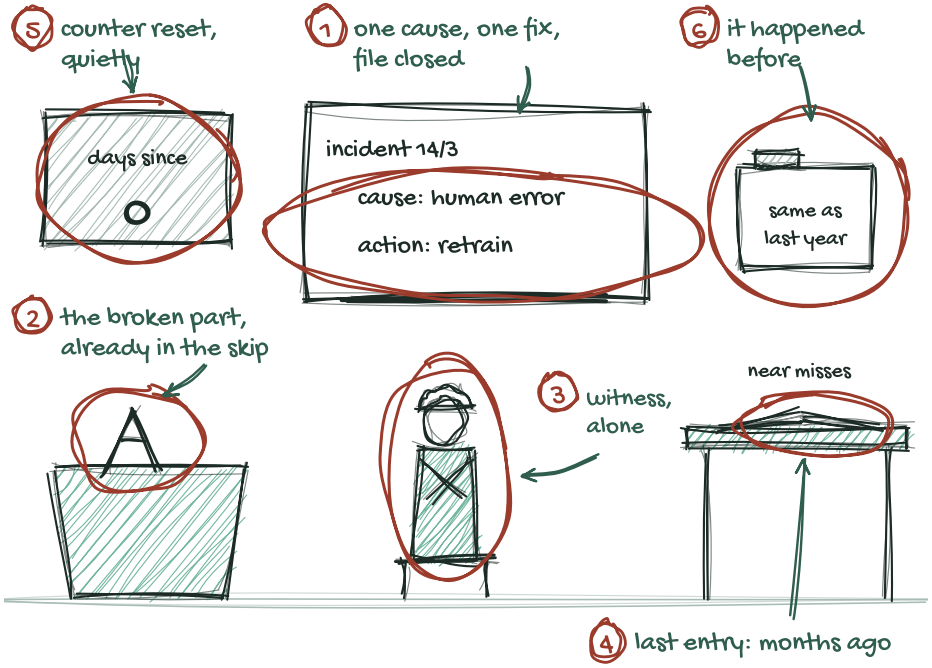
Getting ready

- [ ] Before 1 April 2027, update your "is it notifiable?" check.
- [ ] Look back over five years of notifiable events. The risks that keep coming up are likely critical risks.
- [ ] Check who decides, out of hours, whether to notify.

Sources MBIE, Health and safety reform (updated 22 July 2026); WorkSafe, Understanding the changes to health and safety law (July 2026); Health and Safety at Work Amendment Act 2026: new ss 17(3)–(5), 25A, examples in s 23. The Amendment Act does not change ss 55 to 57.

The morning after

The emergency is over. The next 24 hours decide whether the event becomes a lesson or a file. Here is what to look and listen for.



The numbers match the table on the next page. The same signs show up in a team meeting, an incident report or a board paper.

When the call comes

It is 2.10 pm. Your phone rings. "Someone's come off the mezzanine. They're talking, but their arm looks bad." You are the most senior person on site.

Be ready

- [ ] Know where the first aid kit, emergency numbers and cordon tape are.
- [ ] Know who decides whether to report, and how to reach them out of hours.
- [ ] Keep WorkSafe's number, 0800 030 040, in your phone.

On the day

- [ ] People first, then make safe, then keep the site.
- [ ] Write down times, names and what you saw, while it is fresh.
- [ ] Photograph the scene before anything is moved.
- [ ] Keep witnesses apart only if you need to. Look after them.

In the weeks after

- [ ] Involve the people who do the job in the review.
- [ ] Tell everyone what you learned and what will change.
- [ ] Check the changes are in place, and that they work.
- [ ] Keep the record for at least five years (s 57).

What to say to the person who reported it

"Thanks for telling me straight away." How you react to the first report decides whether the next one comes.

Senior leaders: set this up before you need it

Agree who decides whether an event is notifiable, who calls WorkSafe, and who talks to families and media. Practise it once a year. In a real event, people do what they have rehearsed.

The crane: what the court decided

Page 2 told how the crane collapsed in September 2018. This is what followed.



September 2018
A mini crane collapses. Nobody is hurt.

Then
A member of the public tells WorkSafe, which investigates.

2020
The Auckland District Court fines the company $26,000.

3 June 2020
WorkSafe publishes the result, naming the company.

The sentence

The company admitted it "did not notify WorkSafe and did not preserve the scene". The fine was under ss 55 and 56. WorkSafe noted that, since July 2018, the company had received 28 notices and letters under the Act.

The fine may look small. The most a court could give was $50,000 for each offence.

> *"All businesses have a duty to preserve the scene and inform WorkSafe of a notifiable event."*
>
> **John Howard, Chief Inspector Northern, WorkSafe**

The lesson for leaders

No injury does not mean no report. Clearing up removes the evidence. And if someone else may report it, better WorkSafe hears it from you.

Other things that can follow an event

- **An enforceable undertaking.** This is a voluntary agreement with WorkSafe, "generally used as an alternative to prosecution". It can't be used for the most serious offence (s 47, reckless conduct). WorkSafe publishes a register of them.
- **Reparation.** If you are convicted, a court can order you to pay for loss, damage or emotional harm caused by the offence. **Sentencing Act 2002, s 32**

Sources WorkSafe media release, Repeat health and safety offender fined (3 June 2020); the Act, ss 47, 55, 56; WorkSafe, Enforceable undertakings and its operational policy.

Six things to notice

	What it looks like	Why it matters, and what to do	Priority
1	"Cause: human error. Action: retrain." File closed.	One cause and one fix rarely explain an event. Ask what made the action make sense at the time.	●●○
2	The broken part, already in the skip.	If the event is notifiable, you must keep the site (s 55). Even if not, keep it for the review.	●●●
3	A witness sitting alone.	People who saw or helped are often shaken. Check on them today, and again in a few days.	●●●
4	A near-miss book with no entries for months.	Reporting has gone quiet, not the risk. Make reporting quick, and thank people who do it.	●●○
5	A "days since" counter, quietly reset.	Counters can make people hide events. WorkSafe says: "Avoid processes that may encourage under-reporting."	●●○
6	A folder marked "same as last year".	It has happened before, so the last fix did not hold. Check the earlier actions were done, and worked.	●●●

Try it this week

Read your last three incident reports. Count how many end in "human error" or "retrain". Then ask the people involved what they would change.

Sources WorkSafe, How to manage work risks (July 2017), for row 5.

Learning, not blaming

The Act does not say you must investigate. But WorkSafe says investigating notifiable events is "part of good practice to identify and manage work risk".

What WorkSafe advises

- "Investigate incidents and near misses to identify their causes."
- "Review incidents or near misses, and talk to your workers to check the control measures."
- "Encourage appropriate reporting. Avoid processes that may encourage under-reporting."

Learning teams

WorkSafe describes how Contact Energy uses learning teams, an idea from Todd Conklin. The team "brings all parties together to discuss the event". It "puts problem identification and solution creation in the hands of our sharp end workers".

Questions that help people learn

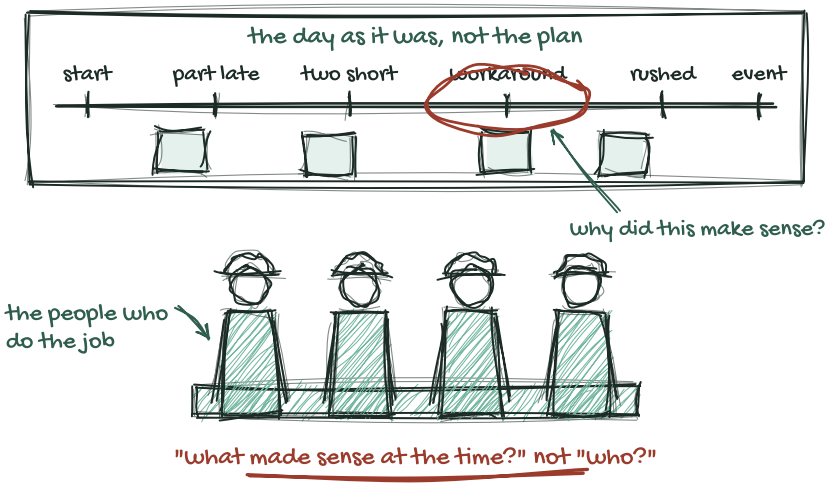
- [ ] What was the work really like that day, compared with the plan?
- [ ] What made sense to the people involved at the time?
- [ ] Which controls were there, and why didn't they stop it?
- [ ] Where else could this happen?
- [ ] What will we change, who owns it, and how will we check it worked?

Ask "what" and "how", not "who". Blame makes people stop reporting, and then you learn less.

Sources WorkSafe, What events need to be notified? (March 2024); quick guides Identifying, assessing and managing work risks and How to manage work risks (July 2017); case study, Involving everyone in learning reaps benefits.

A learning review, step by step

A good review feels more like a conversation than a hearing. The people who do the work tell you what the day was really like.



1. **Bring the right people together,** within a few days, while memories are fresh. Include the crew, not only supervisors.
2. **Map the day as it was.** Start well before the event. Note what was late, short, broken or rushed.
3. **Ask what made sense at the time.** Every workaround solved a problem for someone.
4. **Look at conditions,** such as time pressure, tools, staffing and design, not only actions.
5. **Agree fixes, owners and dates.** Prefer fixes that change the work over reminders to be careful.
6. **Check the fixes later,** and tell everyone what changed.

See also Field guide 2 explains the gap between work as planned and work as done.