Critical Risk Management

Implementation Toolkit for Small Organisations – 2027 – DRAFT

This toolkit helps small businesses find the risks that could cause death or serious harm, put the right protection in place, and check that it works in real work.

Who this toolkit is for

This toolkit is for you if you own, run or work in a **small business**. You do not need to be a safety expert. You do need to know which risks could cause the worst harm, what protection stops that harm, and whether that protection is working today.

Why this matters

Some harm at work is small – a bruise, a cut, a sore back. Some is life-changing – a fall, a crush injury, an electric shock, or a lung disease that shows up years later. Serious harm has happened in small businesses where people cared, the work felt normal and everyone thought it was fine. It usually happens when something important is **missing, broken, bypassed or not working the way people think it is**.

Two thoughts often get in the way: "*We've done this many times and nothing happened*" and "*We have rules and training, so we're fine*." Serious harm is rare, so a good track record can hide weak protection. Rules and training help, but they rely on people getting it right every time. What matters most is simple:

Is the key protection there – and does it work?

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What the law expects of a small business

From 1 April 2027, the *Health and Safety at Work Act 2015* (as amended in 2026) treats small and large businesses (PCBUs) differently. For a **small PCBU**, the main risk-management duties generally apply only to **critical risks**. That is why this toolkit focuses on them. You still have other duties – for example, to engage with workers and to work with other businesses on shared sites.

To check whether you are a small or large PCBU – including how to count contractors and changing numbers of workers – use WorkSafe's guidance *Am I a small or large PCBU?* and *Managing critical risks for small PCBUs*.

How this toolkit links to the Guide

Read this toolkit alongside *Critical Risk Management: A Good Practice Guide (2027)* ("the Guide"). The Guide sets out the principles. This toolkit turns them into simple steps, tools and examples for a small business. It uses plain words, with the formal term in brackets the first time it appears. Tools 1 to 6 each include a blank template and a worked example from Kōwhai Builders.

Toolkit part	Guide section	What it helps you do
Start here and cheat sheet	1–3	See the whole approach on one page
Tool 1: Who does what	4	Be clear on who owns, checks and supports
Tool 2: Find your critical risks	2 and 5	Apply the legal test and describe how harm happens
Tool 3: Choose your key protection	6	Choose the strongest protection and apply the four tests
Tool 4: Check it works	7	Check protection in real work
Tool 5: Stop, fix and learn	7	Act on failures and learn from high-potential events
Tool 6: Get a second look	4 and 7	Test whether your checks can be trusted
Tool 7: Keep track and keep it working	8, 9 and 10	Track what matters, keep skills up and prevent drift

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Please note: This toolkit is not legal advice. Use it alongside the Act, relevant regulations, Approved Codes of Practice and current WorkSafe guidance. Psychosocial risks can be critical risks, but they are outside the scope of this toolkit – that does not change your duties for them.

One-page cheat sheet

Use these five steps for any work that could cause death or serious harm.

Step	Ask yourself	Remember
1. Find	Is the hazard named in Schedule 1A? Or, if the protection failed, would death, a notifiable injury or illness, a notifiable incident or a Schedule 2 occupational disease be likely?	If **either** is yes, it is a **critical risk**. How often it happens does not matter.
2. Protect	What is the strongest protection we can reasonably put in place? Does it pass all **four tests**?	All four needed: stops harm directly · strong enough · keeps protecting despite mistakes · can be checked.
3. Check	Can I see it working, right now, where the work is happening?	There · Works · Used · Good shape. Paperwork is not a check. Recheck after any change, before work resumes.
4. Stop and fix	Is the key protection missing, weak, bypassed – or can we not tell?	Do not start or carry on until protection is restored and checked.
5. Learn	After a high-potential event (any event where death or serious harm was credibly possible, whether or not anyone was hurt): were we **protected**, **lucky,** or can't tell? What are we changing?	No injury does not mean safe. Make learning lead to real change.

A daily owner question: *If something went wrong today, would the key protection work?* If you cannot answer, the job is not ready to start or continue.

Your pathway: start here

Critical risk management is a cycle, not a one-off project. Work through it in order the first time, then keep it turning. You do not need to finish every tool before you act – **if protection is missing today, fix it today**.



The five-step cycle from the cheat sheet. The seven tools help you set it up and keep it running.

#	What you do	Tool	What you end up with
1	Decide who owns critical risks, who checks, and who can stop work. Agree roles with contractors and other businesses.	Tool 1	Clear roles
2	List your main types of work, including maintenance, one-off and rushed jobs. With your workers, find each way someone could die or be seriously harmed.	Tool 2	Critical risk list
3	For each critical risk, choose the strongest reasonably practicable protection. Use the four tests to name your key protection.	Tool 3	Key protection cards

	Everything else that helps is a supporting control – still important, not optional.		
4	Decide who checks, when, and what "working" looks like. Check in real work, and recheck after any change before work resumes.	Tool 4	Simple check log
5	Agree your stop-and-fix rule. Review every high-potential event.	Tool 5	High-potential event record
6	Arrange a periodic second look from a competent person who is independent enough of your routine checks to test them. Match it to the risk.	Tool 6	Second-look summary
7	Ask the weekly questions, keep skills up, and review when work changes or warning signs appear.	Tool 7	Fewer surprises

Throughout: involve the people doing the work. They know where protection is hard to use, where shortcuts happen, and what changes on a busy day. Share information, listen, and tell them what you decided.

Meet our worked example: Kōwhai Builders

Kōwhai Builders (fictional)

Kōwhai Builders is owned and run by Mere. It has a leading hand (Sam), five builders and an apprentice. It builds and renovates two-storey homes. It uses subcontractors for scaffolding, roofing, electrical work and excavation, and hires a digger and operator for site work.

Mere wants a simple system she can run herself, without lots of forms. We follow Kōwhai Builders through each tool, mainly using one critical risk: a person falls from an upper floor or roof edge.

Your business may look different. Use the same steps for your own work, equipment, risks and people.
Names, details and figures are illustrative only. They show the level of detail needed, not technical or legal approval.

Tool 1: Who does what

Guide link: Section 4 – Accountability, leadership and assurance

Critical risks come from the work. So the people who plan, run and do the work own them – not a safety adviser. In a small business, one person often wears several hats. That is fine, as long as each job is clear.

You and your supervisors own the risk and check the protection. Competent support advises and challenges. A second look tests whether your checks can be trusted.



Who	What they do
Owner / manager	Decides what the critical risks are, makes sure the key protection is in place and resourced, makes sure checks happen, and acts on what checks find. Supports people who stop work.
Owner as an officer	If you are a director, partner or someone with significant influence over the business, you are also an **officer**, with a personal duty of due diligence. Ask for – and look at – evidence that critical risks are known, key protection is in place and checks show it works. "No injuries" or a green report is not evidence.
Supervisor / leading hand	Makes sure key protection is in place **before work starts**, checks it during work, stops work when it is not right, and raises problems or resource needs.
Workers	Use the protection, report when it is weak or hard to use, stop when it is not right, and help find risks and better ways.
Competent support (if used)	Someone outside your business with the right know-how for the risk. Gives advice, coaches, challenges and can provide the "second look" (Tool 6). Match the know-how to the risk. Does **not** take over ownership of your risks, protection or routine checks.

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Put responsibility where decisions are made

The person who decides how, when and with what equipment a job is done must also be able to slow down, change the plan or stop the job. If people have responsibility but no power to act, safety relies on luck.

Involve your workers

Involving workers is a legal duty, and it makes protection better. Talk with the people affected when you find risks, choose or change protection, decide what "working" looks like, plan checks and learn from high-potential events. If you have a Health and Safety Representative, involve them too. Involving workers does not move your duties onto them.

People watch how you react. If you thank people who raise problems or stop work, they will speak up sooner. If you react badly to bad news, they will stay quiet.

Working with contractors and other businesses

Contractors may bring their own critical risks, and they may be exposed to yours. When you share a site or a job, you must consult, cooperate and coordinate with each other. Agree, in simple words:

- which critical risks are involved – yours and theirs
- which key protection must be in place, and who provides, maintains and checks it
- that one business's protection does not weaken the other's
- what happens if protection is missing or changed – including who can stop work and who must be told.

Agreeing who does what does **not** hand over your legal duty. Do not rely only on a contractor saying it is safe – spot-check that the key protection is really there and working. **If critical risks overlap, checks must overlap too.**

Template: Who does what

Question	Our answer
Who owns our critical risks overall?	[name / role]
Who are our officers (if any)?	[names / roles]
Who checks key protection before and during work?	[roles, by type of work]
Who can stop work? (Everyone should be able to.)	[roles]
How do we involve workers?	[e.g. weekly toolbox talk, site walk, HSR]
Which contractors share critical risks with us, and what have we agreed?	[contractor – risk – who provides, maintains and checks protection]
Who gives us a second look (Tool 6)?	[competent person or adviser]

Kōwhai Builders – who does what

- **Mere (owner and director – an officer): owns all critical risks, approves the plan for each job, funds protection, and reviews checks every Friday.**
- **Sam (leading hand): checks key protection each morning and before any high-risk task, and stops work if it is not right.**
- **Builders and apprentice: use protection, report problems and stop if it is not right. The apprentice is always paired with a builder at height.**
- **Scaffolding subcontractor: designs, erects, alters and inspects the scaffold, and hands it over in writing. Mere and Sam still check it daily.**
- **Digger operator (hire company): agrees the exclusion zone with Sam before work starts each day.**
- **Second look: a health and safety adviser from the local builders' association visits twice a year.**

Tool 2: Find your critical risks

Guide link: Sections 2 and 5 – Legal context; Identifying and assessing critical risks

What makes a risk critical

The law gives two routes to a critical risk. A risk is **critical** if it meets **either** of these tests:

Test	What it means
Test 1: A named hazard	The risk comes from a hazard listed in **Schedule 1A** of the Act that applies to your work. If so, it is critical – no further test needed.
Test 2: The likely outcome	The risk comes from **another hazard** (one that is not a Schedule 1A hazard), and if it happened it would **likely** result in death, a notifiable injury or illness, a notifiable incident, or an occupational disease listed in Schedule 2 of the Accident Compensation Act 2001.

A simple question for Test 2: *If someone was exposed to this, and the protection failed, would death, a notifiable injury or illness, a notifiable incident or a listed occupational disease be a likely result?* This is about **how bad the outcome would likely be** – not how often it happens.

Two different lists: Schedule 1A lists **hazards**. Schedule 2 of the Accident Compensation Act lists **occupational diseases**. A Schedule 2 disease does not make a hazard a Schedule 1A hazard – it is one of the likely outcomes you check for in Test 2. So for slow harm from dust or fumes, ask: *could repeated exposure likely cause a disease on the Schedule 2 list?*

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Start from how work is really done

List the main types of work your business does. Then think about the times work changes – this is often when serious harm happens:

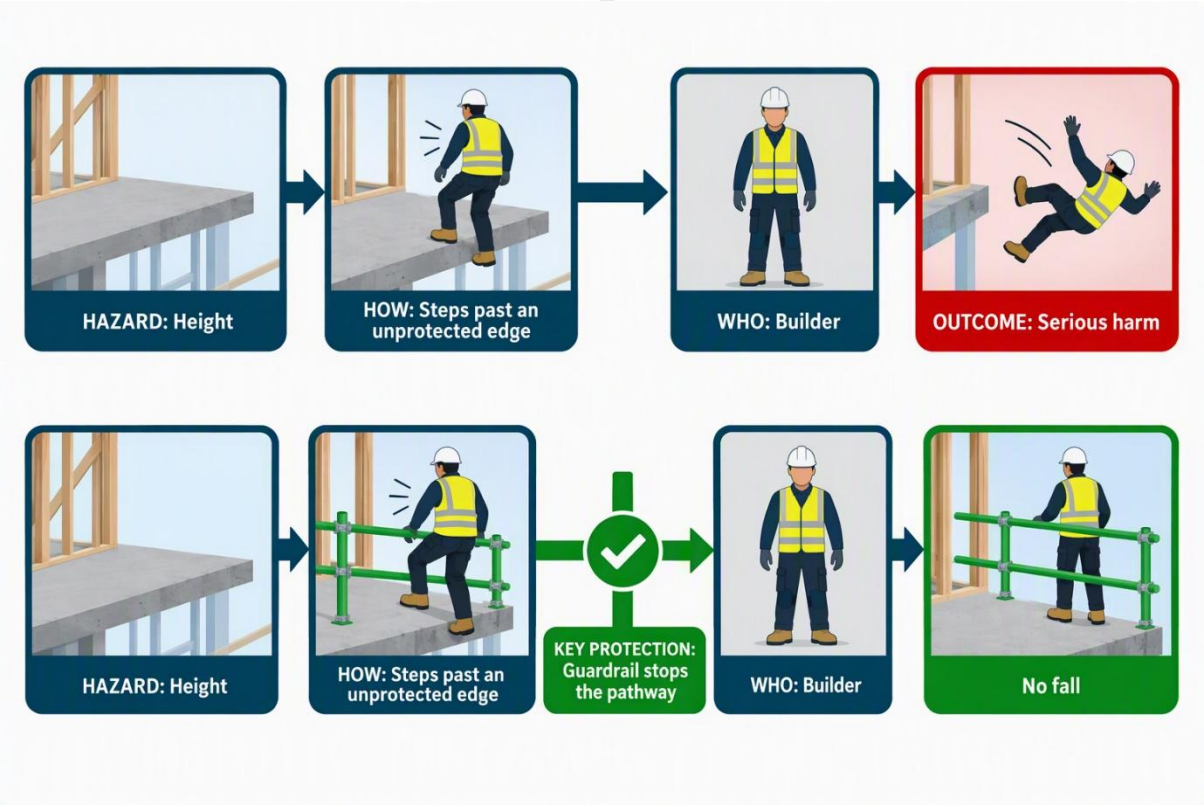
- maintenance, repairs, cleaning and clearing jams
- start-up, shut-down and emergencies
- one-off jobs and “just a minute” tasks
- rushed work, bad weather or work under pressure
- work alongside contractors or other businesses.

Walk the work with the people who do it. Ask them where things could go badly wrong. Use incidents, near misses, industry information and Appendix A to prompt your thinking.

Describe how harm could happen

Do not just name the hazard. Describe **how** it could reach a person and cause serious harm (the *exposure pathway*). This makes it much easier to see what protection you need.

Hazard	How exposure happens	Who	Serious outcome
Height	A person steps or slips past an unprotected upper-floor or roof edge	Builder, apprentice, subcontractor	Fall to the ground – death or serious injury
Mobile plant	A digger slews or reverses into the space where a person is working	Anyone on site	Struck or crushed – death
Silica dust	Dust from cutting concrete or fibre-cement is breathed in, day after day	Person cutting and those nearby	Silicosis – permanent lung disease



Top: how harm happens. Bottom: the same pathway with key protection in place (Tool 3).

One job can include several ways serious harm could happen. Ask the question for **each** pathway, not just once for "the job".

Don't miss risks because harm is rare or slow

- **"It doesn't happen often."** Serious harm is usually rare. That does not make the risk less critical.
- **"Our controls seem fine."** Good results or no recent incidents do not take a risk off your list.
- **"It takes years to show up."** Dust, fumes, chemicals and noise can cause permanent disease through repeated exposure. Include them.

Keep it focused – but complete

Most small businesses have a handful of critical risks. Group similar pathways where it helps, but do not cut risks to reach a set number, and do not use a risk matrix or score to decide whether a risk is critical. A good test is: Can we explain, in plain words, how someone could die or be seriously harmed – and what stops it?

Review Content

Template: Our critical risk list

#	How harm could happen	Why critical (Test 1 or 2)	Where / when	Owner	Review if…
CR1	[hazard → how exposure happens → who → outcome]	[Test 1: Schedule 1A hazard, or Test 2: likely outcome]	[jobs, tasks, conditions]	[role]	[change, high-potential event, failed check]
CR2					
CR3					

Worked example: Kōwhai Builders' critical risk list

Mere and Sam walked two live sites with the team, the scaffolder and the electrician. They checked each pathway against both tests – the Schedule 1A list first, then the likely-outcome test – and agreed this list.

#	How harm could happen	Why critical	Where / when	Review if…
CR1	A person falls from an upper-floor or roof edge,	Test 1: Schedule 1A (work at height). Also	Framing, roofing, cladding,	Scaffold altered, high-potential

	or through an opening, to the level below	likely death (Test 2)	scaffold changes	event, new site layout
CR2	The digger slews or reverses into a person on foot	Test 2: likely death	Site works, drainage, deliveries	New operator, tight site, high-potential event
CR3	A trench wall collapses on a person working in or beside a drainage trench	Test 1: Schedule 1A (excavation). Also likely death (Test 2)	Drainage and service trenches people work in or beside – at any depth where the walls could collapse onto them	Rain, vibration, spoil or plant near the edge, deeper dig
CR4	A person touches live parts on temporary power or an existing switchboard during renovation	Test 2: likely death	Renovations, temporary power	Old wiring found, new electrician
CR5	Respirable crystalline silica from cutting is breathed in over time	Test 2: likely Schedule 2 occupational disease (silicosis)	Cutting fibre-cement, concrete, tiles	New products or tools

Mere is owner for all five risks. They also talked about manual handling and hand tools. These can cause injury, but they did not meet the critical-risk test for this business, so they are managed through normal good practice.

Tool 3: Choose your key protection

Guide link: Section 6 – Selecting and defining critical controls.

For each critical risk you need two things: the **right mix of protection** to make it as safe as is reasonably practicable, and a clear view of which protection you **rely on most** – your **key protection (critical control)**.

Step 1: Start with the strongest protection

First ask whether you can **remove the risk** altogether. If that is not reasonably practicable, work down this list and use the strongest combination you reasonably can:

Type of protection	Builder example	Strength
Remove it (eliminate)	Pre-assemble roof trusses on the ground so no one works at the edge	Strongest
Replace it (substitute)	Use pre-cut cladding so there is less on-site cutting and dust	Strong
Separate or engineer it (isolation / engineering)	Scaffold with guardrails; a fenced exclusion zone around the digger; trench shields; on-tool dust extraction	Strong
Rules and training (administrative)	Safe work method, toolbox talks, permits, supervision	Weaker – relies on people
PPE	Harness, respirator, hi-vis	Weakest – last line

Make sure the protection can actually do the job in your conditions – wind, rain, a tight site, a rushed day. Good use cannot make up for a poor design. Test your choices with the people who will use, maintain or work around them.

Step 2: Work out what is reasonably practicable

"Reasonably practicable" is not just what feels OK to you or what you already do. It is what a reasonable business would do, given what is known – or should be known – about the risk and the ways to control it. Inspectors and courts look at this when deciding what was enough.

- **Look outside your business:** regulations, Approved Codes of Practice, WorkSafe guidance, industry good practice and what others in your trade do.
- **Use what you know:** incidents, near misses and what your checks have found.
- **Consider cost last.** Only after you know the risk and the options. You can only rule out a protection on cost if the cost is **grossly disproportionate** to the risk – not just because it is expensive or over budget.

- **Write down why** if you don't use a stronger option that is available: the main reasons, the evidence, and how you will control what remains. Keep it short, but clear.

Step 3: Is it really key protection? Ask four questions

Not everything that helps is key protection. Training, procedures, permits and supervision are supporting controls. They are still important and not optional – they are just not what you rely on most (see Step 4). If everything is "key", nothing is clear. A protection is **key protection** only if the answer to **all four** questions is **yes**:

Question	What it means on a building site
1. Does it stop the harm directly?	It acts on the danger itself or the way harm reaches the person – like a guardrail at an edge – not a sign, a rule or a reminder.
2. Is it strong enough?	It can actually stop serious harm in the conditions it is used in – not just reduce it a bit. A guardrail must take the load of someone falling against it.
3. Once in place, does it still protect if someone makes a mistake?	People may set it up, but once it is established it keeps protecting despite foreseeable mistakes, forgetting or lost attention. If it only works when everyone does the right thing every time, it is not key protection.
4. Can you check it?	You can see, measure or test that it is there and working – for example, rails at the right height, fixed, with no gaps.

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People can set up key protection – but once it is in place it must protect on its own. Isolating equipment and proving it is de-energised can be key protection. The lock-out procedure, the permit or the training is not. Once protection is in place, it must not depend on every person doing every step right.

Checking is not the same as validating. You can check that protection is there, in good condition and being used as intended. You may need a competent person with the right technical knowledge to confirm that it is designed and installed to provide the protection you need – as Kōwhai Builders' scaffolder does for the scaffold.

Step 4: Know your supporting controls

Training, procedures, permits, supervision, signs, and alarms that need someone to react are **supporting controls (supporting measures)**. They rely on people responding correctly. That does not make them optional:

- Many supporting controls are **essential**. They need an owner, a clear standard and checks, and they must be fixed when they fail.
- If a supporting control fails and you can no longer be sure people are protected, **stop the work**.
- A supporting control does **not** become key protection just because it is the best you have. If you are relying only on supporting controls, say so clearly – to yourself and any officers – and make getting real key protection a priority. A plan to improve does not make it OK to work without effective protection.

- Key protection that is missing or broken is still key protection. Don't downgrade it because it failed – fix it.

Step 5: Write it down simply – and protect it from change

For each key protection, write a short **key protection card**: what it is, what "working" looks like, who is responsible, how it is checked and what happens if it fails. Keep it to one page that anyone on site can understand. Supervisors and leading hands can use it on site to check the protection – it is not paperwork to keep in the office.

Build key protection into how you plan and price jobs, buy or hire equipment, and engage contractors. **Before any change** – a new site layout, a different subcontractor, a tighter programme, fewer people – ask: *could this weaken our key protection?* If so, agree how protection will be kept, put it in place and check it **before** the work starts or carries on.

Template: Key protection card

Item	Our answer
Critical risk	[ID and how harm could happen]
Key protection	[in plain, observable words]
Four tests – evidence	[1 Stops harm directly · 2 Strong enough · 3 Works despite mistakes · 4 Can be checked – how we know each is yes]
What "working" looks like	[W1, W2, W3 – things you can see, measure or test]
Supporting controls	[training, procedures, supervision, PPE – and who checks them]
Stronger options not used, and why	[option – reason – evidence – how remaining risk is controlled]
Who provides, uses, maintains and checks it	[roles, including contractors]
If it fails	[stop – make safe – fix or approved alternative – check – who can restart]
Review if…	[change, failure, high-potential event, new information]

Worked example: Kōwhai Builders – falls from height (CR1)

Mere and Sam started at the top of the list. Pre-assembling trusses on the ground removes some edge work, so they now do this where the crane access allows. For the rest, they compared options with the team and the scaffolder:

Option	1 Direct	2 Strong	3 Despite mistakes	4 Checkable	Decision
Perimeter scaffold with guardrails, mid-rails and toe boards	Yes	Yes – designed by the scaffolder	Yes	Yes	**Key protection**
Fixed covers or edge protection on floor openings and stairwells	Yes	Yes – if fixed and load-rated	Yes – if fixed and labelled	Yes	**Key protection**
Harness and lanyard on the roof	Partly	Depends on anchor	No – must be clipped on	Partly	Supporting – only where scaffold is not reasonably practicable
"Stay back from the edge" rule and toolbox talk	No	No	No	No	Supporting

Key protection card – KP1.1: Edge protection (CR1)

Key protection: A complete perimeter scaffold with guardrail, mid-rail and toe board at every open edge where people work above 2 m. Fixed, labelled covers on every floor opening.

What "working" looks like: W1 Rails continuous with no gaps, at the right height, all fixings tight. W2 Scaffold tag shows a current handover or inspection (within 7 days, and after any alteration or high wind). W3 Every floor opening is covered, fixed and labelled, or has edge protection.

Supporting controls: Only the scaffolder alters the scaffold. Briefing on site induction. Harness use where roof work is beyond the scaffold – with a rated anchor, and checked by Sam.

Stronger option not used: Elevating work platforms for all roof work – not suitable on sloping sections; the scaffold gives continuous protection instead. Reviewed for each new site.

Who: The scaffolder provides, alters and inspects. Sam checks daily. Mere reviews weekly and funds any changes.

If it fails: Stop all work on that level. Barricade the area. Call the scaffolder to fix it. Sam checks W1–W3 and restarts work.

Review if: scaffold altered or hit, a delivery disturbs a rail or cover, high wind, a high-potential event, new site layout, or new subcontractor working at height.

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Tool 4: Check it works

Guide link: Section 7 – Critical control verification, monitoring and assurance

Many serious incidents happen even though protection was "in place". Checking (verifying) means **looking at the protection itself, in real work** – not at paperwork, training records or the fact that nobody has been hurt. Checks are part of running the job, done by the people who run and supervise it.

Four things to check

Check	Ask	Builder example
There	Is it actually in place where the work is happening?	Guardrails on every open edge on this level today
Works	Would it do its job, to the standard on the key protection card, if it was needed right now?	Rails fixed and firm, no gaps, right height
Used	Is the work being done the way the protection needs?	No one has removed a rail to pass materials up
Good shape	Is it maintained and not worn, damaged or altered?	Scaffold tag current; no damage after last night's wind

Record each check as **Pass**, **Fail** or **Can't tell**. "Can't tell" is not a pass – treat it like a fail until you know.

When to check

- **Regular checks:** set a routine that matches the risk – for example, before work each day, before each high-risk task, and a fuller weekly check.
- Recheck after anything that could disturb the protection: a delivery, an alteration, an impact, damage, bad weather, a change to the job or site, or a new contractor or worker. Recheck before the affected work resumes – do not leave it to the next routine check. Also check when someone raises a concern or after a high-potential event.
- **Cover the hard times too:** early starts, late finishes, weekends, rushed jobs, and the one-off tasks where shortcuts are most likely.

Make checks meaningful

- Focus on **key protection first**. Check supporting controls where their failure would weaken protection – but don't let them crowd out checks on key protection.

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- Look, test or measure. Talk to the people doing the work: *Is it hard to use? Do you ever have to work around it?*
- Checking does not need to be complicated. A short, honest check is better than a long form that nobody reads. The key protection card and the simple check log can be used on site, by supervisors and leading hands, as the work happens.
- Make sure the person checking knows what "working" looks like and has the authority to stop work.

Template: Simple check log

Date	Site / task	Key protection	What was checked (W1…)	Pass / Fail / Can't tell	What we did	Checked by

Kōwhai Builders – how they check KP1.1

- **Every morning: Sam walks each working level before anyone goes up and checks W1–W3. He records the result on a phone checklist (about five minutes).**
- **Before roof work: Sam checks the anchor and harness set-up for anyone working beyond the scaffold.**
- **After a delivery, wind, impact, alteration or damage: Sam rechecks W1–W3 before work on that level resumes. If the scaffold was altered or damaged, the scaffolder re-inspects and re-tags it before use.**
- **Fridays: Mere walks one site with a builder, checks a sample of edges and openings herself, and asks the team where they've had to work around the protection.**

In March, Mere's Friday walk found two checks marked "Pass" on a day a stair opening cover had been lifted for a delivery. Nobody had been hurt. She and Sam agreed that anyone who lifts a cover or rail for a delivery tells Sam, and Sam rechecks it before work on that level resumes.

Tool 5: Stop, fix and learn

Guide link: Section 7 – Act on findings; interpret evidence from high-potential events

The stop-and-fix rule

If key protection is missing, not working, bypassed – or you can't tell – the work does not start or carry on.

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1. **Stop** the affected work.
2. **Make it safe** – keep people away from the danger.
3. **Fix it**, or put in place an effective alternative agreed by the person in charge.
4. **Check it** works before anyone goes back to the task.
5. **Restart** only when the person in charge is satisfied, and record what happened.

The same applies if an essential supporting control fails and you can no longer be sure people are protected. A due date or a plan to fix it later never makes it OK to carry on unprotected. Back anyone who stops work – every time.

Protected or lucky?

A high-potential event is any event where death or serious harm was credibly possible – whether or not anyone was hurt, and whether or not protection worked. It can be:

- a near miss – nobody was hurt, but someone easily could have been;
- an incident where someone was hurt less seriously, but much more serious harm was credible; or
- another event or observation showing that serious harm was credibly possible – for example, finding that key protection had been missing while people worked.

Review every one, and ask one key question: what actually prevented serious harm? Classify it on evidence of what the protection did – not because nobody was hurt.

Result	What it means	What to do
Protected (failed safely)	Evidence shows key protection was in place, did its job and stopped serious harm.	Good news – but check why the event happened, and whether the protection was close to its limit.
Lucky (failed lucky)	Evidence shows key protection was missing or did not work, and	Treat it like a serious incident. Stop and fix now,

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	serious harm was avoided by chance.	then find out why the protection was missing.
Can't tell (not established)	You don't have enough evidence to know what prevented harm.	Find out. Until you know, assume you were lucky.

Left to right: Protected – a complete guardrail stops the fall. Lucky – the rail has been removed, and only chance prevents a fall. Can't tell – not enough evidence to know what protected the person.

Learn without blame

Most failures come from how the work is set up, not from people being careless – time pressure, the wrong gear, a change nobody planned for. Ask *what made it hard to do the job safely?* rather than *who got it wrong?* Then make a real change: better protection, better planning, more time or more resources. A reminder to "be careful" is not a fix.

Template: High-potential event record

Question	Answer
What happened? (date, site, task)	
Which critical risk? What was the worst credible outcome?	
Which key protection should have stopped it? Was it there and did it work?	
Protected, lucky or can't tell? What evidence shows what prevented harm?	
What did we do straight away?	[stop, make safe, fix, check, restart]

What made it hard to do the job safely?	[ask the people involved]
What are we changing? Who, by when?	
How will we know the change worked?	[check date and what we will look for]

Kōwhai Builders – a lucky high-potential event (a near miss)

What happened: A roofer's labourer removed a section of guardrail to pass up roofing iron. A builder walking backwards stepped toward the gap and grabbed a standard. No one was hurt. The worst credible outcome was a 6 m fall.

Protected or lucky? Lucky – key protection KP1.1 had been removed, and chance prevented the fall.

Straight away: Sam stopped work on that level, barricaded the gap and called the scaffolder, who installed a gate and refitted the rail. Sam checked W1–W3 before work restarted.
Why it happened: There was no planned way to load materials onto the scaffold, so removing a rail seemed the easiest option. The roofing subcontractor had not been told that only the scaffolder may alter the scaffold.

What changed: Loading bays with gates are now part of every scaffold design. The scaffold rule is now in the subcontractor agreement and site induction. Sam rechecks the rails after every delivery, before work on that level resumes. Mere checks the next three sites to confirm the change works.

Tool 6: Get a second look

Guide link: Sections 4 and 7 – Assurance: testing the system and verification findings

It is hard to see the gaps in your own checks. People get used to how things are, and checks can drift into ticking boxes. A second look (assurance) is when a competent person with enough independence from your routine checks tests whether those checks – and your protection – can be trusted. It is recommended good practice. It is not, by itself, a legal requirement for an annual paid external audit.

Who can do it

Who does it depends on the risk. It might be a suitably competent peer from another business, an industry association adviser, a health and safety adviser, or someone with the right know-how for more technical risks. For some risks, such as silica dust, go to someone with specific know-how in that risk, not just a general adviser. They need to know the work and the risk well enough to give a useful challenge, and be independent enough from your routine checks to say what they find. A second look does not take over your responsibility for the risks, the protection or the routine checks.

What they do

- Review a sample of your check records.
- Go to site and look at the same protection themselves – including at harder times, such as early starts or busy days.
- Compare what they see with what your records say. Explore any differences.
- Talk to workers about where protection is hard to use or gets worked around.
- Look at how you responded to failures and high-potential events – was the fix real and did it last?
- Tell you, plainly, **how much you can trust your checks**, and what needs to change.

How often: periodically, to suit your risks – about once a year is a sensible starting point for many small businesses. After a “lucky” high-potential event, a failure of key protection or a material change, match the extent and competence of the second look to the nature of the risk or weakness – a competent peer may be enough for a simple fix; someone with specific know-how may be needed where the weakness is technical. Expect it to find gaps – that is the point. A general safety audit or a certificate does not, on its own, show that your key protection works.

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Template: Second-look summary

Item	Finding
Reviewer, date, sites and risks looked at	
What we sampled	[records, site visits, conversations]
Do our records match what was seen?	
Gaps in protection or checks	
How much can we trust our checks?	[High / Some / Low – and why]
What we will change, who, by when	

Kōwhai Builders – second look, June

The builders' association adviser visited two sites unannounced at 7.15 am, before Sam's morning walk. She sampled four weeks of check records against what she saw. Edge protection was in good shape and matched the records. But the digger exclusion zone (CR2) was taped, not fenced, on one site, and the daily record said "Pass". The dust extraction on one saw was blocked.

Her view: "*Some* trust – strong on heights, weaker on plant and dust. Checks on those risks may be ticking boxes."

Mere's actions: Hire fencing for every digger job, add a weekly extraction-flow check, and walk through what "Pass" means for CR2 and CR5 with Sam. The adviser will return in three months to confirm the changes worked.

Tool 7: Keep track and keep it working

Guide link: Sections 8, 9 and 10 – Capability; Measurement and reporting; Preventing drift

Keep track of what matters

Injury numbers and how much safety activity you do don't tell you whether key protection works. Ask these questions every week – at a toolbox talk or your own weekly review:

1. Which critical risks were we exposed to this week?
2. Did we check the key protection – including at the harder times?
3. What did checks find? Any fails or "can't tell"?
4. Did we stop work when we should have? Is everything fixed and checked?
5. Any high-potential events – protected, lucky or can't tell?
6. Where are people working around protection, and why?
7. What is changing next week that could weaken protection?

If you want numbers, keep two simple ones for each critical risk: how many checks were done compared with planned, and how many passed, failed or couldn't be told. Keep high-potential events separate, sorted into protected, lucky and can't tell.

Read the results with care

- **More problems found can be good news.** Better checking often uncovers gaps that were always there. They still need fixing.
- **Always perfect results deserve a closer look.** Ask whether checks cover the hard times and whether people feel pressure to mark "Pass".
- **Compare like with like.** Edge protection on a finished scaffold will pass more often than a digger exclusion zone on a changing site. Use differences to target checks – not to accept weaker protection.
- **Check the checks against what is really happening.** If checks say "Pass" while you are seeing near misses, workarounds or damage on the same protection, don't trust the Pass – find out why.
- **If you are an officer,** ask to see this evidence and challenge it. "No injuries" is not proof.

Keep skills real

Being capable means being able to do the job safely in practice – not just having been on a course. Everyone should know how serious harm could happen in their work, which protection matters most, what "working" looks like and what to do when it isn't right.

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- **Watch people do it.** Confirm capability by observing work or a quick practical demonstration, including what they would do if something went wrong.
- **Focus on key roles:** whoever checks protection, authorises work, plans jobs or makes changes.
- **Re-check after change** – new people, new equipment, new types of job, or when checks find gaps – rather than waiting for a refresher date.

Watch for drift

Drift is the slow weakening of protection as small changes build up. It rarely comes from people not caring. It comes from busy days, competing goals and decisions that each seem reasonable. Because serious harm is rare, drift can go unnoticed – until something goes wrong.

Warning signs	What to do
Workarounds becoming normal ("we always do it this way")	Ask why with the team; fix the cause
More reliance on rules, PPE or "just be careful"	Look again for stronger protection
Checks getting shorter, skipped or always "Pass"	Do a spot-check yourself; ask for a second look
The same problem keeps coming back	Treat it as a work design problem, not a people problem
Work, people, equipment or programmes changing	Review the critical risk list and key protection cards
A "lucky" high-potential event	Stop, fix and review now – don't wait

Review at least once a year, and whenever a warning sign appears. Check that your critical risk list still covers the work you actually do, that key protection still works in real conditions, and that your checks, skills and second look are still good enough to spot problems early. **Never delay action where protection is in doubt.**

Self-check: how are we going?

Area	Starting	Getting there	Strong
Critical risks	General hazard list	Critical risks listed using the legal test	Clear pathways, reviewed with workers after change
Key protection	Rules and PPE mostly	Key protection named for each risk	All four tests met with evidence; cards in use
Checks	Paperwork or when something happens	Regular checks of key protection	Checks cover hard times; “can’t tell” acted on
Stop and fix	Work often continues	Stopping is expected	Stopping is backed every time; restart is checked
Learning	Focus on who	High-potential events reviewed	Protected / lucky used; changes checked for effect
Second look	None	Occasional	Regular and matched to the risk; trust in checks understood

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Appendix A: Critical risk cards

These cards are examples to prompt your thinking – not a complete list or a technical specification. Each possible key protection qualifies only if it passes all four tests in your actual work and conditions. Get competent technical advice for complex risks.

Critical risk	How harm happens	Possible key protection	Supporting controls	False confidence
Falls from height	A person falls from an edge, through an opening or fragile roof	Guardrails, scaffold, fixed covers, elevating work platform	Harness systems, rescue plan, training, supervision	"It's only a quick job" / "they're clipped on"
Mobile plant and vehicles	Plant or a vehicle moves into a space where a person is	Physical barriers or fenced exclusion zones separating people and plant	Spotters, reversing alarms, cameras, hi-vis, traffic plan	"The operator can see us"
Moving machinery	A person or clothing reaches moving parts	Fixed guards; interlocked guards that stop the machine	Signs, safe operating procedure, training	"Guards are fitted" – but removed for cleaning or clearing
Hazardous energy	Equipment starts up or stored energy is released during maintenance	Secured isolation of every energy source, with stored energy released and the equipment proven de-energised	Permit, isolation procedure, locks and tags, competence	"It's switched off" / a tag alone
Electricity	A person touches live	Proven de-energised before work; RCD	Licensed electrician, test-and-tag,	"The breaker is off"

	parts or an arc occurs	protection on temporary supplies	safe work method	
Excavations and collapse	A trench wall, structure or stockpile collapses on a person	Trench shields, shoring or battering to an engineered design	Ground assessment, inspections, exclusion from edges	“The ground looks firm”
Lifting and falling loads	A suspended or stacked load falls or swings onto a person	Physical exclusion from under the load; engineered racking or restraint	Rated rigging, lift plan, competent operators, inspections	“The load is stable”
Confined spaces	A person breathes a toxic or low-oxygen atmosphere, or is engulfed	Eliminate entry; isolate inflows; forced ventilation with continuous monitoring and automatic alarm	Permit, standby person, rescue plan, gas testing	“It was fine last time”
Fire and explosion	Flammable material ignites near people	Remove or separate flammables; engineered ventilation; automatic suppression where suitable	Hot work permit, fire watch, extinguishers	“We’ve got extinguishers”
Hazardous substances	A chemical is breathed, swallowed or contacts skin or eyes	Safer substitute; closed transfer systems; engineered extraction	Safety data sheets, PPE, training, health monitoring	“It’s only a small amount”

Silica and harmful dust	Dust is breathed in, often over years	Avoid cutting; enclosed processes; on-tool extraction or water suppression proven to protect health	Respirators, fit testing, exposure and health monitoring	"We wear masks" / "there's not much dust"
Noise	Harmful noise damages hearing over time	Quieter equipment; enclosures; distance	Hearing protection, noise monitoring, hearing tests	"It doesn't seem that loud"
Working near water	A person falls into water and cannot get out	Barriers or guardrails at water edges	Lifejackets, rescue equipment, supervision	"They're good swimmers"

Note on alarms and emergency stops: anything that needs a person to notice and react – a warning alarm, an emergency stop button, a rescue plan – is a supporting control. It can still be essential, and must be checked.

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Appendix B: Plain-language glossary

Term (Guide term)	Plain meaning
Critical risk	A risk from an applicable Schedule 1A hazard; or from any other hazard where, if it happened, death, a notifiable injury or illness, a notifiable incident or an occupational disease listed in Schedule 2 of the Accident Compensation Act would be a likely result. Schedule 1A lists hazards; Schedule 2 lists diseases – they are different routes.
How harm happens (exposure pathway)	The way a hazard reaches a person and causes serious harm – for example, "a person steps past an unprotected roof edge and falls".
Key protection (critical control)	Protection that passes all four tests: stops the harm directly, is strong enough, keeps protecting despite foreseeable mistakes, forgetting or lost attention once it is in place, and can be checked.
Supporting control	Training, procedures, permits, supervision, signs, PPE and alarms that need people to respond. Often essential, but not key protection.
Reasonably practicable	What a reasonable business would do, given the risk, how bad the harm could be, what is known about it and the ways to control it. Cost is considered last and only rules out a control if grossly disproportionate.
Checking (verification)	Looking at the key protection in real work to confirm it is there, works, is used and is in good shape – that it is effective. Some protection also needs a competent person to confirm it is designed and installed to do the job.
Second look (assurance)	A competent person with enough independence from your routine checks testing whether your checks and protection can be trusted. Recommended good practice, not an automatic annual external audit. It might be a competent peer, an industry association adviser, a health and safety adviser or someone with the right know-how for the risk.
High-potential event	Any event where death or serious harm was credibly possible, whether or not anyone was hurt. It can be a near miss, an incident where someone was hurt less seriously but much worse was credible, or another event or observation showing serious harm was credibly possible.

Protected / lucky / can't tell (failed safely / failed lucky / not established)	Based on evidence of what protected people. Protected: key protection worked and stopped harm. Lucky: key protection was missing or failed, and chance stopped harm. Can't tell: not enough evidence to know – treat it as lucky until you find out.
Change and drift	Change: anything new or different in the work, people, equipment or site that could weaken protection. Drift: protection slowly weakening as small changes build up.
Officer	A director, partner or person with significant influence over the business, with a personal duty of due diligence.
PCBU	A person conducting a business or undertaking – the business or organisation with the health and safety duties.
Competent person (competent support)	Someone with the knowledge, skill and experience to advise on, check or confirm a particular protection – such as the scaffolder who checks your scaffold. Their support does not take over your ownership of the risk.

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