

We almost always focus on the “safety” in “health and safety”. But diseases caused by work are much more likely to kill workers than accidents. In this issue, we look at new research that highlights workers’ exposure to carcinogens in New Zealand workplaces. We also cover three prosecutions that resulted in significant penalties for businesses – a fine of more than \$500,000 that stemmed from the tragic death of a man in a Wairoa freezing works, a prosecution in the UK that led to a £1 million fine after a worker lost an eye, and a case in Australia where a fine of AU\$730,000 was given to a diving company for reckless conduct even though no one was seriously injured. Finally, we highlight WorkSafe’s guidance on keeping visitors and other persons safe from work-related harm.

Survey finds NZ workers exposed to high levels of cancer-causing agents at work

Work-related disease is estimated to account for 750–900 deaths a year in New Zealand. Cancer contributes to about half of those deaths and at least a third of work-related hospitalisations.

A **recent survey** found that over half (57.5%) of workers in New Zealand are probably exposed to at least one cancer-causing agent or carcinogen at work. Almost a quarter of workers (23.3%) are probably exposed to five or more carcinogens. And nearly three in ten workers (28%) are probably exposed to at least one carcinogen at a high level of exposure.

The New Zealand Carcinogens Survey (NZCS), commissioned by WorkSafe New Zealand, was the first research to examine the prevalence of occupational carcinogens in the working population. It found that the five most common cancer-causing substances and exposures across all industries were benzene (30%), solar UV (27%), UV exposure to the eye (26%), diesel engine exhaust (24%), and second-hand tobacco smoke (15%). Two lesser-known carcinogens, shift work and wood dust, accounted for 9% and 8% of exposures respectively.

The three industry sectors with the highest exposure to at least one carcinogen were Mining (97%), Electricity, Gas, Water and Waste Services (92.7%), Agriculture, Forestry and Fishing (88.9%).

Construction workers, farmers, and emergency workers experienced the highest average number of exposures,

with each group exposed to more than seven carcinogenic agents. At medium and high levels of exposure, shift work was the most common carcinogen in Healthcare and Social Assistance, and Public Administration and Safety (17.5% and 12.3%, respectively). Māori and Pacific workers and men were the most likely to be exposed to at least one carcinogen.

You can read more about identifying and managing the risks of carcinogens on WorkSafe’s [website](#). You can also find a useful discussion about the NZCS in [The Conversation](#).



“I’m getting some unusually high readings around you.”

Looking after visitors and other persons in the workplace

Most businesses will have members of the public who are not workers at or near their workplace at least some of the time. WorkSafe refers to these people as “other persons”. They might include **customers** or clients, passers-by, or **children** visiting a parent at their workplace. Homeowners who have a tradesperson carrying out work at their home are also considered to be other persons at work.

Businesses (PCBUs) have a duty to keep other persons healthy and safe. PCBUs must give visitors to their workplace an appropriate and proportionate level of health and safety information and protection. What this

looks like depends on what the PCBU does. A workplace with a high-risk profile, such as a construction site, would be expected to take more steps to inform and protect visitors compared with a workplace with few risks.

Other persons at a workplace also have responsibilities including to take reasonable care of their own health and safety and to comply, as far as they are reasonably able to, with any reasonable instruction.

You can read WorkSafe’s guidance on managing “other persons” at work [here](#).

Freezing works company fined more than half a million dollars after the death of a worker

The death of a worker saw a significant \$502,500 fine being imposed on a large freezing works company after it was [sentenced](#) in the Gisborne District Court for health and safety offending.

In February 2020, the 61-year-old victim was working alone at the back of a blast freezer at the company's Wairoa plant. As he attempted to free a jammed offal carton, the steel frame holding the cartons fell and fatally crushed him.

The victim was described as a man with mana whose death was devastating for his immediate whānau, and the small Wairoa community.

WorkSafe found the company was aware cartons had jammed previously, and the freezer had not been maintained to modern safety standards. Although the

company said the freezer was only used intermittently, the Health and Safety at Work Act 2015 still applied. Following the death, the freezer was decommissioned.

The investigation also identified that while the company had overarching health and safety procedures, these were not applied in practice. WorkSafe commented that having a written process but not following it "... is the same as having nothing at all."

In addition, WorkSafe said the company's management did not spend enough time talking to workers on the job to hear about and fix any safety issues. Workers are an invaluable source of information on uncontrolled risks in a workplace. More information on engaging with workers can be found [here](#).

UK tissue manufacturer fined £1 million after a worker loses an eye

The failure to carry out a suitable and sufficient risk assessment to identify hazards, and then to implement control measures, has led to a [£1 million fine](#) and an order to pay costs of £13,446.50 for a kitchen and toilet tissue paper manufacturer in the UK.

The prosecution followed a 2019 incident at the Welsh company's plant. The victim was attempting to free a paper reel, which had become stuck on the exit rails of a paper machine, by using an overhead crane. Part of the crane contacted the spinning reel causing the crane hook to swing violently striking the man in the face. He suffered the loss of an eye, multiple fractures to the face and lost 9 teeth.

The paper reel was regularly getting stuck, yet no risk

assessment had been undertaken despite operators being provided with basic equipment to use in these circumstances. The company also failed to ensure that control measures were put in place and that employees were provided with information and instructions on what to do should this situation arise.

The UK HSE said the incident could easily have been avoided by carrying out a suitable risk assessment which included the non-routine operations such as clearing of blockages, and by implementing appropriate control measures and safe working practices. This advice applies equally to New Zealand workplaces. WorkSafe's [Safe Use of Machinery Guidelines](#) provides helpful advice on how to carry out a risk assessment on the use of machinery.

Diving company fined AU\$730k for reckless conduct

An underwater diving inspection company has been fined \$730,000 for seven charges covering a string of [health and safety failures](#) in Victoria, Australia. The fine was made up of a \$600,000 fine for recklessly engaging in conduct that placed workers in danger of serious injury or drowning, \$70,000 for failing to provide the necessary training for workers to perform their tasks safely, and \$60,000 for failing to provide safe systems of work.

Despite the high fine, no serious harm occurred. But the company repeatedly placed workers at risk. It failed to ensure workers were trained and qualified for the tasks allotted to them such as diving in confined spaces, using specialist equipment, and acting as a dive attendant, backup diver or land-based supervisor.

The company also provided ill-fitting or unfamiliar equipment; and inadequate communication equipment which prevented workers communicating while performing underwater tasks. In addition, it failed to ensure that employees knew and understood rescue procedures and emergency plans.

During one incident in 2018, a diver had to shimmy backwards to escape a culvert less than one metre in diameter. The diver crawled into the 3.5m long irrigation culvert to inspect it but could not move when her umbilical cord became stuck on the outside. Lying in murky water with rats around her, she started to panic. The worker called for help via a communication system. No one responded, and after about 15 minutes she managed to exit the culvert herself. WorkSafe's investigation found a backup diver on the same job was not adequately trained to undertake a rescue.

WorkSafe Victoria said the scope of offending was astounding given the highly specialised nature of commercial diving. It commented that: "Diving is inherently hazardous, with deadly risks such as asphyxiation and drowning, making such a cavalier approach to safety especially egregious."

This newsletter is published as part of Vero Liability's commitment to supporting better work health and safety outcomes for all New Zealanders. We want everyone to go home safe.

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