

Organisational Excellence Committee

28 April 2026

Report for Agenda Item | Rīpoata moto e Rāraki take [2]

Department: Corporate Services

Title | Taitara: Health Safety and Wellbeing Report

Purpose of the Report | Te Take mō te Pūroko

The purpose of this report is to provide the Organisational Excellence Committee with a regular update on the Health & Safety performance of the organisation.

Recommendation | Kā Tūtohuka

That the Organisational Excellence Committee:

1. **Note** the contents of this report.

Prepared by:



Name: Alan Thomas

Title: Health & Safety Manager

26 March 2026

Reviewed and Authorised by:



Name: Katie Church

Title: Director of People & Capability

26 March 2026

Context | Horopaki

1. Queenstown Lakes District Council (QLDC) has duties under the Health and Safety at Work Act 2015 and subsequent regulations to ensure the safety of employees, and all other persons, at, or in, the vicinity of work or subsequently affected by the work. This duty is upheld through QLDC's safety management system, which is guided by good practice and designed to address operational risks and workforce behaviour.

2. Reporting Period

All health, safety and wellbeing information is captured at the end of each calendar month. The statistics in this report cover the period 1 September 2025 to 28 February 2026.

3. Key Risks

Key organisational health and safety risk themes that require continuous or improved management, are outlined below:

Contractor Activities

- Refers to contract workers and work, engaged by or on behalf of QLDC.

Fleet Operations

- Refers to all QLDC work related vehicle and mobile plant use.

Public Interaction

- Refers to all direct engagement with the public for work purposes.

Fitness for Work

- Refers to workers physical & mental capacity to perform work safely.

Isolated Workers

- Refers to workers operating alone or from remote locations.

Volunteer Activities

- Refers to volunteer workers and work, engaged by or on behalf of QLDC.

4. Please refer to **Attachment A** for the full health, safety and wellbeing statistics report for the period 1 September 2025 to 28 February 2026.

Analysis and Advice | Tatāritaka me kā Tohutohu

5. This report is for noting only, so no options are presented.

Consultation Process | Hātepe Matapaki

Significance and Engagement | Te Whakamahi I kā Whakaaro Hiraka

6. This matter is of low significance, as determined by reference to the Council's Significance and Engagement Policy 2024 because it is purely operational in matter.
7. The persons who are affected by or interested in this matter are employees, contractors, volunteers, and public persons engaged with Council for the purposes of work or directly influenced by the Council's work process.
8. The Council has not consulted directly on this matter in the past.

Māori Consultation | Iwi Rūnaka

9. Iwi consultation is not required for this matter.

Risk and Mitigations | Kā Raru Tūpono me kā Whakamaurutaka

10. This matter relates to the Workforce risk category. It is associated with RISK10032 Health, safety or wellbeing incident affecting employee within the QLDC Risk Register. This risk has been assessed as having a moderate residual risk rating.
11. The noting of the information contained in this report will allow Council to implement additional controls for this risk. This will be achieved by ensuring that councillors are suitably informed about Council's health, safety and wellbeing functions and responsibilities, thereby facilitating effective oversight.

Financial Implications | Kā Riteka ā-Pūtea

12. There are no financial implications.

Council Effects and Views | Kā Whakaaweawe me kā Tirohaka a te Kaunihera

13. The following Council policies, strategies and bylaws were considered:
 - Reference alignment with and consideration of the principles of the Strategic Framework including the Vision Beyond 2050: Our Strategic Framework | Queenstown Lakes District Council.
 - Workplace Health and Safety Management System.

- Health and Safety Policy Statement.

14. The recommended option is consistent with the principles set out in the named policies above, since the report is for noting only.

15. This matter is not included in the Long Term Plan/Annual Plan.

Legal Considerations and Statutory Responsibilities | Ka Ture Whaiwhakaaro me kā Takohaka Waeture

16. QLDC has legal duties owed under the Health and Safety at Work Act, and associated regulations, which must be considered in all Council health, safety, and wellbeing matters.

Local Government Act 2002 Purpose Provisions | Te Whakatureture 2002 o te Kāwanataka ā-Kiaka

17. Section 10 of the Local Government Act 2002 states the purpose of local government is (a) to enable democratic local decision-making and action by, and on behalf of, communities; and (b) to promote the social, economic, environmental, and cultural well-being of communities in the present and for the future. Council adhering to good practice and legislative health, safety and wellbeing practices contributes to the wellbeing of staff, and the community Council serves.

18. The recommended option:

- Can be implemented through current funding under the Long-Term Plan and Annual Plan;
- Is consistent with the Council's plans and policies; and
- Would not significantly alter the intended level of service provision for any significant activity undertaken by or on behalf of the Council or transfer the ownership or control of a strategic asset to or from the Council.

Attachments | Kā Tāpirihaka

A	Health, Safety & Wellbeing Report: September 2025 - February 2026
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1. Health & Safety Committee Chair: Quarterly Summary

There were two contractor Notifiable Events to WorkSafe during the reporting period (this is summarised in Sections 9 of this report). WorkSafe chose not to investigate the Notifiable Events and closed out the reports immediately. The Notifiable Events have been investigated by the relevant contractors.

There continues to be an excellent level of engagement for the organisation's wellbeing initiatives. Highlights during this reporting period include the Blue Zone Challenge, a well-received Te Whare Tapa Wha workshop, and a series of webinars and activities associated with October 2025's Mental Health Awareness week.

2. Health & Safety Manager

During this reporting period, one employee Lost Time Injury (LTI) was recorded. The Health and Safety Team, supported by Health and Safety Reps continue to work with the organisation to strengthen understanding of procedures for managing incidents requiring off-site medical treatment. While this has contributed to a reduction in LTIs, our primary focus remains on the care, recovery, wellbeing and ongoing support of our employees.

During this reporting period contractors recorded two WorkSafe Notifiable Events, three contractor Lost Time Injuries (LTI) and ten Serious Occurrences. Please see section 9 of this report.

To note: Council regards any strike to a service as a Serious Occurrence as there is no indication at the time of what type of service has been contacted. In some cases, these may be disused cables or lateral water pipes. Contractors and QLDC actively update their 'as built plans' as this information is received.

A Serious Occurrence is classified as follows:

QLDC classifies a Serious Occurrence. As any incident that had the potential to cause a Notifiable Event, serious damage to assets, loss of containment or damage to reputation. Note: Any strike to utility services is considered a Serious Occurrence

Council's Health and Safety Team and Project Managers have continued to support expectations with contractors in relation to excavation planning, service identification, and adherence to industry good-practice guidelines.

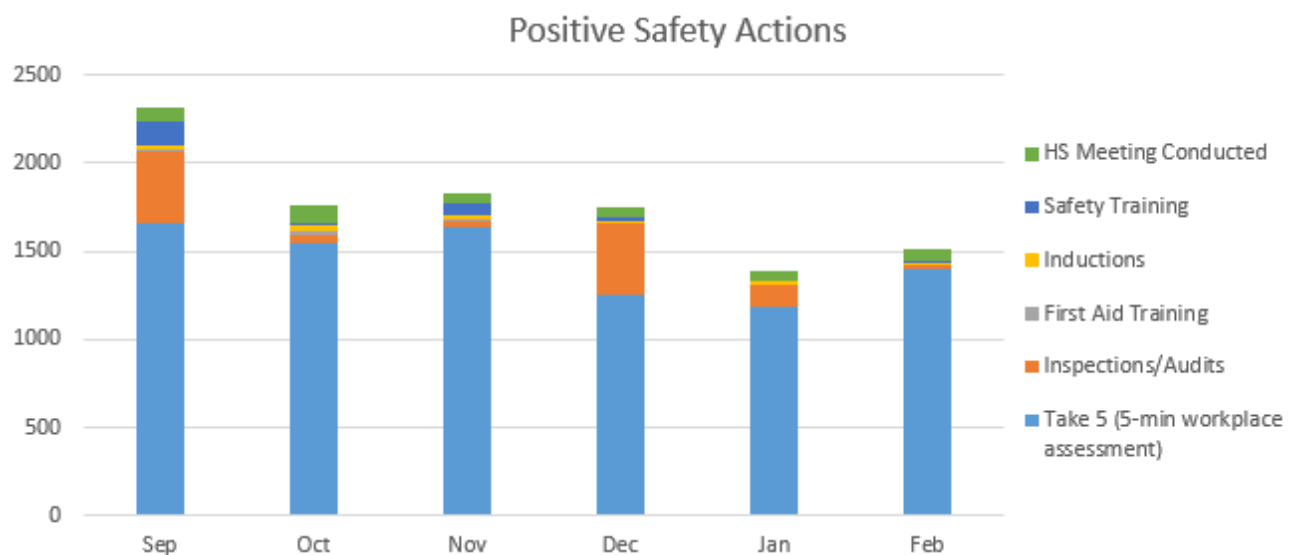
3. Performance Indicators - Reporting Period 1 September 2025 to 1 February 2026

Note that results that follow from this point relate specifically to the reporting period 1 September 2025 through 28 February 2026. These address detailed safety performance results since the last Audit, Finance and Risk Committee now the Organisational Excellence Committee

4. Lead Indicators

Positive Safety Actions

- a. Health and Safety Meetings conducted within departments or with contractors. (Total 397)
- b. Safety Training-Education: Any sessions conducted with employees that provide skills and knowledge to perform work safely. (Total 243)
- c. Inductions. The first step in engaging our employees in working safely at QLDC. (Total 129)
- d. First Aid Training. (Total 39)
- e. Inspections/Audits. Opportunities for improvement and to ensure that our workplace or our contractor's workplaces are compliant. (Total 1053)
- f. Take 5. Any assessments that identify the risks and control measures associated with a work process or situation. (Total 8672)

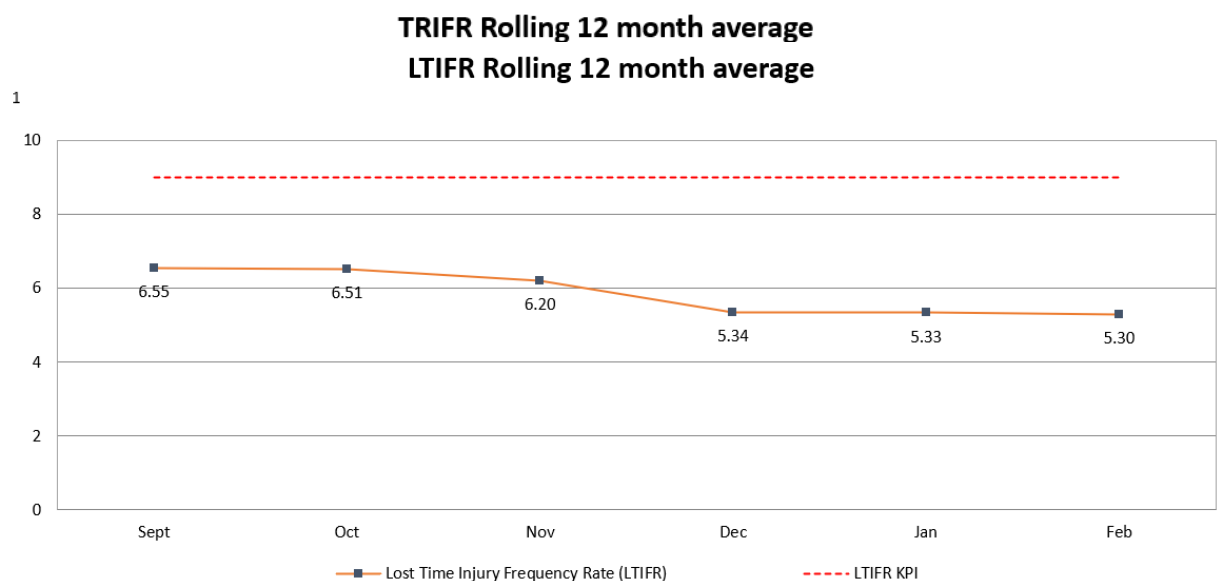


- g. **Department Safety Behaviours** Council departments are required to rate their monthly safety performance based on a simple question; Have they improved safety (A score), or has it been business as usual (B score)? A department is expected to rate themselves a C in response to a significant incident occurring where insufficient (or no) action has been taken to remedy



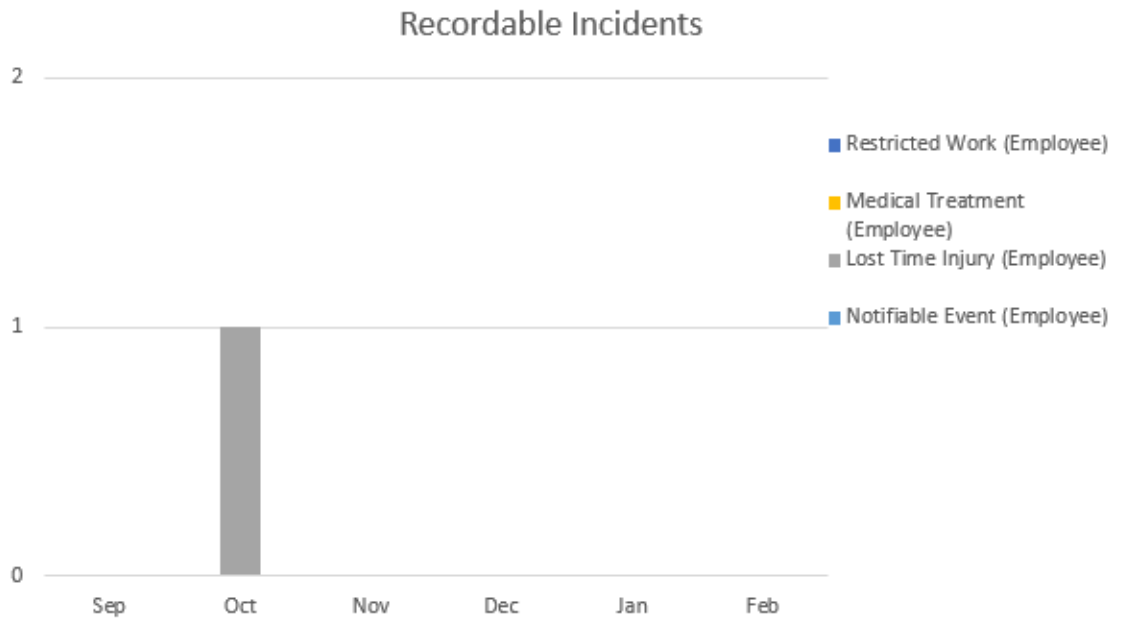
5. Safety Statistics

- a. **Total Recordable Incident Frequency Rate (TRIFR)** (These include all Recordable incidents: Medical Treatment Case, MTC. Restricted Work Case, RWC. Lost Time Injury, LTI.)
- b. **Lost Time Injury Frequency Rate (LTIFR)** (This only covers Lost Time Injury). The number of recordable cases, multiplied by 1,000,000, then divided by the total number of exposure hours worked



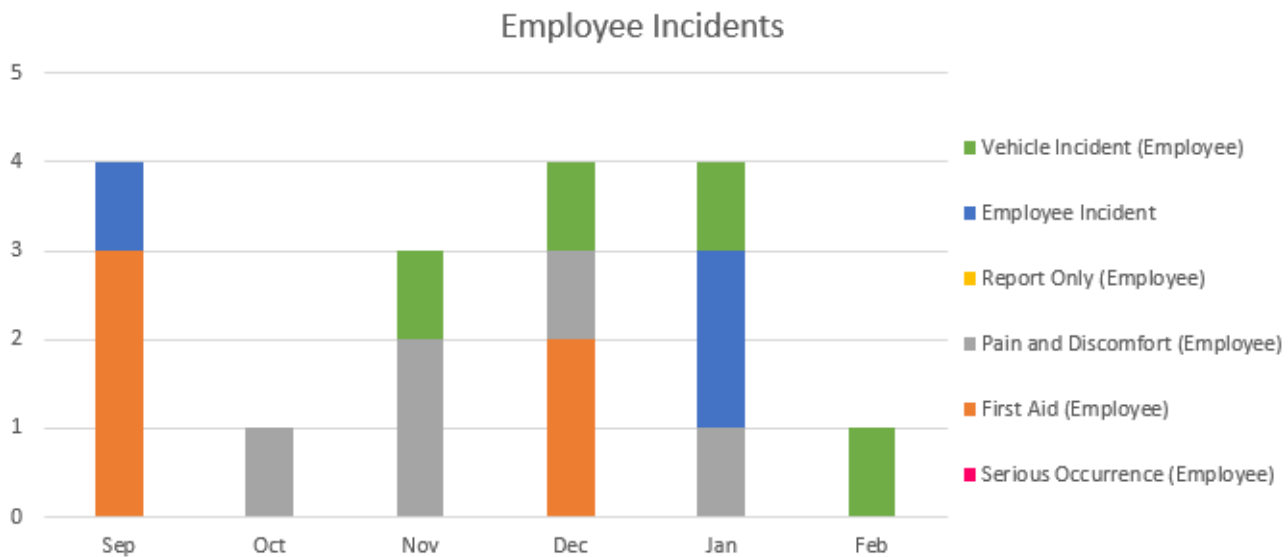
NB: There has been one Lost Time Injury Frequency Rate (LTIFR) during this reporting period, this is summarised at item 9. Council’s LTIFR KPI is 9 or below for the end of the year, currently this is at 5.30

- c. **Employee Significant Incidents** These are Recordable Incidents plus any Notifiable Events. Notifiable Events are notifiable to WorkSafe New Zealand.



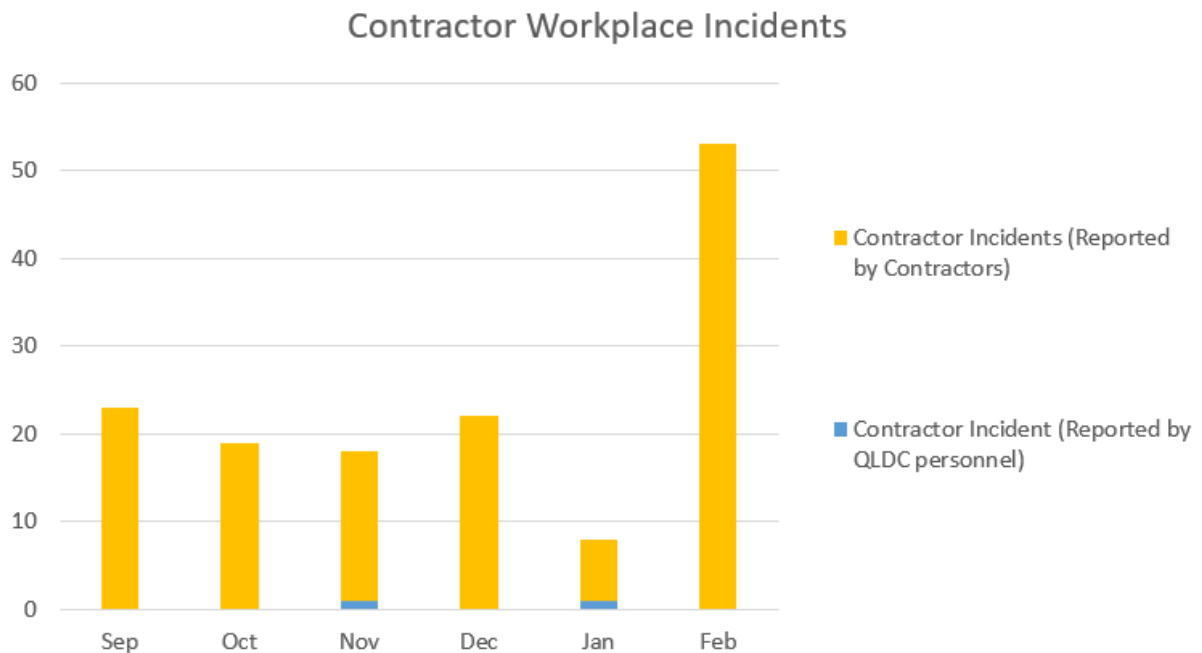
NB: One Lost Time Injury (LTI) was recorded during this reporting period which is summarised in section 9 of this report

- d. **Employee Incidents**



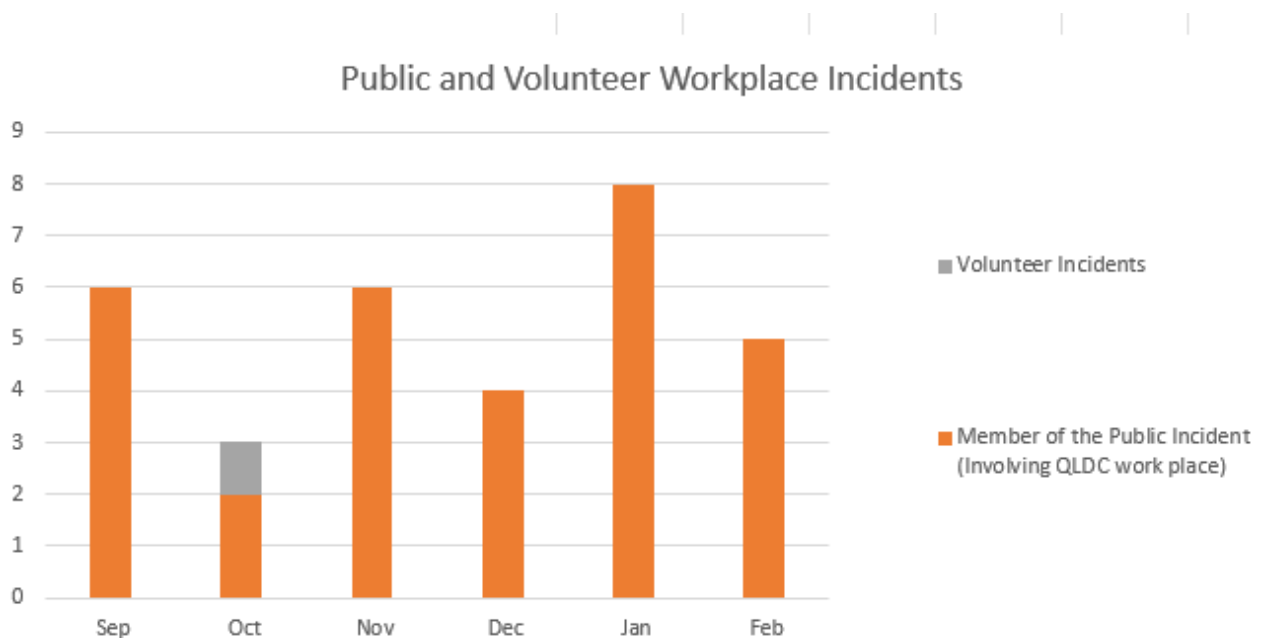
NB: Significant employee events are recorded at item 8c of this report and summarised at item 9

e. Contractor Incidents



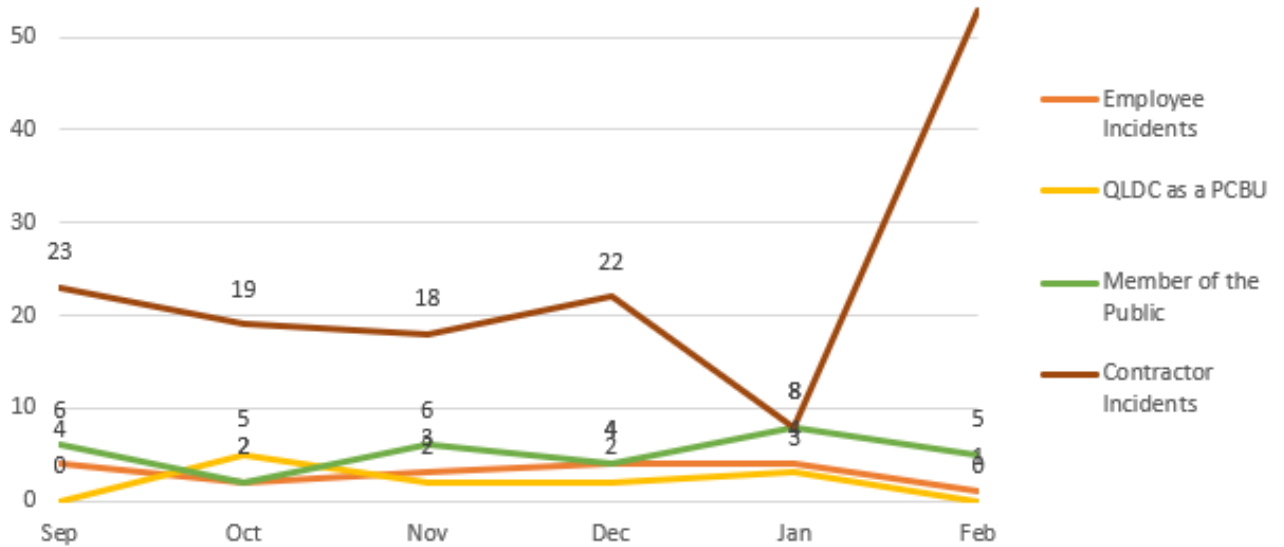
NB: During this reporting period, contractors recorded two WorkSafe Notifiable Events, two Lost Time Injuries (LTIs) and ten Serious Occurrences. These are summarised in Item 9

f. Public and Volunteer Incidents



NB: One serious occurrence involved a member of the public and is summarised in Section 9 of this report. All other incidents were of a minor nature

g. Incident Trend These are workplace incidents as defined under the Health and Safety at Work Act involving a QLDC employee, QLDC as a PCBU, contractor incidents and incidents involving members of the public



NB: The apparent increase in an upward trend shown in February for contractor incidents is due to the contract reporting date criteria

My Safety (QLDC online incident reporting system) has a 'set' recording parameter that records the date that the event was entered into the system for reporting

To note: This report covers six months. The average is circa 23 per month. Which is the expected trend for the volume of work undertaken

6. Significant Incidents (1 September 2025 to 1 February 2026)

Incident	Findings and Action taken
<p><u>Employee: Lost Time Injury</u></p> <p>During a swim instructor training session, two employees performed a synchronised tumble-turn.</p> <p>One employee pushed off at an incorrect angle and struck their head on the pool floor resulting in a concussion</p>	<ul style="list-style-type: none"> • Tumble turns are common; performing them in pairs is not standard practice • The Swim School Manager had previously advised against this; this was not followed • Team meeting held and the practice of this has been removed
<p><u>Contractor Incident: WorkSafe Notifiable Event</u></p>	<ul style="list-style-type: none"> • Contractor reported the incident to WorkSafe as precaution. The injury

<p>A worker operating an excavator was positioning a manhole grate when it became jammed</p> <p>While attempting to free the jammed bracket, the operator used a hammer to tap the bracket outward so the grate could slide down over the manhole riser. During this process, the grate suddenly dropped. Worker's finger was caught between the hammer shank and the concrete manhole under the partial weight of the manhole grate resulting in a fractured finger</p>	<p>does not fall under the criteria of a Notifiable Event. WorkSafe chose not to investigate</p> <ul style="list-style-type: none"> • The machine, slings, and lifting equipment used were fit for purpose and compliant • The task was not an exception, and the risk was well understood, however the mandatory controls were not followed by the worker as trained • Contractor has conducted refresher training specifically for slinging and lifting and the risks and controls for lifting work reinforced at project level, company level and site level
<p><u>Contractor Incident: WorkSafe Notifiable Event</u></p> <p>Worker transporting a riser on a pallet with a forklift loader attempted to re-centre the manhole riser by manually pushing and adjusting it. During this action, the riser slipped and fell approximately 150 mm, fracturing and partially degloving two of the worker's fingers</p>	<ul style="list-style-type: none"> • Incident was reported to WorkSafe. WorkSafe chose not to investigate • The task was carried out using manual means instead of using tools such as (bars, crowbars, push/pull) for minor adjustments. These were available at the time • Riser was transported inappropriately on a pallet that was inadequate for the purpose • Contractor has noted in their investigation report; There has been a lack of planning for how the risers would be stored and moved around site. This resulted in inadequate pallets being used • The use of the contractors '3 key defences and stay safe questions' would have prevented this event from occurring
<p><u>Contractor Incident: Lost Time Injury</u></p>	<ul style="list-style-type: none"> • The worker did not report the injury until four days later when the pain


<p>Worker injured their finger while attempting to lift a cut section of asphalt with a crowbar. The asphalt shifted due to its weight, catching the worker's finger and causing a laceration that later became infected and required corrective surgery</p>	<p>worsened and the finger became infected</p> <ul style="list-style-type: none"> • Hand pinch point hazard was not identified in job planning; task lacked hand safety controls and PPE did not adequately protect against injuries • Contractor has reviewed glove selection and updated their Standard Operating Procedure (SOP) to include a matrix for appropriate gloves for differing work processes • Reporting time frames have been reiterated to workgroups. If the worker had reported promptly then attention to the injury would have occurred sooner
<p><u>Contractor Incident: Lost Time Injury</u></p> <p>Worker walked into a horizontal side opening cabinet on truck, that another staff member had opened</p>	<ul style="list-style-type: none"> • Due to the wet weather and wearing a raincoat, the worker's peripheral vision was reduced • Better housekeeping required with a reminder to close the doors when not in use
<p><u>Contractor Incident: Lost Time Injury</u></p> <p>A worker was onsite using an Electric Utility Motorbike and fell when they hit a rut which resulted in fractured shoulder</p>	<ul style="list-style-type: none"> • Worker was not trained in the use of the Electric Utility Motorbike but had prior experience on a E-bike so was allowed to use the vehicle. • Lack of proper training led to the incident • Contractor has put in place training for the use of the Electric Utility Motorbikes
<p><u>Contractor Incident: Serious Occurrence</u></p> <p>A worker struck two shallow fibre ducts during temporary road works</p>	<ul style="list-style-type: none"> • Although the fibre ducts were not shown on the location plan, they had been identified further along the road • Contractor failed to follow procedures by not potholing for the ducts to the crossing

	<ul style="list-style-type: none"> • Contractor has reiterated that their locations procedures must be followed fully
<p><u>Contractor Incident: Serious Occurrence</u></p> <p>The passenger-side wheel on the truck’s front drive axle detached on Frankton Road, but the driver continued unaware. The remaining tyre later burst on Ballarat Street, producing smoke but no fire. Police and Fire and Emergency NZ attended, confirmed no further risk</p>	<ul style="list-style-type: none"> • The tyre dealer fitted torque indicators on only four of ten-wheel nuts, so some unmarked nuts may have failed despite the indicators showing correct torque • Wheel retorque procedures were outdated and have been revised, and the contractor’s pre-start checklist now includes inspection of wheel nut torque indicators • Tyre dealer was asked to attend a post incident meeting to discuss the incident findings which they declined • A safety memo has been communicated by the QLDC Project Manager to contractors to prevent recurrence
<p><u>Contractor Incident: Serious Occurrence</u></p> <p>Contractor struck the casing of an electricity cable during excavation</p>	<ul style="list-style-type: none"> • Permits and procedures, including Before You Dig checks and Ground Penetrating Radar (GPR) scanning, were employed • However, procedures were not followed in this section as use of mechanical means of excavation rather than hand excavation was employed before fully uncovering the service • Contractor has reiterated that their locations procedures must be followed fully
<p><u>Contractor Incident: Serious Occurrence</u></p> <p>Cables were identified via hydro excavation and subsequently damaged when shaping the trench batter</p>	<ul style="list-style-type: none"> • The contractor’s own procedures require fully exposing cables before any mechanical excavation, these were not followed • The contractor has reinforced that all underground services must be located

	<p>before excavation and that WorkSafe, NZUAG, and Before You Dig guidelines are to be strictly followed</p>
<p><u>Contractor Incident: Serious Occurrence</u></p> <p>Worker was on a ride on mower which became stuck in long grass while travelling along the bank with both mower arms lowered. The operator attempted to reverse and raised the right mower arm to free the machine, but during this manoeuvre the mower lost stability and rolled down the bank</p>	<ul style="list-style-type: none"> • The worker did not sustain any injuries • Procedures were not fully followed, worker should have used a weed eater on the bank, however worker decided to use the mower due to perceived time constraints • Weed eater availability was followed up by QLDC HS Manager. Weed eaters were available to the worker • A safety alert reinforcing the contractors 'Stop. Think. Act' has been followed up with contractors' team
<p><u>Contractor Incident: Serious Occurrence</u></p> <p>An excavator struck unmarked power cable and two telecom cables. All permits, Before You Dig checks, service mark-outs by asset owners pre-scans, plan reviews, and spotter oversight were in place from the asset owners</p>	<ul style="list-style-type: none"> • All required checks, permits, and service investigations were completed before excavation, including CAT scanning and potholing, which identified known services and one unrecorded power cable • These cables were not shown on any plans and could not be located by the asset owners
<p><u>Contractor Incident: Serious Occurrence</u></p> <p>Following water mains repair works by a contractor, a QLDC employee reviewing the report noted a photograph showing crew members performing hydro excavation without required PPE, including eye, hearing, and head protection</p>	<ul style="list-style-type: none"> • Formal interview taken place with the individuals regarding the required PPE and following the correct procedures • Company-wide refresher training has been delivered to all staff to reinforce PPE requirements and compliance with standard operating procedures
<p><u>Contractor Incident: Serious Occurrence</u></p> <p>Subcontractor was undertaking trenching activities and struck a sewer pipe</p>	<ul style="list-style-type: none"> • The site engineer confirmed that required processes were not followed, including checking Geographic Information System (GIS), using Before You Dig information or following good-practice service-location guidelines

	<ul style="list-style-type: none"> After discussion with the QLDC Health and Safety Manager, the contractor has reinforced to their teams that all procedures must be followed to meet safety and compliance requirements
<p><u>Contractor Incident: Serious Occurrence</u></p> <p>While laying gravel a front dumper overturned onto its side while reversing and turning. The inside corner had a height difference, and the machine was loaded with gravel at the time</p>	<ul style="list-style-type: none"> Discussion occurred on site; hazard of the height difference was recognised but no controls put into place. If they had been this would have prevented the overturn Contractor's expectations and safe work practices for working on uneven ground have been reiterated to prevent recurrence and ensure hazards are controlled at the time
<p><u>Contractor Incident: Serious Occurrence</u></p> <p>A member of the public failed to stop at the stop/go, driving around stopped cars and proceeding through the site without hesitation. The Site Traffic Management Supervisor (STMS) radioed the Traffic Controller (TC) at the other end, who quickly delayed releasing traffic</p>	<ul style="list-style-type: none"> This was reported to the Police The Contractor's Traffic Management Plan was correctly in place

7. WorkSafe Notification: Unsafe events/tasks that require reporting to the regulator.

		
Notifiable Event Type	#	Description
Notifiable Incident (Contractor)	2	<ul style="list-style-type: none"> Worker positioning a jammed manhole grate fractured their finger between the hammer and concrete riser Worker manually adjusting a manhole riser on a pallet, the riser slipped, fracturing and partially degloving two of their fingers

8. Communications: Critical safety warnings or information that is broadcast across the organisation.



Safety Alerts

December 2025

MMR Vaccination [Measles - Health New Zealand | Te Whatu Ora](#)

9. Training: Courses that have been prepared to ensure employees perform work safely

Month	Type
September 2025	<ul style="list-style-type: none">• Presenting and Providing Advice to Elected Members• Te Tiriti o Waitangi• Persuading and Influencing Others
October 2025	<ul style="list-style-type: none">• Health and Safety Contractor Management Training• Te Tiriti O Waitangi Workshop
November 2025	<ul style="list-style-type: none">• Persuading & Influencing Others• Time Management Workshop• Customer Experience (CX) Foundations Workshop
December 2025	<ul style="list-style-type: none">• Customer Experience (CX) Foundations Workshop
January 2026	<ul style="list-style-type: none">• Start of the year so nothing scheduled
February 2026	<ul style="list-style-type: none">• Libraries Situational Awareness Training• Customer Experience Foundations Workshop• Persuading and Influencing Course•