

Komiti o te Mōrearea me te Tūmaru | Risk & Assurance Committee

Ngā Tāpiritanga – Pūrongo | Attachments – Reports ATTACHMENTS UNDER SEPARATE COVER

Notice is hereby given that an ordinary meeting of Komiti o te Mōrearea me te Tūmaru | Risk & Assurance Committee will be held on:

Ko te rā | Date: Tuesday 2 July 2024
Wā | Time: 9:00
Meeting Room: Council Chambers
Wāhi | Venue: 35 Kenrick Street
TE AROHA

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The NZ mark of competence
Tohu Matatau Aotearoa

BUILDING CONSENT AUTHORITY ACCREDITATION ASSESSMENT REPORT

FINAL ASSESSMENT REPORT WITH ALL GNCS CLEARED

Updated 04/06/2024

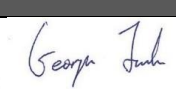
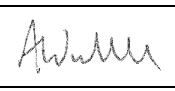
Matamata-Piako District Council

IANZ – ALL FINDINGS CLEARED	
INITIALS:	GJ
DATE:	4 June 2024

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BCA AND ASSESSMENT DETAILS

ORGANISATION DETAILS											
Organisation: Matamata-Piako District Council											
Address for service: Cnr Tui & Tainui Streets, Matamata 3400											
Client Number:		7437		Accreditation Number: 18							
Chief Executive: Don McLeod											
Chief Executive Contact Details: DMcLeod@mpdc.govt.nz											
Responsible Manager: Mr Daniel Kruger											
Responsible Manager Contact Details: dkruger@mpdc.govt.nz											
Authorised Representative: Mr Daniel Kruger											
Authorised Representative Contact Details: dkruger@mpdc.govt.nz											
Quality Manager: Mr Daniel Kruger											
Quality Manager Contact Details: dkruger@mpdc.govt.nz											
Number of FTEs		Technical		Support functions							
Total FTEs should = technical FTEs + admin FTEs + vacancies		8.5		3							
		Vacancies (Technical)		Vacancies (Support)							
		2		0							
Building Consents											
Activity during the previous 12 months						R1	470	R2	143	R3	54
						C1	91	C2	17	C3	2
						CCCs				768	
						New compliance schedules				11	
						BCA Notices to Fix				0	
ASSESSMENT TEAM											
Assessment Date: 11 March 2024 to 13 March 2024											
Lead Assessor: Georgina Jackson											
Lead Assessor Contact Details: gjackson@ianz.govt.nz											
Technical Expert: Phil Judge											
Observer(s): Gary Higham											
ASSESSMENT FINDINGS											
		This assessment (SA):		Last assessment (RR):							
Total # of "serious" non-compliances:		1		2							
Total # of "general" non-compliances:		4		3							
Total # of non-compliances outstanding:		5		5							
Recommendations:		6		10							
Advisory notes:		0		5							
Date all action plans must be accepted:		24 April 2024									
Date all non-compliances must be cleared:		24 June 2024									
NEXT ASSESSMENT											
Recommended next assessment type:		Routine Reassessment									
Recommended next assessment month:		March 2025									
IANZ REPORT PREPARATION											
Prepared by: Georgina Jackson		Date: 22 March 2024		Signature: 							
Checked by: Adrienne Woollard		Date: 22 March 2024		Signature: 							

INTRODUCTION

This report relates to the special accreditation assessment of the **Matamata-Piako District Council Building Consent Authority (BCA)** which took place remotely during **March 2024** to determine compliance with the requirements of the *Building (Accreditation of Building Consent Authorities) Regulations 2006* (the Regulations).

This report is based on the document review and interviews with the BCA's employees undertaken during the accreditation assessment.

A copy of this report, and subsequent information regarding progress towards clearance of non-compliances, will be provided to the Ministry of Business, Innovation and Employment (MBIE) in accordance with International Accreditation New Zealand's (IANZ) contractual obligations. This report may also be made publicly available by the BCA as long as this is not done in a way that misrepresents the content within. It may also be released under the Local Government Meetings and Official Information Act 1987 consistent with any ground for withholding that might be applicable. IANZ may also be required to release this report and assessment documentation if requested under the Official Information Act 1987.

ASSESSMENT SUMMARY

In March 2023, the Routine Reassessment of the BCA identified five non-compliances. These included two repeated findings, which resulted in these being raised as serious non-compliances. While the findings were able to be addressed within the assessment clearance timeframe, a Special Monitoring Assessment was planned for March 2024 to ensure that the resolutions relating to the findings from the 2023 Routine Reassessment had continued to be implemented appropriately.

As the BCA's request, this assessment was conducted remotely. It was found that once access into the BCA's systems were provided, the BCA had set up all required documentation appropriately and were well prepared for IANZ to navigate the BCA's systems. The BCA team was seen to have been consistently friendly, helpful and took time during the assessment to ask clarifying questions regarding findings.

During the assessment, the BCA was seen to have maintained a number of improvements including those relating to internal audits, training, lapsing of building consents and 24-month CCC decisions. In addition, the BCA had largely maintained compliance with statutory timeframe requirements.

The BCA was particularly proactive at identifying issues and were seen to have taken actions, recorded reasons for decisions, recorded relevant outcomes and kept track of each step in their root cause analysis process. This was seen to be particularly effective for investigations relating to statutory timeframe compliance.

There were however, some outstanding issues including a repeated point relating to compliance schedules. These are detailed below. The outstanding non-compliances must be addressed in order for accreditation to continue.

CONTINUING ACCREDITATION

Accreditation is a statement, by IANZ, that your organisation complies with the Regulations and MBIE BCA accreditation scheme guidance documents (as relevant). Where non-compliance with the Regulations has been identified, the Act requires that it must be addressed.

IDENTIFYING AND NUMBERING OF NON-COMPLIANCES

Non-compliance numbers have been issued to each Regulation and sub-Regulation which was assessed and found to be non-compliant, however, where more than one non-compliance is identified within one Regulation or sub-Regulation, then only one finding number is generated.

Regulations 7(2)(d)(v) and 7(2)(f) had been split out into their component parts to enable easy recording and management of the key issues.

Where both a Serious Non Compliance (SNC) and a General Non Compliance (GNC) have been issued for the same Regulation, each of these are recorded separately.

STEPS TO ADDRESSING NON-COMPLIANCES IDENTIFIED

Step 1	<p>Action plans Non-compliances raised during the assessment have been summarised and recorded in detail in this report. BCA to analyse the root cause of the finding within the finding tables nested under the relevant regulation, and then develop and document an action plan to address each finding (including documenting the evidence that will be submitted to address the finding).</p>	Required to be submitted within 10 working days of the receipt of this report.
Step 2	<p>IANZ Reviews the action plans provided IANZ will analyse the submitted action plans with the proposed evidence of implementation indicated, and will respond to the BCA accordingly with required improvements and/or acceptance of the plan.</p>	IANZ has a KPI of 10 working days to review and respond. Action plans and proposed evidence required to be accepted within 20 working days of the receipt of this report.
Step 3	<p>Submitting clearance evidence Upon the acceptance of all action plans, the BCA can proceed to provide clearance evidence to IANZ.</p>	BCA to submit a separate email to address each GNC, ideally containing all listed proposed evidence.
Step 4	<p>Review of clearance evidence Upon receiving clearance evidence, IANZ will review the appropriateness of the evidence to clear the identified non-compliance(s). Note that where the evidence provided does not provide sufficient assurance that the non-compliance has been addressed then IANZ may request further information to be satisfied, even if supply of that information was not detailed in the original action plan.</p>	IANZ has a KPI of 10 working days to review and respond to each piece of clearance evidence provided.
Step 5	<p>Last date for information submission The BCA must provide its final clearance information in sufficient time to allow for review, revision and resubmission of the information before the last date for final information submission provided.</p>	If insufficient or incomplete information is received by the last date for information submission, the BCA must apply for an extension of time (if relevant). Alternatively, an initial notice of possible revocation of accreditation may be issued.
Step 6	<p>Final clearance The BCA must clear all identified non-compliances.</p>	Within 3 months of the issuing of this report (unless an extension is granted or a finding is conditionally cleared waiting for future information).

If you do not agree with the non-compliances identified, or if you need further time to address non-compliances, please contact the Lead Assessor as soon as possible. Where you are seeking an extension to an agreed timeframe to address a non-compliance, your Chief Executive is required to make a formal request for an extension of the timeframe. These will only be granted for unpredictable and unmanageable reasons.

Please note that failure to provide timely objective evidence that identified non-compliances have been

effectively and sustainably resolved may result in a recommendation to revoke accreditation.

If you have a complaint about the assessment process, please refer to the BCA Accreditation disagreements guidance which can be found [here](#), or contact the IANZ Lead Assessor, IANZ Programme Manager – Building, or IANZ Operations Manager - Inspection and BCA sectors, for further information about the IANZ appeals and complaints process.

RISK ASSESSMENT

The BCA’s risk, both to the Territorial Authority, as a BCA and also as an organisation accredited by IANZ was assessed. The BCA was considered to pose a **Medium Risk**. The Risk Decision table is displayed below for reference.

High risk	A non-functioning BCA - depending on extent and type of risk and agreed management method. E.g. there is a pattern of failure to follow a policy, procedure or system (PPS) by a single or multiple employees, and/or that the PPS had not been consistently and effectively implemented.	Some form of monitoring within 6 months
Medium risk	The BCA is not currently compliant and is unlikely to demonstrate substantial compliance at the next assessment, or there was a failure to implement PPS over two or more assessment cycles.	1 year
Low risk	“Normal” risk (the BCA is likely to remain substantially compliant over the next two years).	2 years
Extra Low risk	The BCA is almost fully compliant and likely to remain that way.	Reduced monitoring at next 2 yearly assessment

The main reasons for considering this risk category were:

NEGATIVE

- Despite the limited scope of this assessment, five non-compliances were raised.
- One serious non-compliance was raised due to a repeated issue relating to compliance schedules.

POSITIVE

- The BCA was seen to be proactive at identifying issues and recording any actions and outcomes relating to these.
- The BCA had maintained many improvements made following the 2023 routine reassessment.
- Staff were seen to be positive and engaged with the accreditation process throughout the assessment, including discussing possible resolutions for the outstanding non-compliances.
- The BCA were able to clear the non-compliances from the previous 2023 routine reassessment within the clearance timeframe.

The above listed reasons and the concern about the BCA’s compliance with the Regulations would normally result in the need for a monitoring assessment to be planned within a year’s time, so IANZ can be assured that you have regained and are maintaining compliance with accreditation requirements. As the BCA’s next routine reassessment is planned for March 2025, no monitoring assessment has been planned in the interim.

NEXT ACCREDITATION ASSESSMENT

Unless your BCA undergoes a significant change, requiring some form of interim assessment, or the BCA is unable to clear the identified non-compliances within the agreed timeframe, the next assessment of the BCA is planned as a **Routine Reassessment** for **March 2025**.

You will be formally notified of your next assessment six weeks prior to its planned date.

ABBREVIATIONS

the Act	the Building Act 2004
AOB	Accredited Organisation Building
BCA	Building Consent Authority
BCO	Building Control Officer
the Code	the Building Code
CCC	Code Compliance Certificate
Consent	Building Consent
CI	Continuous improvement
Col	Conflict of Interest
Forms Regulations	Building (Forms) Regulations 2004
GNC	General Non-compliance
IANZ	International Accreditation New Zealand
MBIE	Ministry of Business, Innovation and Employment
LBP	Licensed Building Practitioner
NCAS	National Competence Assessment System
NTF	Notice to Fix
the Regulations	Building (Accreditation of Building Consent Authorities) Regulations 2006
RFI	Request for Further Information
SNC	Serious Non-compliance

ASSESSMENT OBSERVATIONS AND RECORDS OF NON-COMPLIANCE

Regulation 7(2)(b)	Receiving building consent applications
Observations and comments, including good practice and performance	
Building consent applications were seen to have been received through the AlphaOne portal. Sighted examples of receiving building consent applications were seen to be appropriate.	
Regulation 7(2)(c)	Checking building consent applications
Observations and comments, including good practice and performance	
Vetting of applications was completed within the AlphaOne system using a checklist. Sighted examples were seen to have been vetted appropriately.	
Regulation 7(2)(d)(i)	Recording building consent applications
Observations and comments, including good practice and performance	
Building consent applications were recorded within the BCA's AlphaOne system following submission into the online portal.	
Regulation 7(2)(d)(ii)	Assessing building consent applications
Observations and comments, including good practice and performance	
Sighted examples of building consent applications were seen to have been assessed appropriately.	
Regulation 7(2)(d)(iii)	Allocating building consent applications
Observations and comments, including good practice and performance	
Sighted examples of building consent applications were seen to have been allocated to employees and contractors appropriately.	
Regulation 7(2)(d)(iv)	Processing building consent applications
Observations and comments, including good practice and performance	
Building consent application and amendment application records reviewed were seen to have been processed appropriately, with appropriate reasons for decisions recorded.	


Regulation 7(2)(d)(v) Granting and issuing building consents and Compliance with Form 5
Observations and comments, including good practice and performance
<p>The information regarding the specified systems included on the Form 5 (building consent) were not always considered to be appropriate for the following reasons:</p> <ul style="list-style-type: none"> Some performance standards included on the Form 5 were not considered to be appropriate. For example, versions not being provided when referencing standards or indicating a standard as an AS when it is a AS/NZS. Performance standards were not provided for all systems. Some items were included as specified systems which would not be considered to be relevant. <p>See GNC 1 – To be resolved.</p> <p>Examples were observed where a contractor had granted and issued the Building Consent, when the contractor had not been delegated the powers to do so. As the BCA demonstrated the following, this is being raised as a recommendation, rather than a general non-compliance:</p> <ul style="list-style-type: none"> In three of four instances, this non-compliance had been immediately identified by the contractor and raised with the BCA. The BCA had reached out to their system provider to create a block to stop this error occurring, but found this to not be possible within the BCA's system. Where the BCA had identified other issues with their contractors, the BCA was able to demonstrate the recording of actions taken and the outcomes of those actions, so it was understood that the BCA would continue to take similar steps relating to this issue. <p>Therefore, the BCA is recommended to ensure they monitor their contractor's compliance when working within the BCA's systems. See Recommendation R1.</p>

General Non-compliance No. 1: Action Plan accepted Cleared 31/05/2024

Breach of requirement:	Regulation 7(2)(d)(v)						
Breach of requirement:	Regulation(s)	<input type="checkbox"/> 5(a)	<input type="checkbox"/> 5(b)	<input checked="" type="checkbox"/> 5(c)	<input type="checkbox"/> 6(b)	<input checked="" type="checkbox"/> 6(c)	<input type="checkbox"/> 6(d)
FINDING DETAILS							
<p>The information regarding the specified systems included on the Form 5 (building consent) were not always considered to be appropriate for the following reasons:</p> <ul style="list-style-type: none"> Some performance standards included on the Form 5 were not considered to be appropriate. For example, versions not provided when referencing standards or indicating a standard as an AS when it is a AS/NZS. Performance standards were not provided for all systems. Some specified systems were included which would not be considered to be relevant. 							

IMPORTANT DATES	
Date this action plan was accepted by IANZ:	9 April 2024
Final date evidence of implementation can be accepted from BCA:	10 June 2024
PLAN OF ACTION <i>(To be provided by BCA)</i>	
<ul style="list-style-type: none"> • Documented procedure for Building Consent Processing to be amended to include the following: <ul style="list-style-type: none"> ○ Specified Systems listed on the Form 5 are to include the Performance Standards, versions and any amendment details noted in full (where there is no amendment the word 'original version' stated). ○ Specified Systems that have been nominated on the Form 2, along with the Performance Standards (Versions and Amendments) for Specified Systems listed on the Form 5, are all to match those stated on the fire report and/or any other relevant documentation, where these don't match a Request for Further Information will be required. • Training to be provided for processing BCOs on the above amended procedure. 	
PROPOSED EVIDENCE OF IMPLEMENTATION <i>(To be provided by BCA):</i>	
<ul style="list-style-type: none"> • Copy of amended Processing procedure. • Copy of Training sign off, for the training of the amended Processing procedure, by BCO's who process commercial consents. • Copy of 3 x Form 5s with processing records including relevant documentation and/or fire reports attached. Where the sample size of Form 5s available (including Specified Systems) is less than 3, a minimum of 3 samples will be supplied which will include previously issued Form 5s that have been updated as evidence. 	
EVIDENCE OF IMPLEMENTATION AND ANY DISCUSSIONS:	
3/04/2024 IANZ (GJ)	<p>This plan of action is mostly appropriate, however please outline within your plan of action how the BCA plans to communicate this change in documented procedure to ensure successful implementation (e.g. training to be provided). Please also update the proposed evidence of implementation accordingly.</p> <p>Please also provide processing records as part of the documentation to be provided with the Form 5's, to demonstrate appropriate considerations made regarding the specified systems.</p>
21/05/2024 IANZ (GJ)	BCA provided material. IANZ sent to TE for review.
2/05/2024 TE - PJ	<p>GNC 1: NOT cleared. BC 202554 - OK BC 202562 -</p> <ul style="list-style-type: none"> • The performance standard referenced on the Form 5's (includes an amendment) for SS4 & SS15/4 regarding the Ecoglow system is not considered technically correct as it is indicating an alternative solution to acceptable solutions and it has combined F6/AS1 & F8/AS1 with the same version as per snippet below. If the system has been considered an alternative solution, a relevant performance standard would be required. <div style="border: 1px solid black; padding: 2px; margin: 5px 0;">Ecoglo – Alternative Solution to F6/F8/AS1, 2nd Edition, Amendment 4, dated Jan 2017</div> <p>BC 202613 –</p> <ul style="list-style-type: none"> • The documented performance standards within the processing sheet for SS2, SS4 and SS14/2 do not align with those referenced on the Form 5.

	<ul style="list-style-type: none"> ○ SS2 - <ul style="list-style-type: none"> SS 2. Automatic or manual emergency warning systems for fire or other dangers. Record any arrangement for review of system design or shop drawings that may occur after consent is granted. Y LB 11/10/2023 10:19 am SS2. Automatic / Manual Emergency Warning system is correctly specified, location is identified on plans, and documentation correctly identifies maintenance and inspection requirements. Type 3 emergency warning system as per Kirk Roberts C/VM2 fire report dated 22 Aug 2023 Performance standard NZS4512:2010 IMR NZS4512:2010 Part 6 Monthly and annual inspections by an IQP standards for those systems required by the building code: SS2 Automatic or manual emergency warning systems for fire - performance standard NZS 4512:2021 Fire detection and alarm systems in buildings ((Original Version – 07 May 2021) ○ SS4 - <ul style="list-style-type: none"> SS 4. Emergency lighting systems. Record any arrangement for review of system design or shop drawings that may occur after consent is granted. Y LB 11/10/2023 10:19 am SS4. Emergency lighting system correctly is specified, location is identified on plans, and documentation correctly identifies maintenance and inspection requirements. Emergency lighting design Enhance lighting dated 30 August 2023 Performance standard AS 2293 Part 1:2005 and associated AS 2293 Part 3:2005 IMR ASANZS 2293 Part 2:1995. SS4 Emergency lighting systems - performance standard AS2293:Parts1 and 3:2018 as amended by Appendix B,F6/AS1 (Amendment 1 – 14 May 2021) ○ SS14/2 - <ul style="list-style-type: none"> SS 14/2 & SS 15/4 Signs Y LB 11/10/2023 10:19 am SS 14/2: Performance standard: F8/AS1 (January 2017) Paragraph 5.1; F8.3.1 (January 2017); F8/AS1 (January 2017) Paragraph 5.2. IMR procedures: Compliance Schedule Handbook (2014) SS14/2 Signs relating to specified systems - performance standard F8/AS1((Amendment 4 - 01 January 2017) subsection 2.0, 3.0 and paragraph 5.4.) • The performance standard for SS4 is not considered appropriate as the 2018 version of NZS 2293 parts 1&3 have not been amended by F6/AS1 as referenced in the performance standard as per snip it below. The 2018 version is not sighted by F6/AS1. SS4 Emergency lighting systems - performance standard AS2293:Parts1 and 3:2018 as amended by Appendix B,F6/AS1 (Amendment 1 – 14 May 2021)
<p>24/05/2024 IANZ (GJ)</p>	<p>BCA submitted further material for review. IANZ sent material to TE for review.</p>
<p>27/05/2024 TE - PJ</p>	<p>BC 202562 – Now OK with changes made to reflect TE comments. BC 202613 – Still has issues (refer notes in RED below)</p> <ul style="list-style-type: none"> • The documented performance standards within the processing sheet for SS2, SS4 and SS14/2 do not align with those referenced on the Form 5. <ul style="list-style-type: none"> ○ SS2 now OK with changes made to reflect TE comments. ○ SS4 now OK with changes made to reflect TE comments. ○ SS14/2 has been amended to align with the processing notes, however it also includes a reference to NZBC clause F8.3.1 which is not within the processing notes, and it is indicating the version of the building code and referencing a paragraph. Does not make sense. (refer snip it below). <p>SS14/2 Signs relating to specified systems - performance standard F8/AS1 (January 2017) Paragraph 5.1; F8.3.1 (January 2017) Paragraph 5.2.</p> <ul style="list-style-type: none"> • The performance standard for SS4 is not considered appropriate as the 2018 version of NZS 2293 parts 1&3 have not been amended by F6/AS1 as referenced in the performance standard as per snip it below. The 2018 version is not sighted by F6/AS1. <ul style="list-style-type: none"> ○ Issue now cleared with changes made to reflect TE comments.
<p>28/05/2024 IANZ (GJ)</p>	<p>IANZ provided TE feedback to BCA. IANZ enquired with BCA regarding effectiveness of training due to issues identified. BCA then provided revised material for BC202613, as well as a further example to demonstrate implementation.</p>

29/05/2024 IANZ (GJ)	IANZ sent material to TE for review.
31/05/2024 TE (PJ)	BC 202613 – All issues identified above have now been rectified. Additional information has been provided to support the clearance of this GNC. BC 201566.A2 – The systems and performance standards listed on the Form 5 are considered appropriate from the limited information provided. GNC 1 – Cleared with evidence provided.
NON COMPLIANCE CLEARED	
Signed: 	Date: 31 May 2024

Regulation 7(2)(d)(v) Lapsing building consents

Observations and comments, including good practice and performance

The BCA was seen to have implemented their documented procedure relating to sending a reminder letter 9 months after the issued date of the building consent (regarding the upcoming lapsing of the building consent) and then calling the applicant at 11 months if no response had been received. The recordings of these actions and any related correspondence was seen to have been filed appropriately.

For sighted examples, the BCA had appropriately recorded their reasons for deciding whether or not to approve extensions to the building consent lapse date. In addition, the BCA demonstrated considerations such as the appropriateness of the extension's length of time and any relevant code clause changes. However, some recordings of reasons for approving extensions to the building consent lapse date did not appear to include all relevant details that were taken into account. For example, in one case the BCA had referred to the short length of time as a reason for the decision but had not recorded the consideration of H1 changes, despite having described this when asked about any considerations made. Therefore, the BCA is recommended to ensure that all considerations made are consistently recorded for extension requests.

See Recommendation R2.

Regulation 7(2)(d)(v) Compliance with statutory timeframes for granting and issuing building consents

Observations and comments, including good practice and performance

The BCA's compliance with the statutory timeframe for granting and issuing building consents within 20 working days was seen to be averaging around 91.3%, which was not considered to be substantially compliant.

The BCA was seen to have consistently conducted a full root cause analysis investigation for each example of processing a building consent that had gone over 20 working days. This was seen to be an example of best practice, where the BCA had clearly recorded each step of their clock management (including relevant stages involving contractors), decisions made, reasons for decisions, actions taken, relevant continuous improvement records, and outcomes.

With consideration being made to the improving trend for statutory timeframe compliance and the work that has been undertaken for the root cause analysis of all cases of non-compliance with statutory timeframes, as well an average of 93.2% compliance in the last three months prior to this Special Assessment, this non-compliance with Act requirements has only been raised as a recommendation where this would normally be considered a general non-compliance. The BCA is recommended to ensure that statutory timeframe compliance is consistently maintained.

See Recommendation R3.

Regulation 7(2)(e) Planning, performing and managing inspections

Observations and comments, including good practice and performance

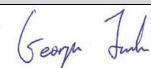
Due to the limited scope of this assessment, 7(2)(e) was only assessed with specific regard for the implementation of the BCA's minor variation procedures.

The recorded reasons for decisions for accepting a minor variation were not considered to be appropriate, as they did not discuss compliance with the Building Code or how compliance had been achieved. The recorded reasons only described what the minor variation was. For example, "Kitchen rangehood ventilation through roof cladding rather than the soffit" & "Remedial work to portal leg connections at slab saw cut locations".

See GNC 2 – To be resolved.

General Non-compliance No. 2: Action Plan accepted Cleared 23/05/2024

Breach of requirement:	Regulation 7(2)(e)						
Breach of requirement:	Regulation(s)	<input type="checkbox"/> 5(a)	<input type="checkbox"/> 5(b)	<input checked="" type="checkbox"/> 5(c)	<input type="checkbox"/> 6(b)	<input checked="" type="checkbox"/> 6(c)	<input type="checkbox"/> 6(d)
FINDING DETAILS							
The recorded reasons for decisions for accepting a minor variation were not considered to be appropriate, as they did not discuss compliance with the Building Code or how compliance had been achieved.							
IMPORTANT DATES							
Date this action plan was accepted by IANZ:					9 April 2024		
Final date evidence of implementation can be accepted from BCA:					10 June 2024		
PLAN OF ACTION <i>(To be provided by BCA)</i>							
<ul style="list-style-type: none"> Documented procedure will be amended to ensure allocation to Building Control Officer with the appropriate competency (or under supervision) and that reasons for decisions for accepting a minor variation are to be recorded. Copy of amended procedure submitted as evidence. Training to be provided for BCOs on the above amended procedure. 							
PROPOSED EVIDENCE OF IMPLEMENTATION <i>(To be provided by BCA):</i>							
<ul style="list-style-type: none"> Copy of amended Minor Variation procedure. Copy of 3 x Training Plans evidencing the training of the amended Minor Variation procedure. Evidence Minor Variations completed by Building Control Officer with the appropriate competency (or under supervision) and appropriate reasons for decisions recorded – sample size 3 Minor Variations 							
EVIDENCE OF IMPLEMENTATION AND ANY DISCUSSIONS:							
3/04/2024 IANZ (GJ)	This plan of action is mostly appropriate. However, please also outline within your plan of action how the BCA plans to communicate this change in documented procedure to ensure successful implementation (e.g. training to be provided). Please also update the proposed evidence of implementation accordingly.						
21/05/2024	BCA provided material. IANZ sent to TE for review.						

IANZ (GJ)	
22/05/2024 TE - PJ	GNC 2 is cleared with agreed evidence provided.
NON COMPLIANCE CLEARED	
Signed: 	Date: 23 May 2024

Regulation 7(2)(f) 24-month CCC decisions

Observations and comments, including good practice and performance

The BCA had appropriately made 24-month CCC decisions on whether to issue a Code Compliance Certificate where no application for Code Compliance Certificate had been received, in accordance with Regulation 7(2)(f).

Sighted examples of reminder letters sent 22 months (from the date of granting the building consent) and reasons for decisions recorded on letters relating to 24-month CCC decisions were considered to be appropriate.

Regulation 7(2)(f) Compliance with statutory timeframes for code compliance certificates

Observations and comments, including good practice and performance

The BCA's compliance with the statutory timeframe for issuing Code Compliance Certificates within 20 working days was seen to be averaging around 97.7%, which was considered to be substantially compliant.

Regulation 7(2)(f) Compliance schedules

Observations and comments, including good practice and performance

It is noted that the BCA has made good progress with the level of detail and information captured within the compliance schedules. However, the content of the compliance schedules observed was not always considered appropriate for the following reasons:


- Where standards have been amended (for example, AS/NZS 2293.1:2018 or AS/NZS 2293.1:2018 Amd 1:2021), the standards referenced for the performance & inspection / maintenance standards did not include the version.
- Specified systems were included on the Form 5 but were not always included on the compliance schedule and there was no documented reason for the change.
- Specified systems were included in the compliance schedule which were not included on the Form 5 and there was no documented reason for the change.
- Some performance standards referenced were not considered to be appropriate for the system.
- The system description did not always cover all relevant parts of the system. For example, SS15/3 did not include the fire rated doors.

<ul style="list-style-type: none"> The specified systems listed within the Table of Systems did not always align with those within the body of the compliance schedule. SS14/2 & SS15/4 were combined within the compliance schedule, which was not always considered to be appropriate, as some compliance schedules did not include both systems and the performance standard was not always appropriate to both systems when both systems were applicable. <p>See GNC 3 – To be resolved.</p> <p>The content of the compliance schedules observed was not always considered to be appropriate as some performance standards on the compliance schedule differed from those on the Form 5, with no documented reason for the change. As this specific point is a repeat from the last assessment, this has been raised as a serious non-compliance.</p> <p>See SNC 1 – To be resolved.</p>
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Serious Non-compliance No. 1: Action Plan accepted Cleared 28/05/2024

Breach of requirement:	Regulation 7(2)(f)						
Breach of requirement:	Regulation(s)	<input type="checkbox"/> 5(a)	<input type="checkbox"/> 5(b)	<input checked="" type="checkbox"/> 5(c)	<input type="checkbox"/> 6(b)	<input checked="" type="checkbox"/> 6(c)	<input type="checkbox"/> 6(d)
FINDING DETAILS							
The content of the compliance schedules observed was not always considered to be appropriate as some performance standards on the compliance schedule differed from those on the Form 5, with no documented reason for the change.							
IMPORTANT DATES							
Date this action plan was accepted by IANZ:					9 April 2024		
Final date evidence of implementation can be accepted from BCA:					10 June 2024		
PLAN OF ACTION <i>(To be provided by BCA)</i>							
<ul style="list-style-type: none"> Documented procedure for Building Consent Processing to be amended to include the following: <ul style="list-style-type: none"> Specified Systems listed on the Form 5 are to include the Performance Standards, versions and any amendment details noted in full (where there is no amendment the word 'original version' stated). Specified Systems that have been nominated on the Form 2, along with the Performance Standards (Versions and Amendments) for Specified Systems listed on the Form 5, are all to match those stated on the fire report and/or any other relevant documentation, where these don't match a Request for Further Information will be required. Documented procedure for Compliance Schedules to be amended to include: <ul style="list-style-type: none"> Description of how we will manage applications where there has been a change in the Performance Standards or inspections, maintenance and reporting requirements, this will also include the need for records to be maintained where changes are noted. All Specified Systems listed on the Compliance Schedule to include Performance Standards, Versions, and any Amendment details (where there is no Amendment the word 'original version' to be stated). The Performance Standards to be recorded correctly i.e where a standard is an AS/NZS it must be referenced as such, not just AS or NZS. SS14/2 and SS15/4 will be separated in MPDCs Compliance Schedule Template – Councils operating system Authority. 							

PROPOSED EVIDENCE OF IMPLEMENTATION <i>(To be provided by BCA):</i>	
<ul style="list-style-type: none"> Copy of amended Processing procedure. Copy of 3 x Form 5s with relevant documentation and/or fire reports attached. Where the sample size of Form 5s available (including Specified Systems) is less than 3, a minimum of 3 samples will be supplied which will include previously issued Form 5s that have been updated as evidence. Copy of amended Compliance Schedule procedure. Copy of MPDCs Compliance Schedule Template evidencing SS14/2 and SS15/4 separated. Copy of all new Compliance Schedules issued between 24th April and 24th May 2024. Where the sample of new Compliance Schedules created for the above period is less than 2, a minimum of 2 samples will be supplied which will include previously issued Compliance Schedules that have been updated as evidence. Along with the copies of the Compliance Schedules all associated documentation including Form 5s, Form 7s, any evidence of minor variations/amendments etc. will be provided. (Upon BCA request, this was changed to the below point on 11/04/2024) Copy of two new Compliance Schedules issued. Along with the copies of the Compliance Schedules all associated documentation including Form 5s, Form 7s, any evidence of minor variations/amendments etc. will be provided. 	
EVIDENCE OF IMPLEMENTATION AND ANY DISCUSSIONS:	
3/04/2024 IANZ (GJ)	<p>The proposed action plan and evidence of implementation is mostly appropriate. However, please also provide:</p> <ul style="list-style-type: none"> MPDCs Compliance Schedule Template with changes, as indicated in the proposed action plan. Associated documentation with the Compliance schedules (e.g. Associated Form 5s including any draft compliance schedules, Form 7s, any evidence of minor variations/amendments etc).
11/04/2024 IANZ (GJ)	<p>BCA requested that the point starting 'Copy of all new Compliance Schedules' above is changed to "<i>Copy of two new Compliance Schedules issued. Along with the copies of the Compliance Schedules all associated documentation including Form 5s, Form 7s, any evidence of minor variations/amendments etc. will be provided.</i>"</p> <p>Approved by IANZ and proposed evidence of implementation updated above.</p>
21/05/2024 IANZ (GJ)	BCA provided material. IANZ sent to TE for review.
23/05/2024 TE - PJ	<p>SNC 1: NOT cleared</p> <p>CS 4196 BC 201415: Overall, the performance standards on the compliance schedule align with those referenced on the Form 5 with some additional information regarding the versions which are acceptable. However, the performance standard on the compliance schedule for SS15/4 has been altered to include an additional performance standard being Alternative Solution F6/AS1. Firstly, there is no documented reason for the change, and secondly, the reference to F6/AS1 as an alternative solution is not considered appropriate.</p> <p>CS 4198 BC 202594: OK. Systems and performance standards on the compliance schedule align with those referenced on the Form 5 with some additional information regarding the versions which is acceptable.</p>
24/05/2024 IANZ (GJ)	BCA submitted further material for review. IANZ sent material to TE for review.
27/05/2024	SNC 1 is cleared with the information provided amended to reflect the TE comments.

TE - PJ	
NON COMPLIANCE CLEARED	
Signed: 	Date: 28 May 2024

General Non-compliance No. 3: Action Plan accepted Cleared 28/05/2024

Breach of requirement:	Regulation 7(2)(f)						
Breach of requirement:	Regulation(s)	<input type="checkbox"/> 5(a)	<input type="checkbox"/> 5(b)	<input checked="" type="checkbox"/> 5(c)	<input type="checkbox"/> 6(b)	<input checked="" type="checkbox"/> 6(c)	<input type="checkbox"/> 6(d)
FINDING DETAILS							
<p>the content of the compliance schedules observed was not always considered appropriate for the following reasons:</p> <ul style="list-style-type: none"> Where standards have been amended (for example, AS/NZS 2293.1:2018 or AS/NZS 2293.1:2018 Amd 1:2021), the standards referenced for the performance & inspection / maintenance standards did not include the version. Specified systems were included on the Form 5 but were not always included on the compliance schedule and there was no documented reason for the change. Specified systems were included in the compliance schedule which were not included on the Form 5 and there was no documented reason for the change. Some performance standards referenced were not considered to be appropriate for the system. The system description did not always cover all relevant parts of the system. For example, SS15/3 did not include the fire rated doors. The specified systems listed within the Table of Systems did not always align with those within the body of the compliance schedule. SS14/2 & SS15/4 were combined within the compliance schedule, which was not always considered to be appropriate, as some compliance schedules did not include both systems and the performance standard was not always appropriate to both systems when both systems were applicable. 							
IMPORTANT DATES							
Date this action plan was accepted by IANZ:					9 April 2024		
Final date evidence of implementation can be accepted from BCA:					10 June 2024		
PLAN OF ACTION <i>(To be provided by BCA)</i>							
<ul style="list-style-type: none"> Documented procedure for Building Consent Processing to be amended to include the following: <ul style="list-style-type: none"> Specified Systems listed on the Form 5 are to include the Performance Standards, versions and any amendment details noted in full (where there is no amendment the word 'original version' stated). Specified Systems that have been nominated on the Form 2, along with the Performance Standards (Versions and Amendments) for Specified Systems listed on the Form 5, are all to match those stated on the fire report and/or any other relevant documentation, where these don't match a Request for Further Information will be required. Documented procedure for Compliance Schedules to be amended to include: 							

- Description of how we will manage applications where there has been a change in the Performance Standards or inspections, maintenance and reporting requirements, this will also include the need for records to be maintained where changes are noted.
- All Specified Systems listed on the Compliance Schedule to include Performance Standards, Versions, and any Amendment details (where there is no Amendment the word 'original version' to be stated). The Performance Standards to be recorded correctly i.e where a standard is an AS/NZS it must be referenced as such, not just AS or NZS.
- Statement 'Where Form 5 issued prior to (will include date of new procedure) the Compliance Schedule details listed on the Form 5 cannot be deemed to be accurate, therefore the Form 2, Form 5, Fire Report and relevant documentation will need to be checked and where discrepancies are found requests for further information made".
- CS4192 will be revised and updated.
- SS14/2 and SS15/4 will be separated in MPDCs Compliance Schedule Template – Councils operating system Authority.

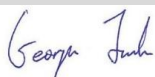
PROPOSED EVIDENCE OF IMPLEMENTATION (To be provided by BCA):

- Copy of amended Processing procedure.
- Copy of 3 x Form 5s with processing records including relevant documentation and/or fire reports attached. Where the sample size of Form 5s available (including Specified Systems) is less than 3, a minimum of 3 samples will be supplied which will include previously issued Form 5s that have been updated as evidence.
- Copy of amended Compliance Schedule procedure.
- Copy of MPDCs Compliance Schedule Template evidencing SS14/2 and SS15/4 separated.
- Updated copy of CS4192.
- Copy of Requests for Further information sent and responses received, for CS4192.
- ~~Copy of all new Compliance Schedules issued between 24th April and 24th May 2024. Where the sample of new Compliance Schedules created for the above period is less than 2, a minimum of 2 samples will be supplied which will include previously issued Compliance Schedules that have been updated as evidence. Along with the copies of the Compliance Schedules all associated documentation including Form 5s, Form 7s, any evidence of minor variations/amendments etc. will be provided.~~ (Upon BCA request, this was changed to the below point on 11/04/2024)
- Copy of two new Compliance Schedules issued. Along with the copies of the Compliance Schedules all associated documentation including Form 5s, Form 7s, any evidence of minor variations/amendments etc. will be provided.

EVIDENCE OF IMPLEMENTATION AND ANY DISCUSSIONS:

<p>3/04/2024 IANZ (GJ)</p>	<p>The proposed action plan and evidence of implementation is mostly appropriate. However, please also:</p> <ul style="list-style-type: none"> - Provide MPDC's Compliance Schedule Template with changes, as indicated in the proposed action plan. - Provide associated documentation with the Compliance schedules (e.g. Associated Form 5s including any draft compliance schedules, Form 7s, any evidence of minor variations/amendments etc).
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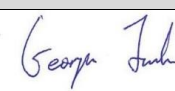
	<p>- As per discussion comments for GNC 1, please also provide processing records as part of the documentation to be provided with the Form 5's, to demonstrate appropriate considerations made regarding the specified systems.</p> <p>In addition, regarding the non-compliance point “<i>The system description did not always cover all relevant parts of the system. For example, SS15/3 did not include the fire rated doors</i>”, could you please explain how this is being addressed within the plan of action and what evidence will be provided by the BCA to support this? (CS4192)</p>
11/04/2024 IANZ (GJ)	<p>BCA requested that the point starting ‘Copy of all new Compliance Schedules’ above is changed to “<i>Copy of two new Compliance Schedules issued. Along with the copies of the Compliance Schedules all associated documentation including Form 5s, Form 7s, any evidence of minor variations/amendments etc. will be provided.</i>”</p> <p>Approved by IANZ and proposed evidence of implementation updated above.</p>
21/05/2024 IANZ (GJ)	<p>BCA provided material. IANZ sent to TE for review.</p>
23/05/2024 TE - PJ	<p>GNC 3: NOT cleared</p> <p>Several of the points raised within the finding have been cleared with the evidence provided, However, a couple points still remain as per the notes below. (GREEN indicates point cleared)</p> <ul style="list-style-type: none"> • Where standards have been amended (for example, AS/NZS 2293.1:2018 or AS/NZS 2293.1:2018 Amd 1:2021), the standards referenced for the performance & inspection / maintenance standards did not include the version. • Specified systems were included on the Form 5 but were not always included on the compliance schedule and there was no documented reason for the change. • Specified systems were included in the compliance schedule which were not included on the Form 5 and there was no documented reason for the change. • Some performance standards referenced were not considered to be appropriate for the system. • The system description did not always cover all relevant parts of the system. For example, SS15/3 did not include the fire rated doors. • The specified systems listed within the Table of Systems did not always align with those within the body of the compliance schedule. • SS14/2 & SS15/4 were combined within the compliance schedule, which was not always considered to be appropriate, as some compliance schedules did not include both systems and the performance standard was not always appropriate to both systems when both systems were applicable. <p>CS 4192 BC202562:</p> <ul style="list-style-type: none"> • The performance standard and inspection/maintenance procedure for SS4 Ecoglo system is not considered technically correct as it is indicating an alternative solution to acceptable solutions, and it has combined F6/AS1 & F8/AS1 with the same version which is not applicable to both acceptable solutions. Also, if the system has been considered an alternative solution, a relevant detailed performance standard would be required. • The performance standard for SS15/3 is not considered complete, as it only covers the fire rated door set. Therefore, there is no performance standard to cover the fire rated walls as described in the system.

	<ul style="list-style-type: none"> The performance standard and inspection/maintenance procedure for SS15/4 Ecoglo system is not considered technically correct as it is indicating alternative solution F6/AS1 & F8/AS1 with the same version which is not applicable to both acceptable solutions. Also, if the system has been considered an alternative solution, a relevant detailed performance standard would be required. <p>CS 4196 BC 201415:</p> <ul style="list-style-type: none"> The performance standard on the compliance schedule for SS15/4 has been indicated as Alternative Solution F6/AS1. The reference to F6/AS1 as an alternative solution is not considered appropriate. <p>CS 4198 BC 202594: OK. The information within the compliance schedule is considered appropriate.</p>
24/05/2024 IANZ (GJ)	BCA submitted further material for review. IANZ sent material to TE for review.
27/05/2024 TE – PJ	GNC 3 is cleared with the information provided amended to reflect the TE comments.
NON COMPLIANCE CLEARED	
Signed: 	Date: 28 May 2024

Regulation 9	Allocating work
Observations and comments, including good practice and performance	
<p>Minor variations were observed where the BCO who approved the variation did not hold the appropriate competency. See GNC 4 – To be resolved.</p>	

General Non-compliance No. 4: Action Plan accepted Cleared 23/05/2024

Breach of requirement:	Regulation 9						
Breach of requirement:	Regulation(s)	<input type="checkbox"/> 5(a)	<input type="checkbox"/> 5(b)	<input checked="" type="checkbox"/> 5(c)	<input type="checkbox"/> 6(b)	<input type="checkbox"/> 6(c)	<input type="checkbox"/> 6(d)
FINDING DETAILS							
<p>Minor variations were observed where the BCO who approved the variation did not hold the appropriate competency.</p>							
IMPORTANT DATES							
Date this action plan was accepted by IANZ:					9 April 2024		
Final date evidence of implementation can be accepted from BCA:					10 June 2024		
PLAN OF ACTION (To be provided by BCA)							
<ul style="list-style-type: none"> Documented procedure will be amended to ensure allocation to Building Control Officer with the appropriate competency (or under supervision) and that reasons for decisions for accepting a minor variation are to be recorded. Copy of amended procedure submitted as evidence. Training to be provided for BCOs on the above amended procedure. 							
PROPOSED EVIDENCE OF IMPLEMENTATION (To be provided by BCA):							

<ul style="list-style-type: none"> • Copy of amended Minor Variation procedure. • Copy of 3 x Training Plans evidencing the training of the amended Minor Variation procedure. • Evidence Minor Variations completed by Building Control Officer with the appropriate competency (or under supervision) and appropriate reasons for decisions recorded – sample size 3 Minor Variations 	
EVIDENCE OF IMPLEMENTATION AND ANY DISCUSSIONS:	
3/04/2024 IANZ (GJ)	This plan of action is mostly appropriate, however please outline within your plan of action how the BCA plans to communicate this change in documented procedure to ensure successful implementation (e.g. training to be provided) and please also update the proposed evidence of implementation accordingly.
21/05/2024 IANZ (GJ)	BCA provided material. IANZ sent to TE for review.
23/05/2024 TE – PJ	GNC 4 is cleared with agreed evidence provided.
NON COMPLIANCE CLEARED	
Signed: 	Date: 23 May 2024

Regulation 11(1) The training system

Observations and comments, including good practice and performance

The BCA had developed a training system in accordance with Regulation 11(1). Where omissions were detected, they were addressed under their relevant Regulation in this report.

Regulation 11(2)(a) Making annual (or more frequent) training needs assessments

Observations and comments, including good practice and performance

Training needs were seen to have been identified through competency assessments, peer reviews, technical audits, and 1-on-1 catchups. Records of these were seen to have been appropriately maintained.

Regulation 11(2)(b) Preparing training plans that specify the training outcomes required

Observations and comments, including good practice and performance

Training plans for staff of varying competencies were seen to have been filed appropriately and kept up to date. Training included activities such as external courses, internal training sessions, meetings regarding procedural updates, and observing tasks relevant to their roles.

Recent induction records were also sighted and found to be up to date for new employees.

Regulation 11(2)(c) Ensuring that employees receive the training agreed for them

Observations and comments, including good practice and performance

For all sighted examples of staff training plans, training was recorded as having had been received within agreed timeframes.

Regulation 11(2)(d) Monitoring and reviewing employees' application of the training they have received, including by observing relevant activities

Observations and comments, including good practice and performance

Sighted examples of the monitoring and review of employees' application of training receiving included peer reviews (with specific references of work completed including commentary from supervisors), certificates of completion, marks received while working towards a qualification, meeting minutes and written evaluations. Evaluations of courses included objectives, learning outcomes, and recordings of discussions including reasons for these decisions regarding how has been effective for the trained individual.


Regulation 11(2)(e) Supervising employees doing a technical job under training

Observations and comments, including good practice and performance

Examples were sighted where supervision had not been recorded appropriately for instances where BCOs had approved minor variations when they did not have the appropriate competency.
See GNC 5 – To be resolved.

General Non-compliance No. 5: Action Plan accepted Cleared 23/05/2024

Breach of requirement:	Regulation 11(2)(e)						
Breach of requirement:	Regulation(s)	<input type="checkbox"/> 5(a)	<input type="checkbox"/> 5(b)	<input checked="" type="checkbox"/> 5(c)	<input type="checkbox"/> 6(b)	<input checked="" type="checkbox"/> 6(c)	<input type="checkbox"/> 6(d)
FINDING DETAILS							
Examples were sighted where supervision had not been recorded appropriately for instances where BCOs had approved minor variations when they did not have the appropriate competency.							
IMPORTANT DATES							
Date this action plan was accepted by IANZ:					9 April 2024		
Final date evidence of implementation can be accepted from BCA:					10 June 2024		
PLAN OF ACTION <i>(To be provided by BCA)</i>							
<ul style="list-style-type: none"> Documented procedure will be amended to ensure allocation to Building Control Officer with the appropriate competency (or under supervision) and that reasons for decisions for accepting a minor variation are to be recorded. Copy of amended procedure submitted as evidence. Training to be provided for BCOs on the above amended procedure. 							
PROPOSED EVIDENCE OF IMPLEMENTATION <i>(To be provided by BCA):</i>							

<ul style="list-style-type: none"> • Copy of amended Minor Variation procedure. • Copy of 3 x Training Plans evidencing the training of the amended Minor Variation procedure. • Evidence Minor Variations completed by Building Control Officer with the appropriate competency (or under supervision) and appropriate reasons for decisions recorded – sample size 3 Minor Variations • Copy of 2 x BCOs supervision log where at least 2 Minor Variations completed under supervision. 	
EVIDENCE OF IMPLEMENTATION AND ANY DISCUSSIONS:	
3/04/2024 IANZ (GJ)	<p>This plan of action is mostly appropriate, however please outline within your plan of action how the BCA plans to communicate this change in documented procedure to ensure successful implementation (e.g. training to be provided). Please update the proposed evidence of implementation accordingly.</p> <p>In addition, please ensure that for the evidence of minor variations completed, at least 2 of the samples to be provided are completed by BCO under supervision.</p>
21/05/2024 IANZ (GJ)	BCA provided material. IANZ sent to TE for review.
23/05/2024 TE - PJ	GNC 5 is cleared with agreed evidence provided.
NON COMPLIANCE CLEARED	
Signed: 	Date: 23 May 2024

Regulation 11(2)(f) Recording employees' qualifications, experience and training

Observations and comments, including good practice and performance

Sighted qualifications, relevant training, and evidence of experience were seen to have been appropriately recorded and filed.

Regulation 11(2)(g) Recording continuing training information

Observations and comments, including good practice and performance

In some instances (specifically newer staff), professional development logs did not appear to have been updated. The BCA is recommended to ensure that all continuous professional development logs (found to be located in a separate space within training plans) are kept up to date for all staff.
See Recommendation R4.

Regulation 17(2)(h) Undertaking annual audits

Observations and comments, including good practice and performance

The BCA had created appropriate audit schedules for both systems and technical audits. These audits were seen to have been completed as per the schedule. While all staff conducting technical tasks appeared to have been audited at least annually, the BCA is recommended to ensure that they complete an appropriate sample size of audits, particularly for technical tasks which were being conducted by very few staff, such as for Code Compliance Certificates.

See Recommendation R5.

In one instance, it was found that a technical audit had been conducted by an auditor of lower competency than the auditee. The BCA is recommended to ensure that they consistently record their reasons for decisions for why an auditor is considered to be competent to conduct the audit.

See Recommendation R6.

Regulation 18(1) Technical qualifications

Observations and comments, including good practice and performance

The BCA had ensured that all employees and contractors who performed the authority's building control functions by doing a technical job held an appropriate technical qualification or were working towards one.

Regulation 18(3) Technical qualifications

Observations and comments, including good practice and performance

There were currently no employees exempted from the requirement to hold an appropriate technical qualification.

SUMMARY OF RECOMMENDATIONS

Recommendations are intended to assist your BCA to maintain compliance with the Regulations. They are not conditions for accreditation but a failure to make changes may result in non-compliance with the Regulations in the future.

It is recommended that:

- R1 Regulation 7(2)(d)(v)** – A contractor was observed to have granted and issued a building consent when they did not have the delegated powers to do so. The BCA is recommended to ensure they monitor their contractor's compliance when working within the BCA's systems.
- R2 Regulation 7(2)(d)(v)** - Some recordings of reasons for approving extensions to the building consent lapse date did not appear to include all relevant details that were taken into account when making the decision. The BCA is recommended to ensure that all considerations made for extension requests are consistently recorded.
- R3 Regulation 7(2)(d)(v)** - The BCA is recommended to ensure that statutory timeframe compliance is consistently maintained.
- R4 Regulation 11(2)(g)** - In some instances (specifically newer staff), professional development logs did not appear to have been updated. The BCA is recommended to ensure that all continuous professional development logs are kept up to date for all staff.
- R5 Regulation 17(2)(h)** - While all staff conducting technical tasks appeared to have been audited at least annually, the BCA is recommended to ensure that they complete an appropriate sample size of audits, particularly for technical tasks which were being conducted by very few staff, such as for Code Compliance Certificates.
- R6 Regulation 17(2)(h)** - In one instance, it was found that a technical audit had been conducted by an auditor of lower competency than the auditee. The BCA is recommended to ensure that they consistently record their reasons for decisions for why an auditor is considered to be competent to conduct the audit. SUMMARY TABLE OF NON-COMPLIANCE

The following table summarises the non-compliance identified with the accreditation requirements in your BCA's accreditation assessment. Where a non-compliance has been identified, a Record of Non-compliance template has been prepared detailing the issue, and to enable you to detail your proposed corrective actions to IANZ. You must update and return a template for each non-compliance identified.

Staff Climate Survey 2024

Item 8.8

Attachment A

2024 Staff Climate Survey

19/2/24 - 1/3/24

- ▶ Overall score 64% (67% in 2023, 69% in 2022)
- ▶ Participation 48.3% (65% in 2023, 59% in 2022)

Benchmarking

- ▶ 25th out of 57 Councils (2023: 21st out of 54 Councils)

2024 Results

Highest scoring questions (top 10). Based on total amount of agreement.

Question	2023	2024	% Change from 2023 to 2024
I am aware of the Harassment (including bullying and discrimination) policy	89%	99.3%	10%
I understand clearly how the things I do affect the ability of others in my team to do their job	93%	98.6%	6%
MPDC is a great place to work	93%	94.5%	1%
I enjoy working for MPDC	95%	93.2%	-2%
MPDC places an emphasis on the safety and wellness of its staff and customers	94%	92.5%	-1%
I have the autonomy to make decisions on matters I am responsible for	91%	92.5%	2%
I know where to access or who to ask about staff wellbeing initiatives*	86%	91.8%	6%
I am clear on the role I play in helping deliver what our ratepayers/community wants	91%	89.7%	-1%
MPDC cares about my overall wellbeing	89%	89.7%	1%
My own performance targets are aligned with the objectives of MPDC*	87%	89.0%	2%

*New to top 10 this year

2024 Results

Lowest scoring questions (lowest 10). Based on total amount of disagreement.

Question	2023	2024	% change from 2023 to 2024 (increased level of disagreement)
We have the technology to effectively support our processes	38%	44.5%	6%
MPDC has a positive reputation with our ratepayers	34%	39.0%	5%
We work efficiently and effectively between different teams at MPDC	28%	37.0%	9%
We can quickly obtain customised reports from our information systems	28%	37.0%	9%
We effectively identify and realise opportunities to reduce costs*	20%	35.6%	15%
Meetings are generally an effective use of time	26%	34.2%	8%
MPDC allocates resources (equipment, tools, staffing etc) effectively to achieve agreed outcomes	32%	33.6%	1%
I consider our pay is fair compared to similar roles and organisations in the marketplace	37%	32.2%	-5%
What I receive from other teams is accurate, complete and timely enough to do my job well*	23%	31.5%	8%
I am regularly asked for feedback on how to improve MPDC	27%	29.5%	2%

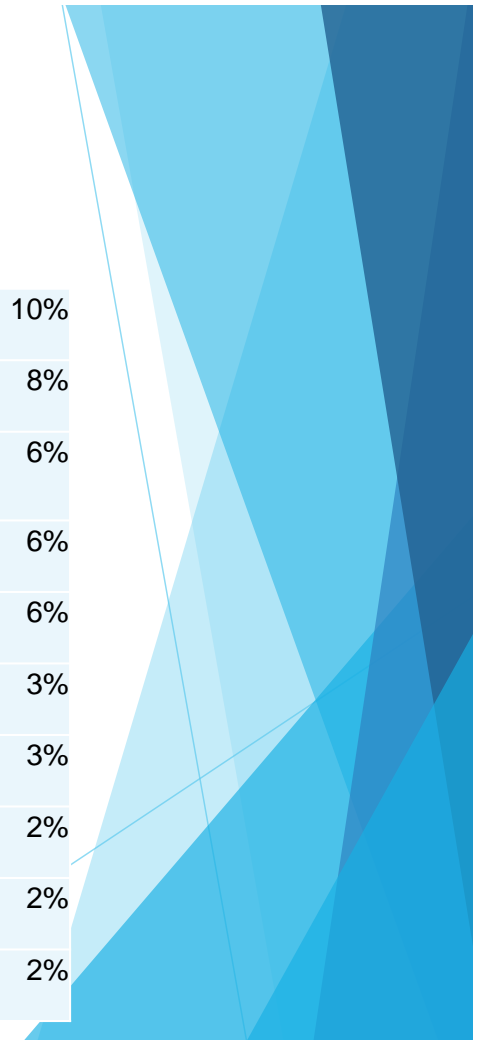
*New to lowest 10 this year

Common themes from staff comments

- ▶ Pay
- ▶ Staff benefits such as ability to work from home, flexible working, four day week, mental health days for staff
- ▶ Connection and opportunities for building relationships within and between teams
- ▶ Technology concerns
- ▶ Organisation structure and the review (a wide range of comments on this - some positive, some negative)
- ▶ Office environment
- ▶ Concerns about the survey: anonymity and length

Result changes between 2023 - 2024 (positive)

I am aware of the Harassment (including bullying and discrimination) policy	10%
I understand the future plans and direction for MPDC	8%
I know where to access or who to ask about staff wellbeing initiatives	6%
I understand clearly how the things I do affect the ability of others in my team to do their job	6%
I understand where MPDC is going and how it's going to get there	6%
The actions of our Exec Team and Management Group are consistent with MPDC's values	3%
Initiatives and projects are researched and planned effectively	3%
I consider our pay is fair compared to similar roles and organisations in the marketplace	2%
My own performance targets are aligned with the objectives of MPDC	2%
MPDC ensures I understand why workplace changes are made when they affect me	2%



Item 8.8

Attachment A

Result changes between 2023 - 2024 (negative)

I feel that I can report harassment (including bullying or discrimination) without repercussions	-11%
Meetings are generally an effective use of time	-9%
We work efficiently and effectively between different teams at MPDC	-8%
We keep up with the best initiatives that are used in other councils	-8%
We effectively identify and realise opportunities to reduce costs	-8%
We have the technology to effectively support our processes	-7%
The contribution of individuals is recognised at MPDC	-7%
There is a strong focus on how we can work together better as a team	-7%
I feel that harassment (including bullying or discrimination) is not tolerated by MPDC	-7%
MPDC supports people who come forward with new ideas	-7%

Update on 2023-2024 Plans

Issue	Planned actions	Status
Reputation	Takatū Anamata Future Ready, review of Events and Marketing Officer position (business relationship)	Takatū Anamata Future Ready review completed and implementation is underway. New Group Managers with focus on relationships and customer experience.
Future of MPDC	Takatū Anamata Future Ready, change management and internal coms	Regular updates as part of the Takatū Anamata Future Ready process and in relation to Three Waters. Smarter, Easier, Better Governance Group recently established to lead our digital enablement journey. Internal Communications role established.
Learning and Development	Framework development, L&D plans for individuals, strategic plan for corporate L&D (including Te Ao Maori - Tikanga, Te Reo, Te Tiriti o Waitangi), increased budget - spending will be planned	L&D Framework development has continued. Corporate L&D has continued, Te Tiriti o Waitangi workshops undertaken, Te Reo pronunciation workshops taking place soon. Strategic plan for corporate L&D 2024/2025 is currently being finalised.
Working between teams	Takatū Anamata Future Ready	Takatū Anamata Future Ready review completed and implementation is underway. Further work will be done once the review is complete to ensure teams are able to work together effectively.
Ways of working	Investigate 4 day week/9 day fortnight	Deferred to next year

Update on Plans for 2023-2024 cont.

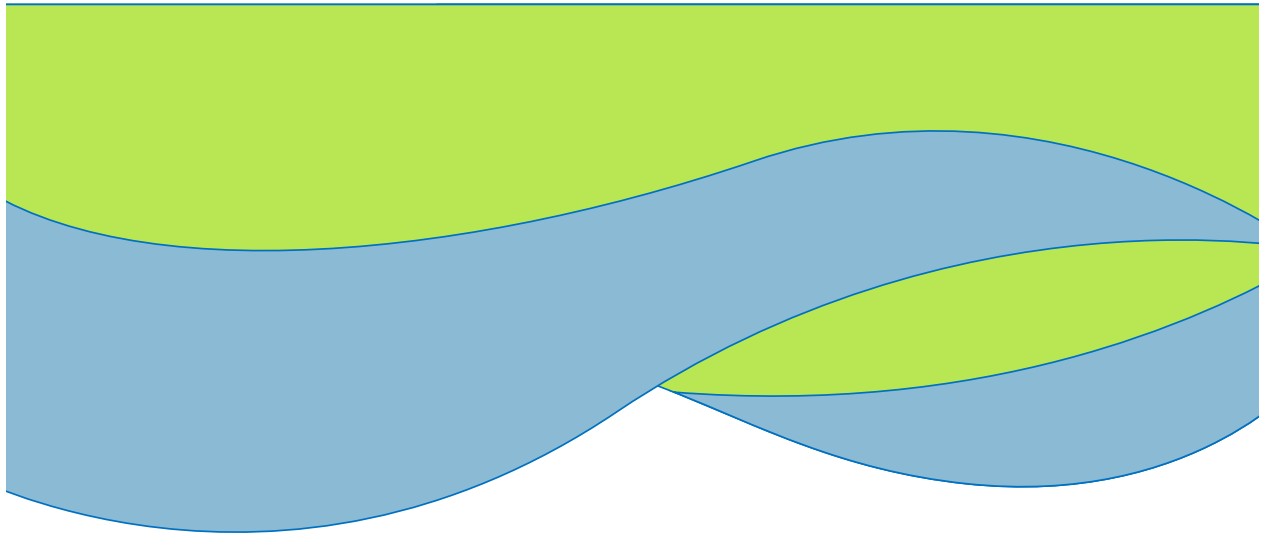
Issue	Planned actions	Status
Capacity/staff resources	Takatū Anamata Future Ready, raise issues with Group Manager to ensure prioritisation of tasks/projects etc	Takatū Anamata Future Ready provided an opportunity for staff to raise issues and these were taken into consideration. We will ask for further feedback from staff once the new structure has been implemented.
Connection	Internal Communication Officer - creating connection events etc	Events have included Waiata Group, Māori language moment, Christmas Party, Matariki breakfast.
Technology/work environment	Work with managers to identify any work environment or equipment issues	Digital Strategy is being implemented and will continue under the Digital Enablement Team. Smarter, Easier, Better Governance Group recently established to lead our digital enablement journey and prioritise initiatives.
Meeting deadlines/respecting others/meeting effectiveness	Work on clarifying business etiquette and expectations for staff e.g. being on time for meetings. Meeting effectiveness review.	Deferred to next year.

PLANS FOR 2024-2025

Issue	Planned actions
Technology	Smarter, Easier, Better Governance Group recently established to lead our digital enablement journey and prioritise initiatives. Obtain more specific feedback from staff on issues raised.
Collaboration and connection	Create a plan to build connections within and between teams to ensure the new organisation structure is successfully implemented.
Opportunities to reduce costs	As part of the LTP process we have considered a number of ways to reduce costs and have consulted with the community on some options. Any further ideas are welcome – please share with your Manager or Group Manager.
Meeting deadlines/respecting others/meeting effectiveness	Work on clarifying business etiquette and expectations for staff e.g. being on time for meetings. Training for managers on running an effective meeting.
Ways of working and staff benefits	We are currently working with a number of teams to review the way that they work to provide more flexibility. As part of the Smarter, Easier, Better project we will be looking at the use of technology to help manage work loads.
Staff climate survey and opportunities to provide feedback	Review how we measure our staff climate and other ways for staff to provide feedback.
Bullying and harassment	Training for managers and team leaders on how to implement low level and early intervention measures.
Pay	The Remuneration Policy is due for review in August 2024
Office environment	We are still waiting for the seismic results for the Te Aroha office and some other buildings. Once received we will be able to review and determine next steps for any changes to our work environment.

Other issues:

Mental health days were suggested. The E-Team note MPDC allows you to use your sick leave to care for your health (including mental health) including attending appointments to maintain your wellness.



Safety & Wellness

Quarterly report:

January-March 2024

Together we create a healthy, safe workplace where we thrive.

Executive summary

This quarter we focussed on reviewing some of our key safety and wellness policies. We used this as an opportunity to simplify the policy wording where possible, and to make these documents easier to read and understand.

The Drug and Alcohol Management Policy was finalised, with some changes to the way we deliver random testing, as described in more detail in the Policy section of this report.

The Health Monitoring Policy was amended to include workplace exposure monitoring and biological exposure, in line with WorkSafe guidance. We also drew on our experience of Covid to draft a separate Immunisation Policy rather than having this embedded in the Health Monitoring Policy as it was previously.

During the process of reviewing the Fatigue Policy it was evident there is commonality between fatigue management and stress management, so we combined the two policies to create a new Fatigue and Stress Management Policy.

We consulted with staff on the proposed changes to the Health Monitoring Policy, Immunisation Policy and Fatigue and Stress Management Policy, and will review this feedback in early April with the intention of finalising these policies prior to the end of April.

We continue to maintain a focus on critical risks, developing critical risk audit templates and trialling them in the field, as part of our critical risk assurance programme.

Events

The graphs and tables below provide summary data from Damstra reports.

Number of events and observations this quarter:					
Incidents	Injuries/illness	Near Miss/ Hazard	Observations	Notifiable Events	Lost Time Injuries
35	7	5	37	1	1

Notifiable Events:

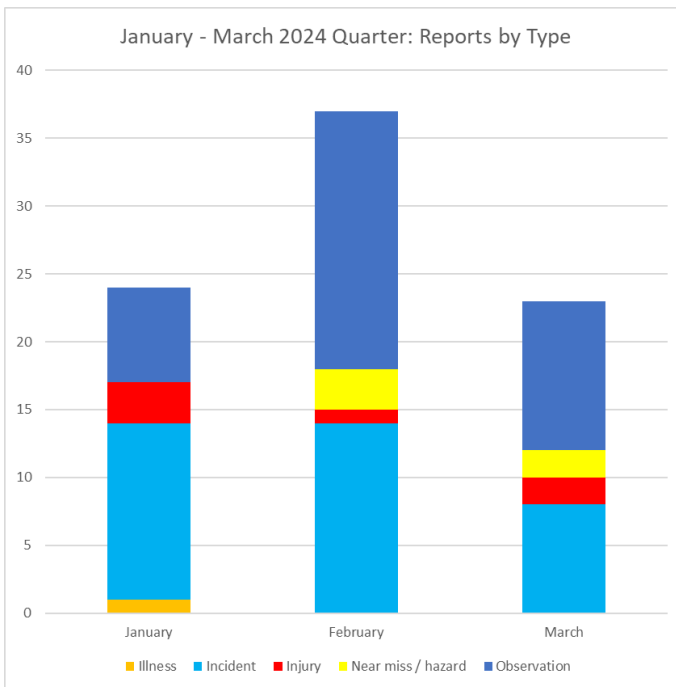
There was one notifiable event this quarter:

Our contractors were carrying out road renewal work at a site set up with full traffic management, including traffic lights. A vehicle failed to stop and drove through the worksite, hitting one of the traffic management subcontractors and causing serious injury. The contractor advised WorkSafe of the event but Police investigated and charged the driver with wounding with intent to cause grievous bodily harm, dangerous driving, threatening to kill, and failing to stop and ascertain injury.

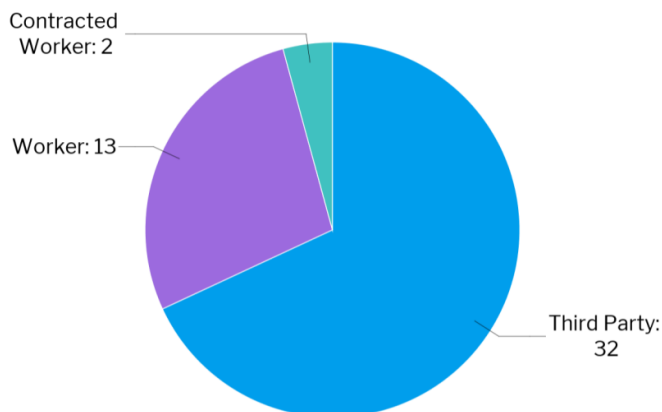
Lost time injuries:

There was one lost time injury (i.e. injuries requiring more than a full shift of time off work) this quarter. A member of staff got some dirt in their eye, which became infected, resulting in time off work.

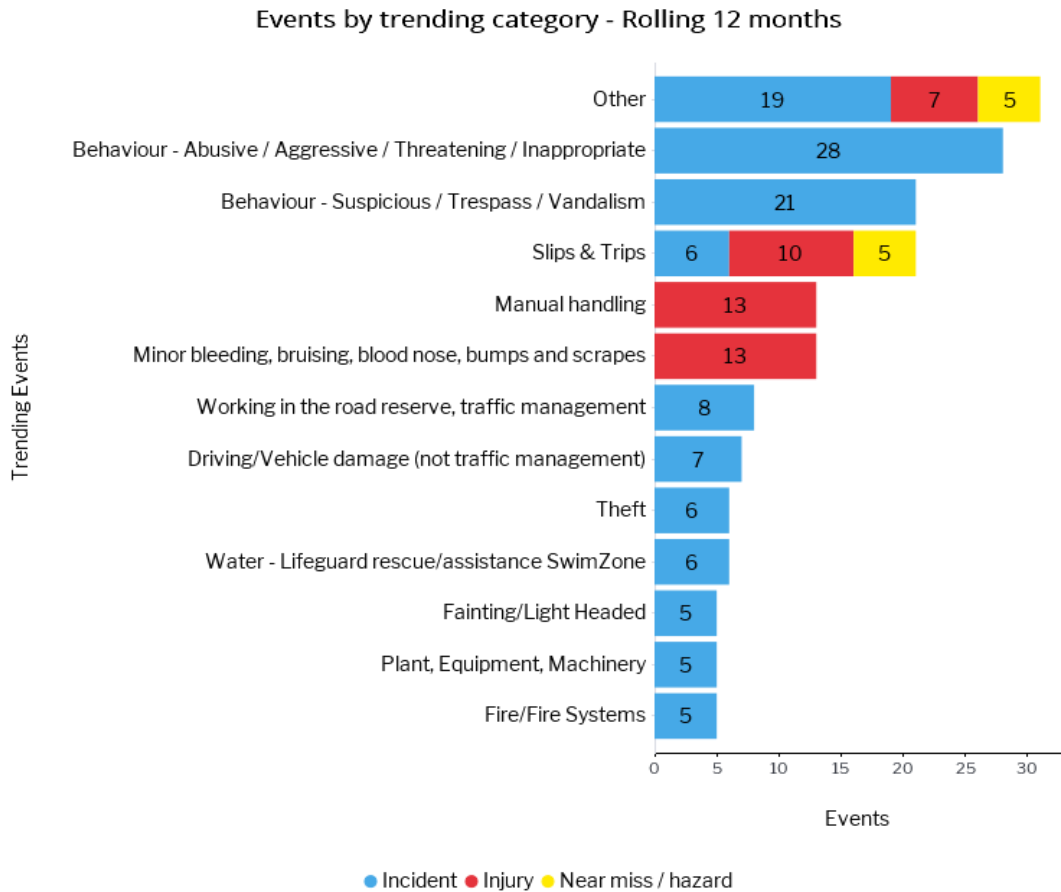
The graphs below set out the number of reports by type (per month, including observations) and events reported according to the person involved.



Events: Person Involved



The graph below shows events from the last twelve months that have occurred five or more times. Public behaviour continues to be the most common type of event reported.



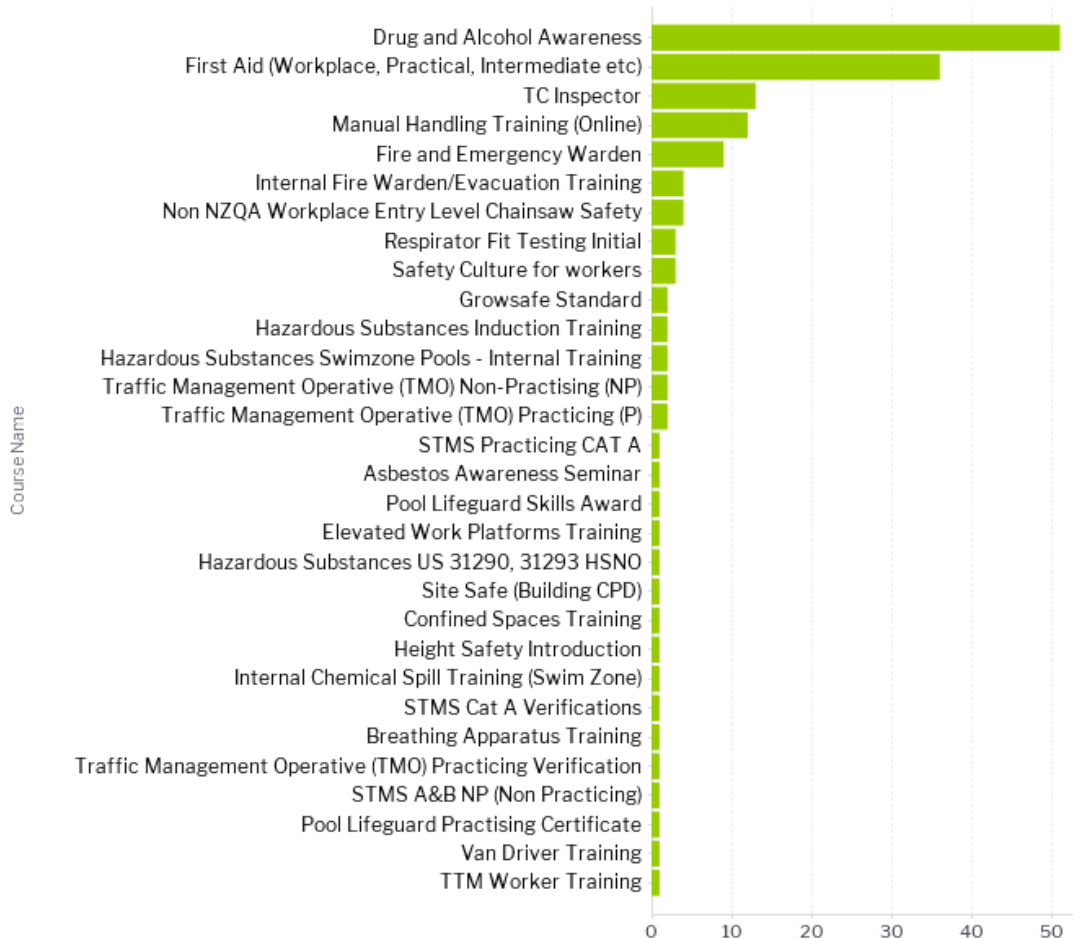
Event Investigations completed this quarter	80	Overdue Investigations at end of quarter	6*
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*Managers have been asked to follow up with their teams on the overdue investigations. For many of these, work has already been undertaken to reduce the risk, but the investigation has not been closed off in the system.

Learning & Development

The graph below shows training (both internal and external) completed this quarter.

Training Completed this Quarter



Risk management

Council has identified its “Top 10” critical risks as follows:



Critical risk updates:



Work at Height:

- We completed a critical risk review for work at height in March, and identified some planned actions to improve our management of this risk including:
 - Review of our Promapp processes to make it easier to find key information such as when a permit is required.
 - Creating a simple visual instruction sheet for roof/safety line access and other key information.
 - Trialling an induction card system for contractors that do work at height, and an online register for all contractor inductions.
 - Trialling changes to the permit process for work at height to reduce paperwork for routine maintenance tasks.
- Three work at height audits were completed with contractors this quarter. There were generally good controls in place, but one was working without a work at height permit, and the second had a permit but did not have it available on site. This has been followed up by our permit issuer.



Hazardous Substances:

- The SwimZone team reviewed their method for pool water dosing with sodium bisulphate after a small amount of the chemical splashed up into a staff member’s eye at the end of 2023.



Working on the Road Reserve:

- Three critical risk audits found traffic management was in place to a good standard.
- Ten Three Waters team members attended traffic management training



Plant, Machinery, equipment:

- One critical risk audit was completed on mobile plant at KVS (a loader). In general the equipment was in good condition but it was noted that the right-side mirror had some minor damage, and the left-side mirror was missing; this was rectified the same day.



Excavation:

- Two critical risk audits were completed this quarter using a newly-created template for this risk. There were no issues identified with the way the work was being done in both instances, and necessary supporting documents such as the prestart meeting, safety induction, toolbox talk meeting, valid permit and safety management plan were available on site.



Psychological factors:

- We continued with monthly meetings with the local police, attended by staff from different teams and held at different venues around the district. These meetings are a good opportunity to discuss shared issues and build relationships.

Lone work:

We continue to monitor lone work device usage and surveyed staff to determine what the barriers were to using the devices. Forgetting to take the device was the most common barrier, but there have also been issues with some of the devices not functioning correctly and we are working with the supplier to resolve these.

Corrective actions:

Completed this quarter	Overdue end of this quarter	Trend for overdue actions
80	35	No change from 35 last quarter

Risk reviews:

Completed this quarter	Overdue end of this quarter	Trend for overdue reviews
145	57	↑ From 42 last quarter*

*Review of the SwimZone Te Aroha risk register has been delayed due to contractor work on site.

Health Monitoring

Data for health monitoring and respirator fit testing for this quarter is shown below.

Annual health monitoring completed	22	Exit health monitoring completed	1
Overdue health monitoring	2	Respirator Fit Testing completed	16
Pre-employment health monitoring	9	Respirator Fit Testing Overdue	0

Policy review

We reviewed the Drug and Alcohol Management Policy this quarter, after seeking feedback from staff, particularly around random drug testing. Staff who provided feedback on this policy indicated they felt random testing should apply to all staff, not just those who are in safety-sensitive roles. We sought legal advice on this and were advised that from a legal perspective we can only do random testing on staff who work in safety sensitive roles. The final policy therefore continues to include random testing for staff in safety sensitive roles only, but with a change to the frequency of random testing so testing is undertaken more regularly. The total number of staff tested over the year will remain the same. We hope this will be less disruptive and will also reduce the likelihood of the same staff being tested multiple times. We continue to undertake pre-employment testing for safety-sensitive roles, and post event and reasonable cause testing for all staff.

We consulted with staff on proposed changes to the Health Monitoring Policy, Immunisation Policy and Fatigue and Stress Management Policy, and will review this feedback in early April.

Emergency management

The Three Waters team completed their fire evacuation training and all of our office, facility and treatment plant site evacuation plans are up to date on the Fire and Emergency NZ system website. The Property Team are working with the community hall committees to encourage them to complete their fire evacuation training as this is overdue.

Contractor management

Four site visits and two contractor annual reviews were completed this quarter.

Celebrating success

The SwimZone Te Aroha repaint was completed as planned this quarter. After some issues with traffic management during the installation of the scaffolding at the start of the job, the KVS Parks Team assisted the SwimZone Team with planning and setting up traffic management for removal of the scaffolding when the work was finished. Collaboration between MPDC Teams provides a great opportunity to share knowledge and resources for better safety outcomes.

Employee Engagement & Participation

There were 18 attendees at the Health and Safety Committee meeting in February. The Committee participated in a 'hazard spotting' activity related to mowing and there was some good discussion about working in the heat. The representatives were also able to raise concerns or queries about safety and wellness, and several items will be followed up through corrective actions in Damstra. We also noted that all outstanding actions from previous meetings had been completed.

Staff feedback was sought as part of the policy review process for the Drug and Alcohol Policy, Fatigue Policy, Health Monitoring Policy and Immunisation Policy.

Governance

Two safety and wellness due diligence workshops were held for Council, focussing on mowing and work at height.

The two newly-elected E-team members attended an internal training session on health and safety governance, and are working with their new teams to get a better understanding of the risks associated with their work.

Assurance activities

Nine critical risk audits were completed this quarter. Further information about these audits is provided in the critical risk section above.

Safety and Wellness Objectives

Below is a summary of progress on our key projects relating to our objectives for this year.

1. We stay focused on critical risks:		
Action	Update	Status
Create a framework and programme for critical risk assurance.	Assurance activities programmed and audits are underway.	Underway
Complete lock-down assessments at offices and facilities. Develop an overarching framework for managing violence and aggression.	Lockdown assessments complete for offices and facilities. Framework for managing violence and aggression completed. Further work required to ensure that emergency exercises are completed.	Underway
Create a guide for lone work at MPDC and optimise use of lone worker devices.	Guide for lone work completed. Ongoing monitoring of lone work devices.	Underway
Hauora mental health and wellbeing strategy implementation.	Strategy finalised and action plan underway. Psychosocial risk training provided for 33 team leaders and managers. Personal Efficiency Training trialled with a group of staff.	Underway
Update and standardise rescue equipment and signage at water and waste water treatment plants. Create working over/near water guidelines.	Good progress with installation of rescue equipment and signage at first three sites identified as highest risk. Working over/near water guidelines completed.	Underway
Clarify our duties towards the different types of volunteers we interact with. Review and update induction information provided to volunteers.	Work on review of our Volunteer Management processes is likely to recommence next year.	Not started
2. We use our systems, policies and processes		
Drug and Alcohol Policy review	Drug and Alcohol Policy review completed.	Completed
Fatigue Policy review	Underway	Underway
Health Monitoring Policy review	Underway	Underway
Finalise processes for return to work after injury/illness.	Some further work required.	Underway
Review the emergency action plan.	Completed	Completed
Review contractor inductions and create a central register to document these and track refresher inductions.	Communications team are working on a central register. Currently being trialled.	Underway
Build staff capability in Damstra so we use the system effectively. Reduce the number of overdue corrective actions to below 50.	Reduced to 34 at the end of this quarter.	Underway

Safety & Wellness Update May 2024



Contractor Safety and Wellness Management

At MPDC a large proportion of our critical risk work is performed by contractors. This includes a wide range of work including:

- longer-term contracts such as kerbside collection, security, roading, cleaning and maintenance contracts
- projects such as the new Lockerbie Water Treatment Plant (pictured above), Transport Choices projects and the planned Matamata Indoor Sports and Recreation Hub
- smaller scale short term work such property refurbishment or engineering work.

Some of this work is done by multiple PCBU's, some by smaller businesses and some by sole traders.

Creating a contractor safety and wellness management system that fits all these different scenarios is challenging and we aim to have enough flexibility in our system to ensure our contract managers can take a risk-based approach. The flow chart over the page outlines the key steps of this process.

We want to have a partnership approach with our contractors, acknowledging that safety and wellness is a shared responsibility and working together to consult, co-operate and coordinate activities.

Over the last six months we have noticed an improvement in pre-start meetings being completed regularly by our contract managers. However annual review meetings with the contractors that work for us on a regular or ongoing basis have fallen behind and this will be an area for the safety and wellness team to provide some additional support for contract managers over the coming year.

**WorkSafe's 'Three C's' of contractor management:
consult, co-operate and coordinate activities.**

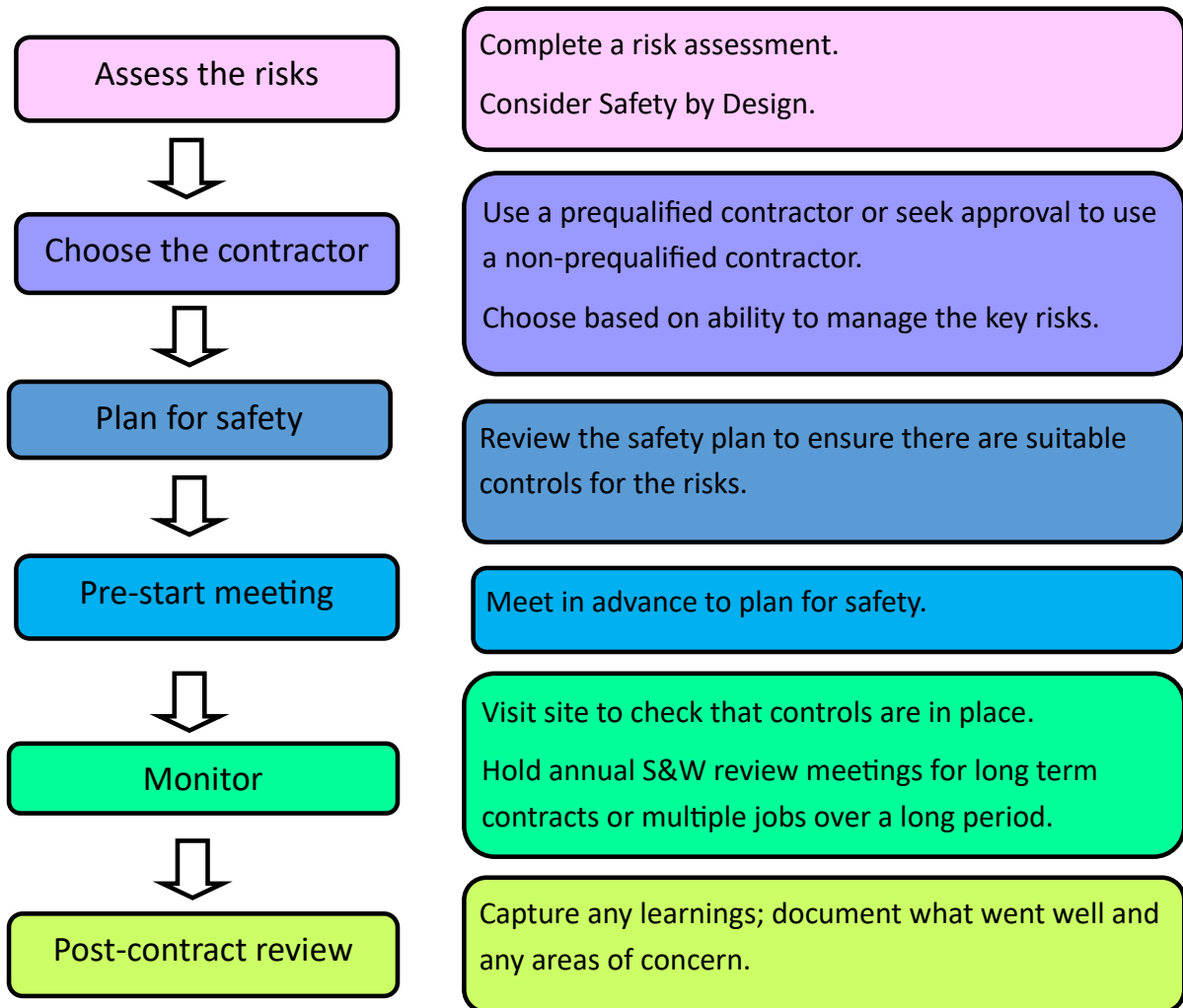
Notifiable event

A sodium hypochlorite leak at SwimZone Te Aroha occurred during the night when a tube split inside the chemical pump. There were no injuries but we reported the incident to WorkSafe under the Notifiable Incidents category. We will hold a learning team to review the incident and consider what further work can be done to prevent a recurrence.

Safety & Wellness Update May 2024



Contract Safety & Wellness Process



Our Safety & Wellness Vision: Together we create a healthy, safe workplace where we thrive.



Safety & Wellness Update February 2024

We are currently reviewing three policies. Here is an update on our progress with this.

Drug & Alcohol Management Policy Review:

Staff who provided feedback on this policy indicated they felt random testing should apply to all staff, not just those who are in safety-sensitive roles.

We sought legal advice on this and were advised that from a legal perspective we can only do random testing on staff who work in safety sensitive roles.

Further feedback is being sought from staff as we are proposing to change the frequency of random testing so testing is undertaken more regularly, but the total number of staff tested over the year will remain the same. We hope this will be less disruptive and will also reduce the likelihood of the same staff being tested multiple times.

Post event and reasonable cause testing will continue to apply to all staff.

Safety Sensitive Roles

Pre-employment testing and random testing are only completed for staff in safety-sensitive roles. These roles undertake the following work:

- Handling hazardous substances
- Driving a heavy vehicle
- Maintenance or operation of machinery or power tools
- Working at height or in confined spaces
- Working in trenches and excavations
- Providing life guard services to the public
- Working in or over water or boats
- Working with dangerous animals
- Working, or visiting, construction sites (including road maintenance sites)
- Working on the road and including road reserves

The Health Monitoring Policy Review:

Health monitoring looks at whether your health is being harmed because of what you are being exposed to while you are at work. Hearing tests to check for hearing loss due to noise exposure is an example of health monitoring.

Exposure monitoring can be used to identify, assess and confirm health risks. Measuring the amount of a noise workers are exposed to is an example of exposure monitoring.

Biological exposure monitoring is another type of exposure monitoring which usually involves taking a blood or urine sample to test for a substance employees are working with. Taking blood samples to test for lead is an example of this.

MPDC's Staff Occupational Health Monitoring Policy included immunisation. We are proposing immunisation will become a separate policy. As part of the review process we have simplified the policy to make it easier to read, understand and implement, and included exposure monitoring.

These policies will be going out for consultation in March.

Fatigue Management Policy Review:

Further work is underway on the Fatigue Management Policy. The proposed policy includes a section on managing fatigue during emergency situations. It will also include stress management, which is currently a separate policy. This will go out for consultation in March.

Our Safety & Wellness Vision: Together we create a healthy, safe workplace where we thrive.

Safety & Wellness Update February 2024

Work at height

Working at height is one of our critical risks. Work at height means working in a place where a person could be injured if they fell from one level to another, whether this is above or below ground level. A fall can result in fatal or serious injury such as a fracture, spinal cord injury, head injury or musculo-skeletal injury. WorkSafe data for the 2022/2023 year shows falls from height to be the second highest cause of fatality (12 incidents), with vehicle incidents (30 incidents) highest.

At MPDC we have several teams that do work at height, including property maintenance, water and waste water operators, reticulation, gardening and building control.

The majority of our high risk work at height is done by contractors, for example construction work, tree maintenance, property maintenance, maintenance of radio masts, solid waste disposal, reticulation renewals, street lighting and electrical work.

The cause of injury could include a fall:

- from a roof
- into a tank, well or excavation
- through upper level surfaces e.g. a corroded roof
- from access equipment e.g. ladder, scaffold or elevated work platform.

There is also a risk of equipment/tools/objects/materials falling on people below the work area.

We use a range of controls to manage this risk:

Elimination is the most effective control e.g. use long-handled tools from the ground, relocate equipment to ground level, build structures at ground level. Consider safety by design when building new plant or facilities.

Substitution reduces the need for work at height e.g. use a drone for investigative purposes.

Group controls that isolate multiple workers from falling are a good approach, such as scaffolding, edge protection, guard rails, mobile elevating work platforms.

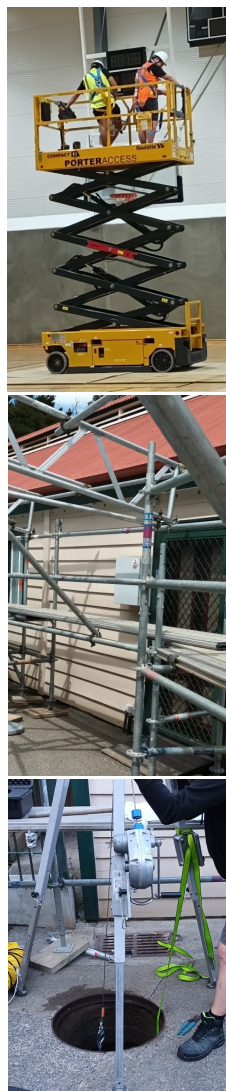
Some of our offices and event centres have permanent safety lines set up: these provide an effective way for workers to attach their harness whilst still being able to move around as needed.

Fixed ladders are used at many of our water and waste water treatment plants. We ensure these are not accessible to the public.

Administrative controls include our permit to work system, internal training and supervision, unit standard training for staff who use a harness, elevated work platform, or set up a low level scaffold. Scaffolding over 5m high is erected by a qualified scaffolder.

Equipment maintenance and inspection systems for harnesses, safety lines, ropes, lanyards, ladders and scaffolding.

Personal protective equipment such as suitable footwear, and a hard hat if there is a risk of objects falling from above.



Permit to work system

MPDC currently require a permit for work above 3 metres, or for work done below 3 metres if the work is high risk or long duration.

A permit assists with planning work in advance, including what equipment will be used, what needs to be checked prior to starting, confirming training is current and planning for rescue.

It is particularly useful when we engage a contractor for whom work at height is not part of their core activities, such as an electrician or plumber.

Issuing a permit can be time-consuming, and where work is routine it may not necessarily increase safety. Next month we will be reviewing our permit process to ensure it is working effectively and can be applied in a way that is proportionate to the level of risk.

Safety & Wellness Update

April 2024

Eye injuries

In the last six months there were three lost time or medical treatment injuries where staff got something in their eye. In all three cases they were not wearing eye protection. Fortunately none resulted in permanent damage.

We looked into this further and found that the contributing factors were:

- The activity was not planned—they were stepping in to help someone else
- Their eye protection did not fit well with the other PPE (Personal protective equipment) they needed to wear.

Below are some reminders for staff and managers which we will circulate in May and discuss at the H&S Committee Meeting.

Staff please check with your manager:

- What eye protection is right for this hazard?
- When do I need to wear it?
- Do I have it readily available?
- Does it fit with the other PPE I need to wear?

We can get technical advice from our PPE supplier, so contact the Safety and Wellness Team for help if needed.

Did you know?

- Ordinary prescription glasses do not provide the same level of protection as safety glasses. Talk to your manager about whether you are eligible for MPDC-funded prescription safety glasses.
- Storing your eye protection in a case or soft bag will prevent it from getting scratched.
- Anti-fog wipes can help to prevent lenses from fogging up. You can order these through KVS.




Internal audit

An internal audit was completed on three Promapp processes:

- Health and Safety by Design
- Purchasing Plant, Equipment or Process: Health and Safety Considerations
- Purchase of Vehicle/Plant/Small Equipment

The audit identified opportunities to improve staff awareness of the processes and streamline the documentation to ensure that staff are able to use them effectively.

Further work is planned with the teams involved to ensure the processes are tailored to the team's needs and reflect current practice.



Ready for winter

Our S&W theme for April was 'Get ready for winter'. We shared health information relating to the theme from '[My Everyday Wellbeing](#)' website which is accessible to MPDC staff.

MPDC offered free influenza immunisation to staff, and 91 staff had flu vaccines.

Our Safety & Wellness Vision: Together we create a healthy, safe workplace where we thrive.

Safety & Wellness Update April 2024

Animal Control



Risks

Animal control work carries a significant level of risk, including:

- Dog attack
- Assault by dog owners or other members of the public
- Psychosocial risks: verbal abuse, euthanizing animals
- Injury from stock e.g. cattle
- Driving
- Traffic
- Infectious diseases e.g. tetanus



Controls:

The team use a range of controls to keep themselves safe at work. These include:

- A purpose-built pound which is secure from unauthorised access. It has internal hatches to allow safe access for cleaning whilst the dog is in a contained area.
- Animal Control Officers use Lone worker devices, carry a mobile phone and their vehicles are GPS tracked. They attend Personal Safety and Self Defence Training. For higher risk situations they get assistance from the Police with property visits.
- Staff are provided with Tetanus immunisation. Dog bites carry a high risk of infection, and prompt medical care is required. Personal protective equipment (PPE) is worn when cleaning.
- Treating all dogs with caution and using good handling techniques are key controls. A pole is useful when handling potentially aggressive dogs.
- Coaching of new staff is an important control, and with a new Animal Control Officer due to start soon we are currently reviewing options for external dog handling training.



Lisa from the Animal Control Team shared her top tips for safety when visiting a property:

1. Notify the property owner that you're going to visit and check whether they have a dog. If so, ask for it to be secured when you are visiting.
2. Don't go onto the property if you can't access it safely. Don't rely on warning signage—some properties have dogs but don't display signage. If you can't see that your way to the door is safe, don't proceed. Always be aware of your situation and keep yourself safe. If you can't safely access the property, contact the property owner or leave a note.

