

Tikanga Whakahaere Raru Ohotata | Incident Management Procedure

Mō wai me te whānuitanga | Audience and scope

This procedure applies to:

- Te Pūkenga kaimahi (workers), ohu kaitiaki (members of governance groups), ākonga (learners), manuhiri (visitors to Te Pūkenga workplaces) and people who may be affected by Te Pūkenga work, learning, social and living activities.
- Te Pūkenga Executive Leadership Team and Incident Management Teams at various levels in Te Pūkenga network.
- Te Pūkenga work, learning, social and living environments.

Mokamoka whakaaetanga | Approval details

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1	May 2023	Pounuku Haumarutanga	Initial version
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Tikanga Whakahaere Raru Ohotata | Incident Management Procedure

1. Pūtake | Purpose

- 1.1. The purpose of this procedure is to provide information on the management of wellbeing and safety incidents.
- 1.2. Effective, efficient and reliable management of incidents will minimise the harm experienced by our people and limit the impact to Te Pūkenga community.

2. Ngā Mātāpono | Principles

- 2.1. Te Pūkenga will effectively, efficiently and reliably manage wellbeing and safety incidents by:
 1. **Putting people first.**
 2. **Communicating clearly, often and on a 'no surprises' basis.**
 3. **Escalating early.**
 4. Having sufficient, competent people in leadership and management roles.
 5. Supporting incident management leaders to make dynamic and flexible decisions.
 6. Demonstrating our values of manawa nui, manawa roa and manawa ora.
 7. Implementing the required processes and practices, such as CIMS (Coordinated Incident Management System).
 8. Consulting, cooperating and coordinating with other organisations.
 9. Practising through drills, scenarios and exercises.
 10. Reviewing processes and practices to determine improvement opportunities.

3. Tirohanga Whānui | Overview

- 3.1. Te Pūkenga is a large, dynamic and diverse organisation. It carries out potentially dangerous activities in a wide variety of environments with people who are not yet competent and confident. Although we will manage the risks inherent in these activities as best as we can, we acknowledge that emergencies and incidents are normal. They happen for many different reasons, notably because humans make mistakes, machines fail and nature is fickle and, sometimes, destructive.
- 3.2. The scale and complexity of Te Pūkenga, and the imperfection of the world in which we live, means that we will need to manage incidents from time to time. Often, we will have little forewarning.
- 3.3. Nevertheless, our incident preparation must consider previous events and what can be reasonably foreseen. With that knowledge, we must build the capacity and capability to respond effectively.
- 3.4. Training and experience will be relied on to achieve positive outcomes. To that end, we will encourage and support our leaders to be competent in using CIMS, where that approach is appropriate.
- 3.5. We can expect most incidents to be confined and small-scale. Management of these incidents will reflect the context and, generally, remain in the hands of the people closest to the situation.

Arguably, their knowledge will be deeper and their relationships stronger than that of people coming in from the 'outside'. Despite that, adhering to our principles means that local management will be proactive in communicating what has happened and welcome the advice and support from colleagues.

- 3.6. Some incidents, due to their criticality, will require a regional or national approach. Two examples are COVID-19 and Cyclone Gabrielle. However, local leadership will be relied on within the larger operation. Autonomy of decision-making and action can be crucial factors in getting the right results.
- 3.7. Incidents can rapidly go from bad to worse and the response needs to keep pace. We will support local-level decision-making that is bounded by the principles outlined in this procedure and in other relevant documents.
- 3.8. A Regional or National Incident Management Team (IMT) is ready for deployment at short notice to assist local leaders in whatever capacity needed.

4. Ngā Hātepe | Procedures

4.1. Process



- a) There are five stages to our incident management process.
- b) Each stage has several expectations or tasks that may or may not be relevant and employed. The main reason for the variability is that, with few exceptions, incidents are unique; the same set of circumstances will rarely repeat in the same way and produce the same outcomes. Therefore, how we manage each incident will differ.
- c) The process is focused on wellbeing and safety incidents and the roles and responsibilities of Te Pūkenga Wellbeing and Safety kaimahi. That does not preclude other kaimahi, such as operational leads, line managers, pastoral care managers, clinical leads, and so on, from being involved as first responders and incident managers. They may be the best people to take the primary responsibilities.

4.2. Respond



- a) If the incident is an emergency, that is, there is immediate danger to someone's health and wellbeing, initiate the emergency response most suitable.
- b) During the emergency response maintain communication with emergency services and the relevant Te Pūkenga functions, such as Wellbeing and Safety, facilities management, campus security and ākongā support.
- c) When the emergency moves into being an incident, or was an incident from the start, use the available time to gather information, evaluate assumptions and make decisions.

- d) The rule of ‘prudent over-reaction and rapid de-escalation’ applies when deciding to declare a critical incident. It is easier and usually more effective to scale down an over-reaction than it is to escalate an under-reaction.
- e) Incidents of a sensitive and confidential nature must only be shared with authorised Te Pūkenga kaimahi and progressed with the agreement of the initiating party. The exception is when it may be necessary for Te Pūkenga to alert other parties if it is determined there is an imminent and credible risk of serious harm to an individual(s).

4.3. **Notify**



- a) Notification - and potential escalation - depends on the severity of the incident.
- b) One of the first people to be informed is the most senior person acting in a Wellbeing and Safety capacity for the workgroup or business division. That person will initiate the early stages of the response, communicate with key people and be instrumental in a decision on whether to escalate the incident.
- c) Minor incidents will more than likely be managed at the local level and may not need escalation to the Regional Wellbeing and Safety Lead. (See Appendix 2 for examples of minor incidents.)
- d) Critical incidents must be escalated to the relevant Regional Wellbeing and Safety Lead. (See Appendix 2 for examples of critical incidents.)
- e) Wellbeing and Safety Director must be informed as soon as possible of critical incidents. These incidents may need to be reported to a regulator and are likely to cause impact to wider operations and, possibly, to organisational reputation.
- f) The Wellbeing and Safety function will communicate to senior levels of Te Pūkenga, such as Executive Leadership Team and Council. It may liaise directly with the regulator and other external agencies following discussions on best approach with local and regional functions.
- g) In keeping with the third principle, people who may be affected by the incident or who may be able to contribute to the incident response and recovery need to be informed. They could include senior leaders and management, ākonga and kaimahi support, international services, specialist cultural and spiritual support services, facilities management, security personnel, external agencies, legal and insurance functions, and so on.

4.4. **Manage**



- a) Preserve the site, where required by law or when it would benefit our learning process.
- b) Assemble the people needed to manage the incident and form an Incident Management Team. The CIMS model is a good resource to guide decisions on the roles and responsibilities.

- c) Define as early as possible who will take command and who will take control. For minor incidents, it may be the same person.
- d) Coordinate the incident response through planning and communicating the various activities needed to repair the harm and restore balance.
- e) Put in place the processes, people, equipment, corrective actions, and so on to resolve immediate and residual concerns.
- f) Publish a 'Kia Tūpato' Safety Alert as soon as possible (if needed).
- g) Monitor the effects of decisions with the aim of detecting changes between what was assumed and what later occurred.
- h) Initiate a learning review of critical incidents and, if warranted, of minor incidents.

4.5. **Record**



- a) Record what happened during and after the management of the incident.
- b) Records can be written documents, photos, videos and audio recordings.
- c) The Incident Controller will designate someone to be responsible for records management and records management will adhere to good practice.

4.6. **Close**



- a) The incident is closed when the response has returned the organisation and the people involved to a state of balance and crucial systems are working effectively and reliably. Closure will be informed by cultural intelligence.
- b) The learning review into the incident, including the sharing of findings and recommendations, may continue past the point the incident response is closed.
- c) A post-incident management review may be carried out for minor incidents and will be carried out for critical incidents.
- d) The aim of the review is to check whether principles and procedures were followed in terms of the management of the incident response and to explore opportunities for improvement. It may examine areas related to prevention of recurrence and the assumptions that led to decisions not within scope of the incident learning review. The review may involve external agencies and be externally facilitated.

5. Ngā Haepapa | Responsibilities

Role	Responsibilities
Ākonga and kaimahi	<ul style="list-style-type: none"> • Read the incident procedure. • Report incidents. • Help in the management of incidents.
Kaimahi leaders	<ul style="list-style-type: none"> • Check that kaimahi understand incident management procedure. • Check that incidents are reported and recorded. • Lead or participate in learning reviews of incidents. • Check that decisions made during or after the incident have been implemented or reviewed. • Help people access support during and after an incident. • Maintain the confidentiality of records.
Ohu kaitiaki Te Pūkenga governance	<ul style="list-style-type: none"> • Ensure Te Pūkenga has sufficient resources to respond to, and recover from, incidents. • Ensure Te Pūkenga has appropriate processes for receiving and considering information regarding incidents. • Approve policy and provide oversight of incident management systems. • Support Executive Leadership Team and other functions to undertake their respective functions. • Support statutory obligations. • Support communication to internal and external interested parties.
Tumuaki Chief Executive (or delegated authority)	<ul style="list-style-type: none"> • Current competence in CIMS application. • Act as Incident Controller or delegate that responsibility. • Approve decisions around operational priorities and resource allocation outside of the scope of the Incident Controller.
Pourangi Executive Leaders	<ul style="list-style-type: none"> • Understand application of CIMS model. • Lead or participate in incident response. • Lead or facilitate actions to improve processes and practices after an incident.
Pounuku Haumarutanga Wellbeing and Safety Director	<ul style="list-style-type: none"> • Current competence in CIMS application. • Provide advice on preparation and response, develop and maintain incident procedures and lead reviews. • Maintain records of incident management capability. • Notify senior leadership and provide advice on escalation and response. • Notify regulator. • Lead or participate in incident response. • Evaluate incident response and share lessons from practices and events. • Liaise with internal functions and external agencies. • Lead or participate in learning reviews and contribute to external investigations. • Check that incidents are closed, and actions implemented.
Regional and Local Wellbeing and Safety Leads	<ul style="list-style-type: none"> • Lead or participate in incident response (CIMS competence). • Escalate incidents to next level. • Notify regulator, if authorised. • Evaluate incident response and share lessons from practices and events. • Liaise with internal functions and external agencies. • Lead or participate in learning reviews and contribute to external investigations. • Check that incidents are closed, and actions implemented.

6. Ngā Tikanga | Definitions

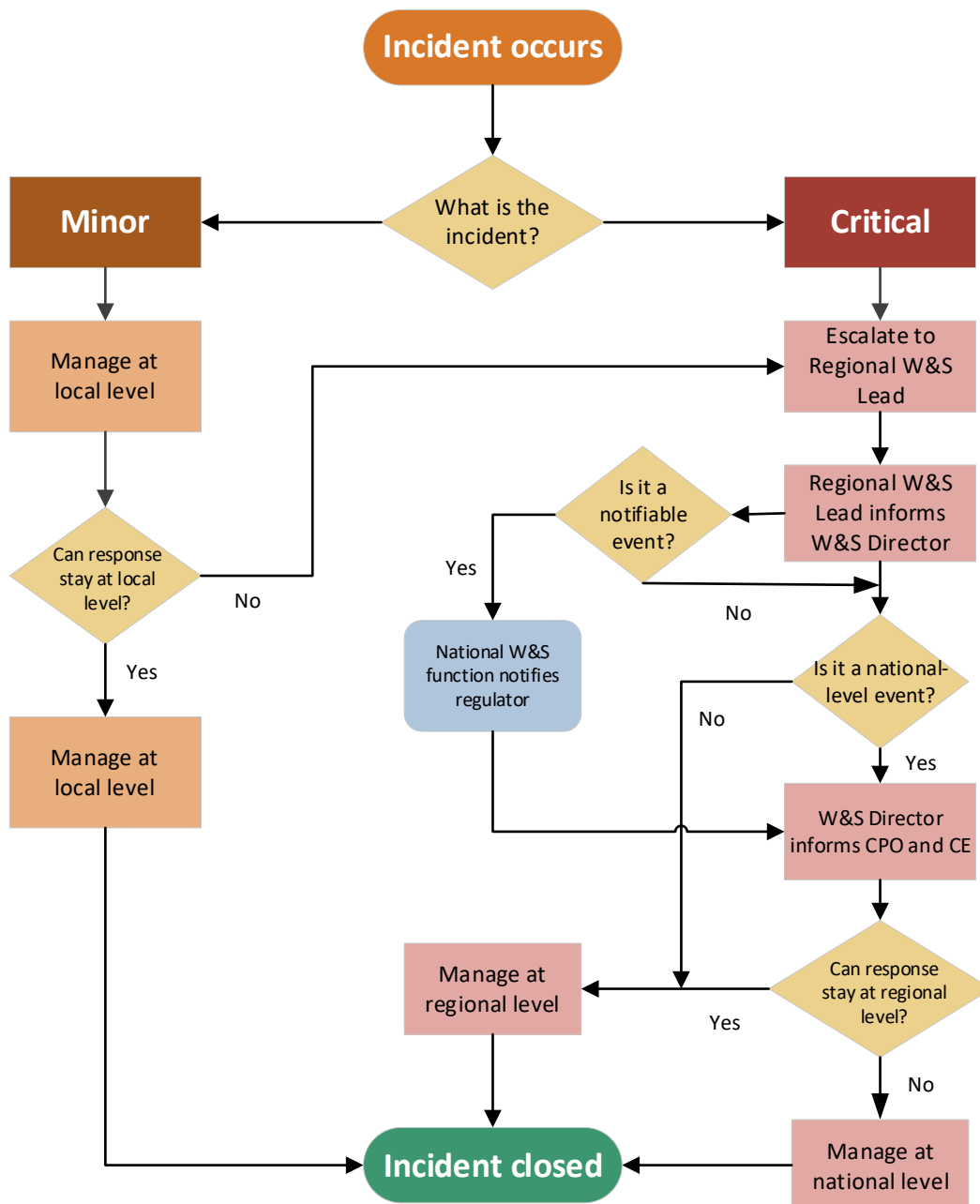
Term	Definition
CIMS (Coordinated Incident Management System)	<p>A management system that identifies key roles and responsibilities in managing a critical event. It is a coordinated and controlled response used primarily by emergency response agencies, such as NZ Police, FENZ, Civil Defence, LandSAR, and so on.</p> <p>Its principles, processes and practices can be adapted to work successfully for a Te Pūkenga-managed incident, with or without the involvement of external agencies.</p>
Emergency	<p>An event that threatens the safety of one or more people and is of short duration (typically less than 12 hours)</p> <p>The velocity, or time to impact, of the emergency is quick, for example, an explosion or earthquake or the rapid onset of medical symptoms through infection, inhalation or ingestion.</p> <p>An emergency may become an incident due to several factors, such as time, response requirements, complexity, significance and severity.</p>
Incident	<p>An actual or impending event involving potential or actual physical and psychological harm to a person or persons and needs a coordinated, medium to long-term response. It may impact on any area of Te Pūkenga activity.</p> <p>A minor incident is, or could be, localised and containable and unlikely to impact on the wider Te Pūkenga network. It is unlikely to escalate in severity.</p> <p>A critical incident is, or could be, a profound impact on people and operations. It will likely fit the definition of notifiable event. It will require focused, ongoing management by a cross-functional team and, possibly, the application of a CIMS approach.</p> <p>Incidents that relate to cybersecurity, production, property, reputation, finances, power supply, and so on are covered in separate documents within Te Pūkenga Risk and Assurance Policy and Business Continuity Plan.</p>
Incident Controller	<p>The person who provides incident response leadership through:</p> <ul style="list-style-type: none"> • having overall responsibility for all activities and personnel involved in the response, including safety • coordinating and managing the response objectives with organisations, communities and people responding to or affected by the incident.
Incident Management Team (IMT)	<p>A group formed in response to an incident that supports the Incident Controller.</p> <p>Depending on the severity of the incident, the IMT may be bolstered by additional expertise and resources, for example, from National and Regional Wellbeing and Safety functions, national corporate functions and external parties.</p>
Notifiable event	<p>Any of the following events:</p> <ul style="list-style-type: none"> • the death of a person • a notifiable injury or illness • a notifiable incident.

Term	Definition
Notifiable injury or illness	<p>Injuries or illnesses that:</p> <ul style="list-style-type: none"> • require, or would usually require, a person to be admitted to hospital for immediate treatment • require, or would usually require, a person to have medical treatment within 48 hours of exposure to a substance. <p>Any serious infection (including occupational zoonoses) to which the carrying out of work is a significant contributing factor.</p> <p>See Appendix 3 or HSWA, s 23 for details on injuries, illnesses and infections.</p>
Notifiable incident	<p>An unplanned or uncontrolled incident that exposes someone to a serious risk to their health or safety arising from an immediate or imminent exposure to situations, such as leaks, spillages, explosions, collapses and electric shocks.</p> <p>See Appendix 3 or HSWA, s 24 for full list.</p>
Work, learning, social and living environments	<p>Environments where work, learning, social and living activities are being carried out, or are customarily carried out, and includes any place where our kaimahi and ākonga go, or are likely to be, while working, learning, socialising or living to the extent that Te Pūkenga has a reasonable level of control and influence over those activities.</p>

7. Ngā Hononga ki Tuhinga kē | Links to Other Documents

<p>Ngā Kaupapa-Here e Hāngai ana Related policies</p> <ul style="list-style-type: none"> • Kaupapa here Policy: Te oranga me te haumarua Wellbeing and Safety
<p>Ngā Tukanga me ngā Hātepe Processes and procedures</p> <ul style="list-style-type: none"> • Emergency Procedures • Risk Management Framework • Business Continuity Procedure • Fatality Checklist
<p>Ture whai take Relevant legislation</p> <ul style="list-style-type: none"> • Health and Safety at Work Act 2015 (HSWA) • Health and Safety at Work (General Risk and Workplace Management) Regulations 2016 • Fire and Emergency New Zealand (Fire Safety, Evacuation Procedures, and Evacuation Schemes) Regulations 2018 • Education (Pastoral Care of Tertiary and International Learners) Code of Practice 2021

Appendix 1: Escalation flow chart



The initial response to the incident, including reporting, will be completed by the people closest to the incident. They will report to a line manager and/or the local Wellbeing and Safety (WS) function. Line managers will check that the local WS function has been informed. To aid effective, timely communication, it is recommended that escalation and notification decisions are managed by key WS team members.

The chain of command for wellbeing and safety incidents is: Local WS Advisor/Manager → Regional WS Lead → WS Director (national) → Chief People Officer → Chief Executive → WS Committee/Council.

Appendix 2: Examples of incidents, and escalation processes

Examples of incidents

Incidents can happen anywhere and to anyone. Some examples are listed below.

For the sake of clarity, in scope of this procedure are incidents that physically and/or mentally harm, or could harm:

- Te Pūkenga people when they are engaged in Te Pūkenga activities.
- Visitors to Te Pūkenga work, learning, social and living places.
- People who may be affected by Te Pūkenga work, learning, social and living activities.

Incidents experienced outside of Te Pūkenga work, learning, social and living environments would not usually be in scope of this procedure.

This appendix is not an exhaustive list of incidents. Furthermore, the examples do not capture the unique characteristics and context of each type of incident. Subjectivity abounds. Each of us will bring our own experiences and biases to the question of what is ‘mild’ or ‘serious’, ‘minor’ or ‘extreme’. Guiding us through this ambiguity are our principles and the knowledge we are part of a connected and collegial organisation.

Minor incidents	<ul style="list-style-type: none"> • Psychological events needing limited intervention • Injuries needing first aid treatment • Mild strains or sprains • Minor fractures, such as fingers or toes • Injuries or illnesses needing limited time off from work or learning • Chemical spills that can be cleaned up in-house and without damage • Near misses that would have likely not caused serious harm • Mild concussion • Vandalism
Critical incidents	<ul style="list-style-type: none"> • Any notifiable event • Systemic bullying involving more than one person • Near misses that could have led to serious harm • Serious psychological event • Missing kaimahi or ākonga • Sexual and/or physical assault • Extreme weather or other natural emergency • Hazardous chemical spills needing closure of area and/or external clean-up • Pandemic • Widespread, food-borne illness • Intruder and terrorist events • Drug dealing • Fire – alarm activation, emergency services call-out

Escalation processes

Rather than setting out a prescriptive rubric and writing pages of worked examples, we rely on decision-makers to apply the principles in this procedure and to use their judgement. We also expect people to live the organisational values of manawa nui, manawa roa and manawa ora. There is much in our values that aligns with the kaupapa of this procedure.

For each incident there will be a decision on who to inform. From the ensuing discussions will come a decision on whether to escalate.

Role	Process (minimum steps, among other things)
Wellbeing and Safety managers and advisors at local sites and workplaces	Unless the incident is closely confined and small-scale: <ol style="list-style-type: none"> 1. Inform your Wellbeing and Safety Regional Lead. 2. Inform relevant managers at the site or workplace. 3. Get the technical expertise required. 4. Contact support services. 5. Complete incident report.
Kaikōkiri Haumarutanga Wellbeing and Safety Regional Lead	Once informed of the incident: <ol style="list-style-type: none"> 1. Determine criticality through testing assumptions, and – <ol style="list-style-type: none"> a. if minor, manage at regional and local levels b. If critical, inform Wellbeing and Safety Director. 2. Check completion of incident report.
Pounuku Haumarutanga Wellbeing and Safety Director	Once informed of the critical incident: <ol style="list-style-type: none"> 1. Decide whether senior leadership should be informed. 2. If so, in the first instance, inform Chief People Officer and Chief Executive. 3. If warranted, propose initiation of NIMT.

It is worth reiterating that if there is any doubt as to what to do, apply the second principle in this procedure, that is, **communicate clearly and often**. Aim to maximise the opportunities for support and resourcing.

Appendix 3: Notifiable event

1. Notifiable events must be reported to Te Pūkenga National Wellbeing and Safety function as soon as possible.
2. The National Wellbeing and Safety function (or delegated function at regional or local level) will notify the regulator as soon as possible using the fastest means in the circumstances (HSWA, s 56).
3. In most cases, the regulator for Te Pūkenga activities is WorkSafe, but there are occasions when the regulator could be Maritime NZ or CAA. If in doubt, notify WorkSafe.
 - a. If the notifiable event is a death, the National Wellbeing and Safety function (or delegated function) will call WorkSafe immediately on 0800 030 040.
 - b. For other notifiable events, the National Wellbeing and Safety function (or delegated function) will complete online notification form, or call or write to the regulator.
4. There is a requirement to preserve the site of the notifiable event (HSWA, s 55). The site must not be disturbed until authorised by an inspector. There are exceptions to this requirement, namely that the action is:
 - a. to assist an injured person
 - b. to remove a deceased person
 - c. essential to make the site safe or to minimise the risk of a further notifiable event
 - d. done by, or under the direction of, a constable acting in execution of his or her duties
 - e. for which an inspector or the regulator has given permission.
5. The National Wellbeing and Safety function will inform NZQA if the event involved an ākonga.

Excerpts from HSWA, ss 23-25:

Meaning of notifiable event

In this Act, unless the context otherwise requires, a notifiable event means any of the following events that arise from work:

- (a) the death of a person; or
- (b) a notifiable injury or illness; or
- (c) a notifiable incident.

Meaning of notifiable injury or illness

- (1) In this Act, unless the context otherwise requires, a notifiable injury or illness, in relation to a person, means—
 - (a) any of the following injuries or illnesses that require the person to have immediate treatment (other than first aid):
 - (i) the amputation of any part of his or her body

- (ii) a serious head injury
 - (iii) a serious eye injury
 - (iv) a serious burn
 - (v) the separation of his or her skin from an underlying tissue (such as degloving or scalping)
 - (vi) a spinal injury
 - (vii) the loss of a bodily function
 - (viii) serious lacerations
- (b) an injury or illness that requires, or would usually require, the person to be admitted to a hospital for immediate treatment
- (c) an injury or illness that requires, or would usually require, the person to have medical treatment within 48 hours of exposure to a substance.
- (d) any serious infection (including occupational zoonoses) to which the carrying out of work is a significant contributing factor, including any infection that is attributable to carrying out work—
- (i) with micro-organisms
 - (ii) that involves providing treatment or care to a person
 - (iii) that involves contact with human blood or bodily substances
 - (iv) that involves handling or contact with animals, animal hides, animal skins, animal wool or hair, animal carcasses, or animal waste products
 - (v) that involves handling or contact with fish or marine mammals.
- (e) any other injury or illness declared by regulations to be a notifiable injury or illness for the purposes of this section.

Meaning of notifiable incident

- (1) In this Act, unless the context otherwise requires, a notifiable incident means an unplanned or uncontrolled incident in relation to a workplace that exposes a worker or any other person to a serious risk to that person's health or safety arising from an immediate or imminent exposure to—
- (a) an escape, a spillage, or a leakage of a substance
 - (b) an implosion, explosion, or fire
 - (c) an escape of gas or steam
 - (d) an escape of a pressurised substance
 - (e) an electric shock
 - (f) the fall or release from a height of any plant, substance, or thing
 - (g) the collapse, overturning, failure, or malfunction of, or damage to, any plant that is required to be authorised for use in accordance with regulations
 - (h) the collapse or partial collapse of a structure
 - (i) the collapse or failure of an excavation or any shoring supporting an excavation
 - (j) the inrush of water, mud, or gas in workings in an underground excavation or tunnel
 - (k) the interruption of the main system of ventilation in an underground excavation or tunnel
 - (l) a collision between 2 vessels, a vessel capsize, or the inrush of water into a vessel
 - (m) any other incident declared by regulations to be a notifiable incident for the purposes of this section.

Appendix 4: Incident Management Team

1. An Incident Management Team (IMT) is activated in response to an incident. Depending on the resources needed, activation may need the authority of a senior executive manager or someone so delegated.
2. The IMT will operate within the context of the incident and the assumptions being made by decision-makers. In some situations, the CIMS model would be the best approach to use because it provides the structure, role descriptions and functions needed to manage a wide variety of incidents and emergencies.
3. Significant, critical incidents may need the establishment of [command and control](#) as separate functions. Less significant incidents may merge these functions.
4. The IMT will be organised as per context or as directed by the CIMS hierarchy. For minor incidents, a condensed hierarchy may be more appropriate than a full response and multiple roles may be performed by the same person.
5. IMTs may be strengthened by Māori and iwi representatives, technical advisors, and kaimahi and ākongā representatives.
6. People expected to fulfil certain roles in a CIMS response will receive training and assessment, including on Unit Standards 32158, 29553 and 29554. Validation of competence will form part of that person's competence record.
7. For critical incidents that require a full, national response, the Incident Controller role may be performed by the Tumuaki | Chief Executive (or a delegated person). In these situations, the national team will generally include (but not be limited to):

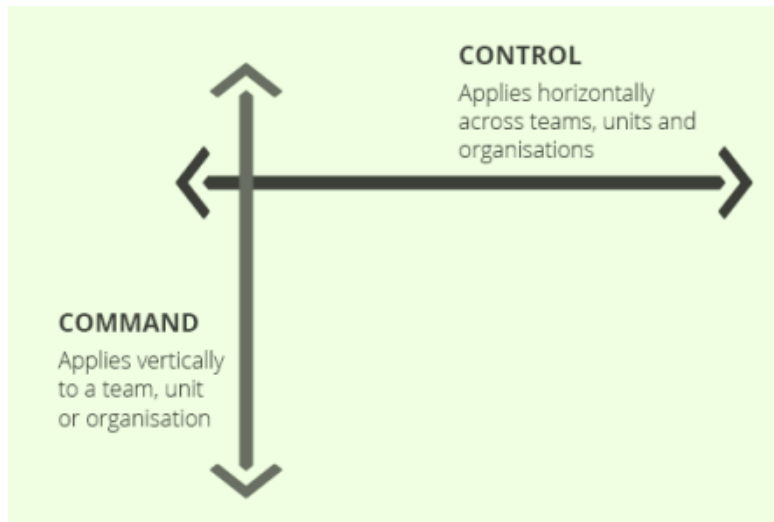
Role	Responsibility
Tumuaki Chief Executive or delegate	<ul style="list-style-type: none"> • Acts as Incident Controller • Has overall responsibility for the incident response, including: <ul style="list-style-type: none"> – communication internally and externally – coordination of activities – delegation of authorities – escalation of decision-making to Te Pūkenga Council – implementation of improvement actions.
Pourangi Tangata Chief People Officer	<ul style="list-style-type: none"> • Welfare function • Responsibility for people-related matters, including: <ul style="list-style-type: none"> – resourcing – support and recovery activities – continuation or cessation of employment – communication to affected parties.
Director of Communications	<ul style="list-style-type: none"> • Public Information Management (PIM) function • Responsibility for internal and external communication, control of information security and maintenance of an incident record or log.

Role	Responsibility
Director of Legal	<ul style="list-style-type: none"> • Acts as a conduit to the Governance function • Provides specialist legal and risk management advice.
Pounuku Haumarutanga Wellbeing and Safety Director	<ul style="list-style-type: none"> • Safety function • Could operate as Response Manager and be involved in Intelligence, Planning and Logistics areas • Point of contact for assisting and cooperating agencies and has responsibility for: <ul style="list-style-type: none"> – monitoring response and recovery activities – providing status briefings – controlling access to the scene – advising on response strategies – responding to requests for assistance – maintaining an incident record or log.

8. Local and regional Wellbeing and Safety team members and managers must play a role within the incident response when there is significant local expertise and consideration required.
9. The composition of local and regional IMTs will be similar to the national IMT. Equivalent roles will assume the functions and responsibilities, for example, a Regional Wellbeing and Safety Lead could act as Incident Controller.
10. IMTs should include ākonga representatives and an executive manager with responsibility and knowledge of the Pastoral Care Code.

Appendix 5: Command and Control

1. Command is the authority to direct and supervise people, tasks and resources up and down the incident management structure.



2. Control is the authority to set objectives and direct activities across teams and organisations.
3. A significant, critical incident may require the establishment of a Command Centre and a Control Centre. Less significant incidents could merge these functions and, for most of the incidents we encounter, will likely be the model we adopt.

Command Centre

4. The Command Centre serves as the centralised facility or workspace in which the IMT will gather, check in and assume their incident response roles. Kaimahi from the Corporate Communications function may be situated in the Command Centre during the incident response.
5. It will be led by the Chief Executive (or delegate), supported by the Chief Executive's Advisory Group and other senior executive managers as required.
6. The Command Centre shall be responsible for:
 - i. making and acting on decisions requiring the highest authority within Te Pūkenga
 - ii. supporting the immediate actions of the Control Centre
 - iii. managing public relations issues and overseeing communications with kaimahi, ākonga, media and public (excluding the communications managed by the Incident Controller)
 - iv. focusing on major strategic issues
 - v. overseeing business recovery and continuity.
7. The Command Centre will maintain key relationships with:
 - i. the Control Centre and the Corporate Communications function
 - ii. the business divisions in Te Pūkenga network
 - iii. relevant, external parties, such as central and local government agencies, unions and iwi.

Control Centre

8. The Control Centre provides the operational management of the incident and serves the needs of the Command Centre. It is led by the Incident Controller.
9. The Control Centre is responsible for:
 - i. coordinating and managing the response to an incident with the immediate focus on saving life and property
 - ii. taking immediate steps to prevent any further injury
 - iii. taking immediate steps to prevent further damage to property
 - iv. providing accurate and timely information to the Command Centre
 - v. providing support for any emergency services agency on site, including provision of information or resources
 - vi. setting up, resourcing and operating a welfare centre for kaimahi and ākonga
 - vii. providing information to kaimahi, ākonga, media and public about the incident.
10. Each shift of the Control Centre will prepare an Incident Action Plan to record administrative details and instructions issued and to provide a reference for managing the incident that can be easily picked up and acted upon by the incoming shift.
11. There are similarities and alignments of Control Centre and IMT roles and responsibilities. The CIMS functions are illustrated below:

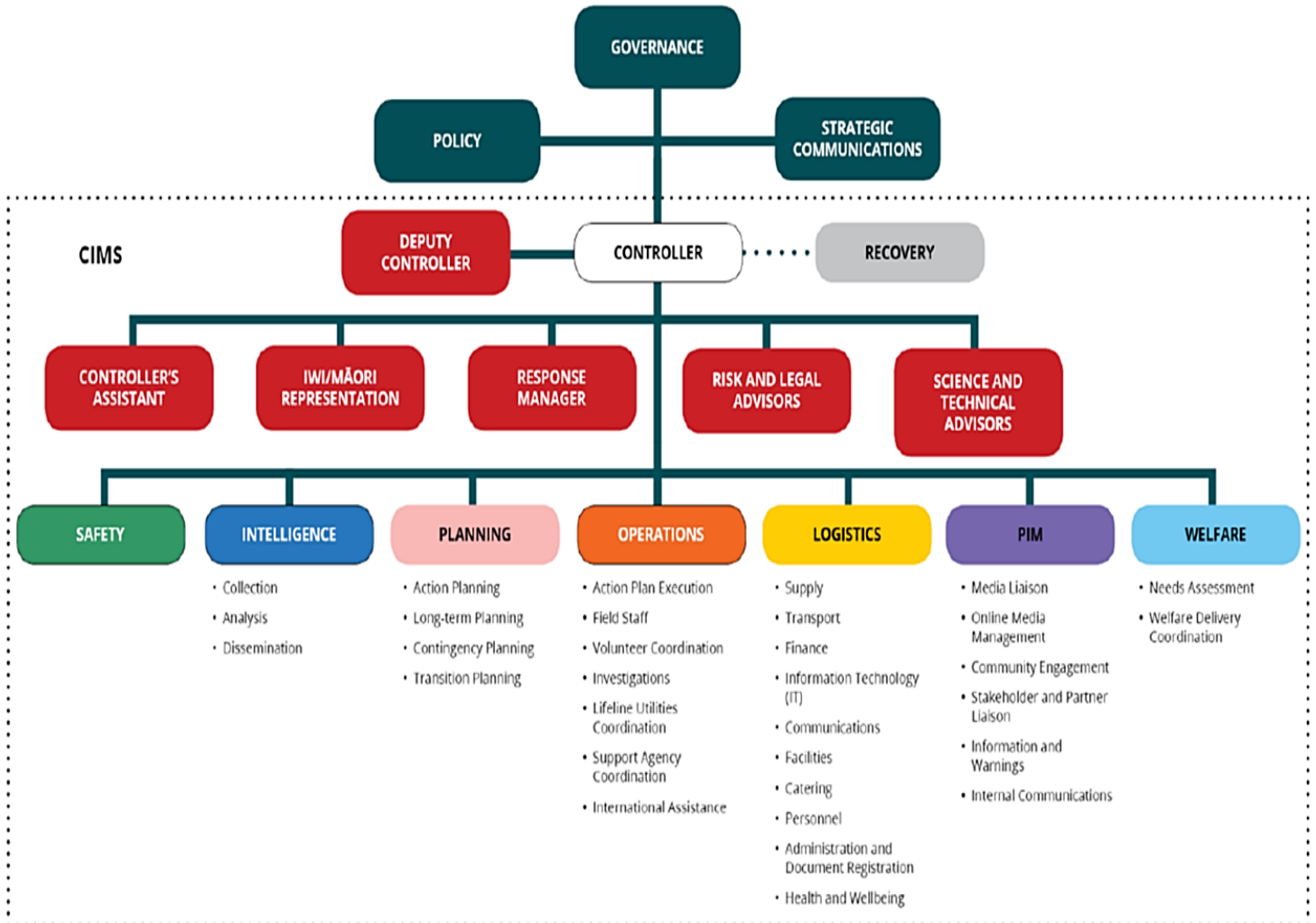
Function	Colour	Responsibilities
Control	White	Controls and coordinates the response.
	Red	Controller's Support
Safety	Green	Advises on measures to minimise risks to response personnel.
Intelligence	Dark blue	Collects and analyses information and produces intelligence related to context, impacts, consequences and forecasts.
Planning	Pink	Plans for response activities and resource needs.
Operations	Orange	Tasks, coordinates and tracks execution of the Action Plan.
Logistics	Yellow	Provides personnel, equipment, supplies, facilities and services to support response activities.
Public Information Management	Purple	Develops and delivers messages to the public and liaises with the impacted community. Develops messaging for Governance when Strategic Communications is not activated.
Welfare	Light blue	Ensures planned, coordinated and effective delivery of welfare services to affected individuals, families/whānau and communities, including animals.
Recovery	Grey	Starts the recovery management process during the initial response phase and ensures the recovery process is integrated with the response.

12. Details on the CIMS functions, including responsibilities and sub-functions, are explained in Sections 4.4-4.11, 'Coordinated Incident Management System (CIMS), Third Edition.

13. Each role or function will provide regular and ad hoc situation reports (SitReps). They will be collated and summarised before being presented to the Command Centre. SitReps will identify key issues, risks and actions and indicate the strategic decisions that need to be made by the Command Centre.
14. Advice may be sought from various parties, including Komiti Māori Advisory, Kaimahi Advisory Committee and Learner Advisory Committee.

Appendix 6: CIMS structures

Full CIMS hierarchy



CIMS structure for an incident involving multiple organisations. The scale and complexity of the incident in this example has allowed for the merging of certain roles.

