PREVIOUS ORDER EXISTS PROHIBITING PUBLICATION OF NAME OF DECEASED VICTIM PURSUANT TO S 202 CRIMINAL PROCEDURE ACT 2011. SEE http://www.legislation.govt.nz/act/public/2011/0081/latest/DLM3360349.html

IN THE DISTRICT COURT
AT INVERCARGILL

I TE KŌTI-Ā-ROHE
KI WAIHŌPAI

CRI-2018-025-000356
[2023] NZDC 15451

WORKSAFE NEW ZEALAND
Prosecutor

v

MCLELLAN FREIGHT LIMITED
Defendant

Hearing:	12 – 15 June 2023
Appearances:	B M Finn and A R Everett for the Prosecutor B R Harris for the Defendant
Judgment:	8 September 2023

JUDGMENT OF JUDGE D G HARVEY

Charges

[1] McLellan Freight Ltd (the defendant) has been charged under the Health and Safety at Work Act 2015 ("HSWA") with two charges namely:

(a) (CRN 0096, under s 34(1) and 2(b) of the HSWA) That on or about 24 February 2017 at South Port, Bluff being a PCBU who had a duty in relation to workers undertaking the loading, unloading, and transportation of PKE at ADM New Zealand Ltd's facility, failed to, so far as was reasonably practicable, consult, co-operate with, and co-ordinate activities with all other PCBUs who had a duty in relation to the same matter, namely Herberts Transport Limited, Transport Services Southland Limited, and [redacted] JB Contracting.

The particulars for this charge are recorded as follows:

It was reasonably practicable for McLellan Freight Limited to have:

(i) Consulted, co-operated and co-ordinated with the abovenamed PCBUs regarding a safe system of work (including a traffic management plan) for truck drivers and plant operators to be followed when using their PKE transitional facility

(b) (CRN 0097, under ss 36(1)(a), 48(1) and (2)(c) of the HSWA) That on or about 24 February 2017 at South Port, Bluff being a PCBU, failed to ensure so far as was reasonably practicable, the health and safety of workers, including [redacted], who worked for Transport Services Southland Limited while he was at work in the business or undertaking and that failure exposed [redacted] to a risk of serious injury arising from vehicles used while loading and unloading PKE.

The particulars for this charge are recorded as follows:

It was reasonably practicable for McLellan Freight Limited to have :

(i) Ensured there was a safe system of work (including a traffic management plan) in respect of workers undertaking loading and unloading activities in ADM New Zealand Limited's transitional facility at South Port, Bluff.

[2] The matter was heard before me as a defended Judge alone trial over four days when evidence was given by both the prosecution and the defence. The matter was then adjourned for the filing of written submissions.

[3] It is regrettable that, for a number of reasons previously covered in filed memoranda, this matter has been significantly delayed in being heard, having finally come to trial some six years following the event which gave rise to the charges.

Background

[4] In 2013 the defendant was invited by Hilton Haulage in Timaru to became involved in the unloading and storage of Palm Kernel Expeller ("PKE"), a stock feed product, at Bluff. Initially, the defendant's staff were trained in Timaru by the staff of Hilton Haulage, dealing specifically with the requirements for unloading PKE, the storage of the same, and health and safety issues. I was told by Mr McLellan that an employee of Hilton Haulage also came to Bluff to assist with training.

[5] The building used by the defendant at Bluff (Shed 4) is owned by Southport New Zealand, who in turn leases it to a company referred to as ADM Ltd. ADM was the actual importer of PKE and the defendant was contracted to use the shed and work in the shed on behalf of ADM. The defendant in turn contracted Herberts Transport Ltd ("HTL") and Transport Services Southland Ltd ("TSSL") to provide machinery, equipment and staff.

[6] Mr McLellan told me that once they obtained machinery and equipment they were able to set up Shed 4 as a transitional facility and once that was achieved, they set about working on how the operation would be conducted. The operation took place in one half of the shed.

[7] Mr McLellan told me that ADM were very "staunch" about processes and they reviewed the operation on several occasions before the defendant commenced work. It was for the defendant to deal with the Ministry of Primary Industries ("MPI") to obtain the necessary registration for dealing with PKE, which poses a biosecurity risk.

[8] During the course of evidence I was referred to a large collection of documents including a Health and Safety Manual and the Bluff Operating Procedures. I was told that at the commencement of each shift there would be a toolbox meeting when safety procedures were discussed. To ensure that everyone understood and that everyone had attended the meeting, there was a requirement for each attendee to sign the toolbox minutes.

[9] In general terms, the practice was to have the trucks loaded at the dock and then, observing a 30 km/h speed restriction, drive towards Shed 4. Approaching the shed, the speed limit dropped to 15 km/h. Prior to entering the shed the driver would get out of his vehicle, roll back the load cover, and unpin the tailgate. Then, when directed to do so, the truck would drive into the shed, tip the load of PKE onto the pile and then drive to the exit door. The truck would partially leave the shed but would ensure that the rear portion of the tray remained in the shed. Once the truck came to a stop a "spotter", if available, would use a hydraulic hose connected to a compressor with a large wand fitted to clean any surplus PKE off the truck before it exited the shed. The reason for this was because the biosecurity risk of PKE was managed by ensuring that it was contained in the shed. When a spotter was not available, it was the driver's responsibility to ensure that all PKE was blown off the tray of the truck.

[10] During this operation there was at least one loader operating. The loader pushed the loads of PKE into the main pile. On occasions it was necessary for a second loader to assist.

[11] As appears from the evidence, as the pile of PKE grew the amount of manoeuvre room decreased.

[12] On the morning of 23 February 2017 the vessel Puget Sound berthed at Bluff, carrying PKE. In anticipation of that the staff arrived at 2.30 am and there was

a toolbox meeting. Once the official procedures had been completed, unloading commenced.

[13] At approximately 1.30 am on 24 February 2017, Mr [redacted] ("Mr [redacted]"), an employee of TSSL, entered Shed 4, deposited his load, and then proceeded towards the exit door.

[14] At this time there was no spotter. Earlier in the evening Mr Colin George Hansen ("Mr C G Hansen"), an employee of the defendant, had been acting as spotter but he noticed that the first loader (which was owned by HTL and operated by [redacted]) was falling behind and accordingly went to the second loader to help.

[15] Mr [redacted] drove his truck towards the exit door but stopped when only a portion of his cab was outside the shed. Consequently, more of his truck remained in the shed than normal – further restricting the amount of manoeuvre room. He got out of his truck and proceeded to the back of the truck, presumably to clean off the PKE as there was no spotter. Whilst he was standing with his back towards the pile, he was struck by the first loader, and he died almost instantly.

[16] A WorkSafe investigation took place. At its conclusion the two charges that I have earlier referred to were laid against the defendant. Charges were also laid against HTL and TSSL. HTL and TSSL pleaded guilty and have been sentenced.

Submissions

[17] At the conclusion of the evidence I requested counsel to file written submissions to assist me and I am extremely grateful to counsel for the very detailed and helpful submissions that were filed. I mean no discourtesy to either counsel when I say that I do not intend to cover all of their submissions in this decision. However, I have been greatly assisted by the detail counsel have provided.

Issues for determination

[18] I have two issues to determine:

(a) First, did the defendant fail to, as far as was reasonably practicable, consult, cooperate with and coordinate activities with all of the other PCBUs who had a duty in relation to the same matter; and

(b) Secondly, did the defendant fail to ensure so far as was reasonably practicable the health and safety of workers, including Mr [redacted] while he was at work in the business or undertaking, and that the failure exposed him to a risk of serious injury.

Case for the prosecution

[19] A summary of the prosecution case is that:

(a) The Bluff Operating Procedures created by the defendant and used for work inside Shed 4 did not effectively provide for the separation of pedestrians and mobile plant. Insufficient controls were in place to manage the obvious and significant risks posed to workers. Too much emphasis was placed on workers following instructions and being vigilant. More could and should have been done by way of traffic management to ensure a safe system of work.

(b) While the defendant ensured the Bluff Operating Procedures were available to workers on site, it did not take the obvious step of consulting with the PCBUs themselves about the specifics of these procedures to determine whether they adequately and effectively managed the relevant risks.

[20] The prosecution accept that they carry the onus of proof and that they must establish each element of the offence beyond reasonable doubt.

Section 36 charge

[21] Dealing first with the charges laid under ss 36 (1)(a), 48(1) and 2(c) of the HSWA, the prosecution submit that there are four elements which need to be proved:

i. The defendant was a PCBU as defined in s 17 of the HSWA.

ii. The defendant had a duty to ensure, so far as is reasonably practicable that the health and safety of workers, including Mr [redacted], was not put at risk while the workers were at work in the business or undertaking (namely the loading and unloading work in Shed 4).

iii. The defendant failed to comply with that duty.

iv. The (alleged) failure exposed workers, including Mr [redacted], to a risk of death or serious injury.

[22] The prosecution has proceeded on the basis that the first two elements are not in dispute, and so far as the fourth element is concerned it appears to be accepted that Mr [redacted] sustained serious injuries and died, and a failure to meet the relevant duty would plainly expose workers doing the work in question to risks of that nature.

[23] The prosecution accordingly submits that the dispute is solely in relation to the third element - whether the defendant failed to meet its duty to provide a safe system of work inside its part of Shed 4.

[24] It is the prosecution case that the defendant's health and safety systems generally, and the Bluff Operating Procedures in particular, were a well-intentioned but flawed attempt to provide for a safe system of work inside Shed 4. It is submitted that the evidence established that these procedures did not ensure the safety of workers so far as reasonably practicable. In particular, it is submitted that they failed to effectively minimise the risks posed to pedestrians by mobile plant.

[25] The prosecution justify that submission by saying that the operation inside the shed was such that the risks to workers in the circumstances were obvious and significant. I am referred to the following matters.

[26] It was essential to the PKE unloading and loading work that there was at least one, if not two, loaders operating in the shed at one time to push up the PKE. Both loaders needed to both move forward and in reverse to do this.

[27] It was common ground that the process of reversing the loader (and in general) created greater risks. The prosecution argue those risks were exacerbated by the specific blind spots and visibility issues of the particular loader.

[28] The process of trucks coming and going, tipping their load of PKE, then leaving, meant there could typically be three pieces of mobile plant operating in that shed at one time.

[29] The prosecution emphasise that trucks would come in one door (east) then exit another (south) after tipping their load. The one-way system would however "switch" at a certain point of time, decided by the store supervisor based on the size of the PKE pile and the reduced space in the shed. It is argued this complicated the traffic flows and increased the risks. The prosecution rely on the evidence given by Mr Nealer, a qualified safety consult, in support of this proposition.

[30] The need for the PKE "blow off" process and the checking of tail doors, together with the layout of the shed, was such that the trucks were required to stop before exiting the shed at the exit door. This put their truck in the path of the reversing loader.

[31] There was a "spotter" present. The precise role of the spotter was, it is submitted, at times opaque. However, it was an expected part of the Bluff Operating Procedures that sometimes the spotter would drive the second loader. In those circumstances truck drivers would then be required to exit their trucks to perform the PKE "blow off" process themselves. In addition, they might also exit their trucks to carry out tasks such as checking their tail doors.

[32] As the PKE pile grew, the available space inside the shed shrank. The size of the loader with its large boom also diminished the available operating space.

[33] It is submitted that all of the above circumstances allowed for limited margins of error in carrying out the operation.

[34] The Bluff Operating Procedures were written by the defendant without any reference to WorkSafe guidance. These procedures were intended to manage the risks. However, it is submitted that these procedures were heavily reliant on worker vigilance and adherence to instructions. Essentially, they were a form of administrative control. It is conceded that this means of controlling risks is not necessarily invalid but it is further submitted that it is a lower form of control given how much then depends on humans not making mistakes or cutting corners. It is the prosecution case that more "layers" were needed to ensure a safe system.

[35] Mr Finn made the point for the prosecution that the workers were performing repetitive tasks, often for many hours at a time and often in the middle of the night. In these circumstances it has to be foreseeable that mistakes may occur because that is simply human nature.

[36] It is submitted that other forms of control were available and were either known, or should have been known, to the defendant. Many of these were detailed in the evidence or were available in publicly available guidance material. They included:

(a) a dedicated spotter at all times;

(b) demarcation lines to assist in determining when sufficient or enough PKE had been piled up;

(c) a stop line or safety cone outside the shed so the driver knows exactly where to stop;

(d) use of a reversing camera on the loader;

(e) use of proximity sensors;

(f) use of blue light indicators on the loader.

[37] The prosecution does not accept that this accident was unforeseeable and could not have been predicted. Neither does the prosecution accept that the circumstances here were out of the ordinary and that it is only by the use of hindsight that the risks have become clear.

[38] In support of that I am pointed to:

(a) The procedures themselves contemplated situations where multiple items of heavy plant were operating in a shrinking space, in which the loader would inevitably be routinely reversing towards trucks stopped by the exit.

(b) Although it is not clear exactly why [redacted] got out of his truck on the night, there were obviously several reasons why he could have done so either that night or generally. The procedures themselves contemplated that occurring.

(c) The potential absence of a spotter was likewise common or foreseeable enough to be written into the procedures.

[39] Based on those factors, the prosecution say that the specific circumstances of this accident were ultimately inherently foreseeable.

[40] The prosecution accept that s 35 of the HSWA permits the court to have regard to the requirements of other enactments when determining whether a person has complied with a duty under the HSWA. In this regard it is accepted that the biosecurity context is relevant. The prosecution submit that this context added a layer of complication in that the operation needed to be managed so as to remain compliant with the relevant MPI rules and the defendant's Bluff Operating Procedures. As at the date of the accident the MPI rules required that as part of ensuring the safe handling of PKE, the "designated holding area" was to be indoors. This was to ensure, of course, that there was no spreading of the PKE outside the shed.

[41] For there to be any change, the defendant would have needed to contact MPI to discuss any potential change. The prosecution notes that the defendant had not approached MPI prior to the incident to suggest or request any changes.

[42] The prosecution points to the fact that after the accident, a change was permitted which enabled the PKE to be blown off outside and this greatly reduced or possibly even eliminated the risk to pedestrians. However, it is the prosecution argument that there were available controls that could and should have been adopted whilst the operation remained inside the shed.

Section 34 charge

[43] Turning to the charge laid under s 34 of the HSWA it is submitted that the elements are:

i. The defendant was a PCBU.

ii. The defendant had a duty in relation to the same matter imposed or under the Act with other PCBUs.

iii. The defendant failed, so far as is reasonably practicable, to consult, cooperate with, and coordinate activities with all other PCBUs who have a duty in relation to the same matter.

[44] Again, the first element is not in dispute. The second is also not in dispute, with the prosecution noting that HTL and TSSL each had overlapping duties relating to the unloading work in the defendant's part of Shed 4, as was recognised by their pleas of guilty to charges under s 34.

[45] As to the third element, the prosecution accept that the defendant sought to make workers from both HTL and TSSL aware of the Bluff Operating Procedures. It is the prosecution case that this is not the focus of the charge. The prosecution argue that the defendant had an obligation to consult first with the other PCBUs in the ways

described by Inspector Lambie and as set out in the "overlapping duties" guidance. In this regard I am referred to Tab 40 in the bundle.[1]

[46] It is argued that the first and most obvious step would be to discuss the Bluff Operating Procedures themselves. After all, this was the most substantial health and safety document for doing work in Shed 4. The prosecution argue that this was not done, despite the fact that multiple workers from HTL and TSSL were to be deployed to do the actual loading and unloading work in the shed. These two companies were not provided with the Bluff Operating Procedures but rather they were sent generic health and safety documents.

[47] The prosecution argue that a process of collaboration is not a mere formality but rather it informs the first step of ensuring a safe system of work. The prosecution submit that in this case both HTL and TSSL ought to have been involved in discussing whether the system being used by the defendant was a safe one, whether all the relevant risks had been identified, and whether these companies might have ideas as to how the risks were managed. This did not occur.

[48] During the course of the trial, the role played by both Mr [redacted] and the loader driver, [redacted], was referred to. The prosecution does not dispute that one or both of these men made mistakes. Clearly, Mr [redacted] parked his truck further inside the shed than was normal, and [redacted] likely did not pay close enough attention when reversing the loader.

[49] With respect to worker conduct generally, I am referred to *Oceania Gold (New Zealand) Ltd v Worksafe* and *Worksafe v Eatim New Zealand Ltd*.[2]

[50] It is submitted that the defendant has, on more than one occasion, focused its attention only on the failures of workers. Indeed, when there was a previous incident involving a collision between a loader and a truck, the defendant blamed the loader driver.

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[1] Tab 40 – Overlapping Duties.
[2] *Oceania Gold (New Zealand) Ltd v Worksafe* [2019] NZHC 365; and *Worksafe v Eatim New Zealand Ltd* [2023] NZDC 8436.

[51] Mr Finn submits that the key failure here lay not with the workers but with the system that was being operated. The Bluff Operating Procedures are not 100 per cent clear as to exactly where a driver stops his or her truck. It would have been easy for a stop line, cone or cones to have been deployed to better define the stopping area. In addition, a permanent spotter could also have better ensured that the vehicles were parked in the correct position at a sufficient distance from the reversing loader.

[52] It is argued that the Bluff Operating Procedures are not entirely clear about whether or not, and if so when, it is acceptable for a driver to stand behind their truck to blow off PKE.

[53] It is submitted that the risks surrounding the reversing loader are obvious and the layout and traffic flow of the shed were obvious. Given the blind spots and the constant risk of having a vehicle or a person behind the loader, more could have been done, and should have been done, to minimise this obvious risk.

[54] The prosecution argue that any suggestion, if made, that the system in Shed 4 was good enough because other industry followed similar practices, will not excuse the defendant from fault. "Industry practice" is not, in itself, a determining factor in deciding what is reasonably practicable. In *Civil Aviation Authority v The Alpine Group Ltd* the court made the comment that industry norms and industry standards are not the same thing. The court said that the standard is not to be judged by what others were doing but rather what they should have been doing.[3]

[55] In conclusion, the prosecution submit that the defendant did not have a safe system of work for the work being done in Shed 4. In particular, there was insufficient care to ensure separation of pedestrians and mobile plant. This failure exposed workers to significant and foreseeable risk of serious injury.

[56] Further, the defendant failed to consult with other PCBUs to ensure the procedures were fit for purpose to manage the risks. Whatever mistakes were made by workers on the night, it is the prosecution case that the flaws in the system were a substantial operating cause of this accident.

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[3] *Civil Aviation Authority v The Alpine Group Ltd* [2022] NZDC 20040.

Case for the defendant

[57] For the defendant, it is accepted that both HTL and TSSL pleaded guilty to charges pursuant to ss 36 (1) (a) and 36 (2) of the Act, but the court is reminded that the focus of this trial must remain on the allegations and the duties imposed on the defendant.

[58] The defendant stresses the importance of the test for what is "reasonably practicable" pursuant to s 22 of the HSWA and the court is also reminded that s 35 of the HSWA is important on the facts of this case, given the overlap between health and safety legislation and the separate but important obligations of biosecurity under that legislation and supervised by MPI.

[59] It is argued that "but for" the death of Mr [redacted], it would not have been possible to ignore or to unilaterally amend the MPI rules.

[60] The court is reminded further that the law does not seek to impose unrealistic and unattainable "perfection" on those organising or undertaking work. It is recognised that most work will involve some "residual" risk.

[61] It is the defence position that the allegation that the defendant failed to ensure a safe system of work (including a traffic management plan) is, in fact, an allegation that there was a complete failure to provide an intangible "safe system of work" and that failure included a failure to have a traffic management plan for workers loading and unloading PKE in and out of Shed 4 at all. The defence reject any assertion by the prosecution that there was a failure to have an adequate traffic management plan, because in the defence perspective, the charge suggests there was no traffic management plan in place and that the workers were exposed to the lack of this planning and also a failure to have an overall safe system of work on or about 24 February 2017.

[62] The defence point to the fact that there is no definition of what is a "safe system of work" and it rejects the notion that because there was a death this in itself establishes there was no "safe" system of work.

[63] The defence make some reference to the adequacy of the particulars and in particular refer the Court to *Talley's Group Ltd v Worksafe* where the Court of Appeal made it clear that some detail in the charging document is required.[4]

[64] Having said that, it is accepted that there was (and there is) enough pith and essence to fairly inform the defence of what is alleged. The defence does not accept that the trial can or should adopt an inquisitorial type process akin to a coronial investigation to determine any failings. The court is reminded of the onus and standard of proof.

Section 36 charge

[65] The defence perceive this charge as an allegation that the defendant failed to ensure there was a safe system of work (including a traffic management plan) in respect of workers loading and unloading in Shed 4.

[66] The defence say that the weight of evidence during the trial established that the risk assessments associated with reversing vehicles was absolutely identified by the defendant, was recorded in writing, and managed as well as possible. I am reminded of the evidence of Mr Lambie who said that the defendant had good procedures in place and that they had been doing some very good work.

[67] It is submitted that the operating procedures for tipping PKE into Shed 4 had been carefully drafted in a practical way to set out a combination of the sequence of work to be done. It is further submitted that the process was designed to safely conduct the work taking into account the various hazards.

[68] I am referred to page 154 of Tab 10 in the bundle which stipulates that a driver must stay inside the vehicle and keep the vehicle stationary at the time the spotter is using the compressor to blow the excess PKE off the back of the vehicle.[5]

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[4] *Talley's Group Ltd v Worksafe* [2018] NZCA 587.
[5] Tab 10 p 154 – Bluff Operating Procedures.

[69] Comparing the three operating procedures for HTL, TSSL and the defendant, it is apparent that there are obvious differences, but it would be entirely unfair to suggest that these procedures could have been prepared in the absence of risk assessments being undertaken.

[70] I am referred to the Health and Safety Procedure Manual and it is suggested that although it was not provided to the prosecution it does set out in great detail the steps taken to avoid risk.

[71] Despite the wording of the s 36 charge, there was, in fact, a traffic management plan for all of the drivers working in and around the port, commencing with the entry into the port, to the weighbridge, and ultimately into and out of Shed 4. The defence submissions take me through the evidence relating to the traffic flow in Shed 4.

[72] It is submitted that there were no failures in the traffic management system for Shed 4 and all drivers appeared to know the work sequence and plan. No comparison exercise was undertaken against the HTL and/or TSSL procedures. It is noted that spotters were not necessarily used in the agri-feeds shed, which meant that drivers would need to go towards the rear of their trucks to undertake that work themselves.

[73] The defence do not accept that the loader being used by [redacted] was either unsafe or that reversing warnings were not working. It is also argued that a reversing camera would have problems of its own necessitating regular cleaning by the operator standing behind the loader. It is submitted that, as we know from the police report, the sounding systems and lights on that loader were working, and the fact that Mr [redacted] was not alerted to the approach of the loader suggests that the loader driver may have allowed the loader to operate in neutral when coming off the PKE stack.

[74] Despite the prosecution evidence, the defence position is that there was no material safety difference between the one-way system in the agri-feeds shed, nor was there any material difference in the bulk of the Standard Operating Procedures between the three companies. Indeed, it is suggested that the defendant's unloading PKE material was more detailed.

[75] It is noted that once the improvement notice was issued there was only one single remedial measure, namely, to require all trucks to exit Shed 4 and check/clean the tail doors once the rear of the truck had exited the shed.

[76] Dealing with spotters, it is observed that the decision to use a spotter was a decision by the defendant which was intended to reduce the number of occasions that truck drivers needed to leave their truck altogether. It was described as a "time based thing".

[77] It was pointed out that the spotter was not a permanent role and that there would be occasions when the defendant's shift supervisor, who would carry out the role of spotter, might be required elsewhere. For that reason, the defendant's Bluff Operating Procedures included guidance on what would happen when a spotter was available, and what would happen when there was no spotter.

[78] The spotter was not educated on true traffic management and it is suggested that if a spotter had been struck while blowing down the rear of the truck, WorkSafe would have questioned the need for a spotter to be involved.

[79] It is submitted that if the prosecution case is that the absence of a spotter was an obvious failure of risk management planning, then it is difficult to reconcile against the Standard Operating Procedures of HTL and TSSL given that, it is understood, there was no suggestion that those Standard Operating Procedures, which completely omitted the use of a spotter, were factors in the charges laid against them. It was not recommended in the improvement notice either.

[80] The court is also reminded that the most important aspect of the prosecution allegations hinged on the improvement notice and the steps taken by the defendant after the accident to allow for trucks to be completely removed outside Shed 4 and the transactional facility area after the accident.

Section 34 charge

[81] It is submitted that on the face of the charge, it is suggested the defendant failed to undertake any aspect of the required consultation, cooperation, or coordination with those specific PCBUs identified. The court is referred to the evidence of Mr Lambie who concluded that the failure to inform these companies of the defendant's procedures was a significant factor in the death of Mr [redacted].

[82] The defence argue that when the evidence is looked at overall, it clearly establishes that there was reasonable consultation, cooperation, and coordination with not only the PCBUs identified in the charging document, but that the defendant met the reasonable expectations of consultation with several other PCBUs too when arranging the safe work to be done in Shed 4.

[83] It is argued that there is no minimum threshold of exactly "what" must be communicated given the large number of worksites and work types across New Zealand. It is submitted that the law does not require 100 per cent foresight and 100 per cent control of all potential risks that might evolve during work. The law expects companies to proactively work with others to plan ahead for the work to be undertaken as safely as "reasonably and practicably" possible.

[84] The defence submit that defence exhibit D, being a traffic flow plan for berth 8, is the first relevant example of consultation, cooperation, and coordination.

Herberts Transport Ltd

[85] Turning to HTL, it is accepted that this company provided a large loader and boom, together with a driver.

[86] I am referred to the exhibits in Tabs 17, 18, 19 and 20.[6] I am also reminded of the evidence that similar health and safety documentation was provided to HTL on 29 August 2014.

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[6] Tab 17 – Contractor Health and Safety Agreement.
Tab 18 - Procedure – Palm Kernel/Fertiliser Boat Procedure x Bluff Wharf.
Tab 19 – Herberts Transport Vessel Standards. Matters discussed: All taildoors to be pinned and tarps

[87] Based on that evidence it is submitted that both HTL management and their drivers were made aware of the processes to be followed in Shed 4.

[88] Mr Horrell, the manager of HTL, confirmed that they would provide a truck and loader to operate in Shed 4 if asked, but said that the information he had seen about the operation for the defendant company was quite generic. He clarified that although he was not aware of how the traffic was flowing in Shed 4, he assumed they were operating under a traffic management plan provided by South Port. Under cross-examination he agreed that the processes in both ends of the shed were fairly comparable and not materially different.

[89] The evidence showed that there were safety documents and procedures within the smoko room at Shed 4. The smoko room was shared between all of the occupants of both sheds.

[90] I was referred to the statement of [redacted], which was accepted as part of the evidence, and in particular the following:[7]

> Everyone knew to keep away from the loaders and to wait for the opportunity to unload. The truck drivers knew where they were going. This worked well, as I said, with no issues. The trucks dumping the palm kernel come to the entrance door and stop.

[91] In the evidence given by Mr Clearwater, a driver for HTL at the relevant time, he said that over the years he had seen documents and procedures for the defendant and that there were "always procedures with McLellan freight" handed on to HTL and provided to him.

[92] Mr Clearwater confirmed he recalled some toolbox notes from McLellan's meeting with the drivers, and he also confirmed he was aware of the operating procedures produced under Tab 10.[8]

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to be used when loaded with PKE.

Tab 20 – Minutes Health and Safety Toolbox meeting held Herberts Transport Smoko Room 23 August 2016, 7.30 am.

[7] NOE p 17 lines 15-19.

[8] Tab 10 – Bluff Operating Procedures.

[93] Under cross-examination the HTL driver, Mr George, confirmed the pre-start toolbox meeting and also confirmed these toolbox meetings would occur in the smoko room where paperwork would be signed off. It is accepted he could not recall a briefing on this particular day, but did confirm that the toolbox notes would normally be signed and not removed by the drivers.

Transport Services Southland Ltd

[94] This company employed Mr [redacted]. He was clearly an experienced driver.

[95] I am referred to TSSL's Health and Safety Procedure Manual produced under Tab 16. The TSSL procedure for PKE at Bluff Wharf (closely resembling the HTL procedure) can be found on page 364. I am told that the defendant provided safety documents described as generic safety materials to TSSL.

[96] It is submitted that the evidence shows Mr C G Hansen, who was also employed by TSSL, had undertaken PKE unloading on three or four ships per year, which is equivalent to 24 shifts at South Port.

[97] I am referred to the evidence given by Mr Williams, the then manager of TSSL, His opinion was that the various drivers working for the defendant would have been made aware of the safety aspects to the work and indeed many of the drivers had been involved previously. It was the view of Mr Williams that there was consultation and coordination at a formal level.

[98] It is submitted that when looking at the evidence from the witnesses and considering the documentation as a whole, there was a considerable amount of evidence that there was consultation, cooperation, and coordination relating to the unloading of PKE.

[99] It is submitted that the intent of s 34 does not change how work is contracted out or directed. Where there is more than one legal identity sharing the same duty, each must discharge the duty to the extent that they can influence or control the matter.

The law does not attempt to interfere with contract law or the "control" of a workplace. It is conceded that the defendant has always accepted that it had ultimate control over the load process and it was effectively "in charge" of that process and Shed 4.

[100] The defendant concludes by submitting that the prosecution has failed to prove either charge to the required standard.

Discussion

[101] During the course of the hearing I heard a great deal of evidence, including the immediate events leading up to the tragedy, concerning the setting up of the PKE unloading operation, traffic management protocols for traffic at South Port, interactions between the defendant and HTL and TSSL in particular, and general evidence as to how the unloading process was handled in Shed 4.

[102] However, as earlier stated, the issues I have to determine are relatively straightforward. They are:

(a) Did the defendant ensure there was a safe system of work (including a traffic management plan) in respect of workers undertaking loading and unloading activities in ADM New Zealand Ltd's transitional facility at South Port, Bluff (Shed 4)?

(b) Did the defendant consult with, cooperate with, and coordinate with the relevant PCBUs regarding a safe system of work (including a traffic management plan) for truck drivers and plant operators to be followed when using the facilities in Shed 4?

[103] Before conducting an analysis of the evidence, I wish to deal with one or two preliminary matters.

Wording of s 36 charge

[104] I do not accept the defence argument that the wording of the charge implies a complete failure to provide an intangible "safe system of work".

[105] The charge detail is that the defendant failed to ensure there was a safe system of work (including a traffic management plan). Obviously, the section must be interpreted as the defendant having an obligation to ensure there was a safe system of work. It follows therefore that any traffic management plan must also be safe. It would not be possible for the defendant to provide a safe system of work if there was no safe traffic management plan. The two go together.

The effect of guilty pleas by HTL and TSSL

[106] It is accepted that both HTL and TSSL had, prior to this trial, pleaded guilty to charges laid by WorkSafe New Zealand as a result of this fatal accident.

[107] Both companies accepted, by their pleas of guilty, that it would have been reasonably practicable for them to have:

i. Inquired prior to undertaking work to ensure that there was a safe system of work (including an effective traffic management plan) in respect of workers undertaking loading and unloading activities in ADM New Zealand Ltd's transitional facility at South Port, Bluff

ii. Addressed and remedied potential issues with controls with this defendant (as the PCBU controlling the workspace) if a safe system of work was not identified prior to that work commencing.

[108] It follows from the pleas of guilty that both of those defendants considered that they had not done sufficient to ensure that there was a safe system of work and that they had failed to identify any potential issues.

[109] During the course of the hearing Mr Finn made it clear that the prosecution was not suggesting that simply because guilty pleas were entered by HTL and TSSL the defendant in this case must be guilty, and he accepted that it was the prosecution's task to prove its case against the defendant beyond reasonable doubt. Mr Finn specifically acknowledged that the fact of those convictions did not affect the defendant's ability to defend the charges.

[110] The defendant's position was simply that although the convictions of the other two companies could not be disputed, the focus of the trial had to remain on the allegations and the duties imposed on the defendant.

[111] Mr Finn's concession was properly made. Simply because HTL and TSSL elected to plead guilty, it cannot follow that those pleas prejudice the defendant.

Section 35 HSWA

[112] During the course of the hearing reference was made to the provisions of s 35 of the HSWA. That section provides:

> In determining whether a duty imposed on a person by or under this Act is being or has been complied with, a person or a court may have regard to the requirements imposed under any other enactment (whether or not those requirements have a purpose of ensuring health and safety) that apply in the circumstances and that affect, or may affect, the health and safety of any person.

[113] In this case, MPI were involved because PKE can potentially be a biosecurity risk. For that reason, the defendant and anyone else operating within Shed 4 had to comply with the MPI rules. It was for this reason that after unloading PKE, the truck was not permitted to leave Shed 4 until any remnants of the load was cleaned off the tray of the truck. This was managed by ensuring that as each truck left Shed 4, it stopped at a point where the remnants of the load could be cleaned off the tray without those remnants leaving the confines of the shed.

[114] It is common ground that after the accident MPI were approached with a view to changing the rules to enable the trucks to be cleaned outside of the confines of Shed 4. As observed by Mr Finn in his submissions, the change authorised by MPI was a temporary arrangement only.

[115] I am of the view that the fact that the defendant did not approach MPI in an attempt to have the rules changed, is not something it can be criticised for. The defendant knew the rules, it had accepted the contract and the conditions imposed by MPI, and it was therefore the defendant's duty to comply with both the HSWA and

MPI rules. It would be unfair for the defendant to be criticised for not seeking a change. The court needs to be very careful not to rely on hindsight.

Driver errors

[116] It was apparent from the evidence that I heard that both Mr [redacted] and the loader driver, [redacted] made errors. Obviously, Mr Hansen parked his truck in an unusual position and [redacted] was not paying close enough attention to his surroundings as he reversed the loader.

[117] Mr Finn submitted that their errors did not and could not affect the defendant's culpability. In support of that submission, I was referred to a passage in *Oceania Gold Ltd v WorkSafe New Zealand* where Venning J, quoting from an earlier decision, said:[9]

> .... But guarding against workplace accidents that result from the foolish carelessness of employees is part of the role of the Health and Safety in Employment Act. So, to allow such carelessness to minimise an employer's culpability would undercut one of the policy objectives of the legislation. This is why the full Court in *Hanham & Philp* refused to place any weight on the careless conduct of the victim in the *Cookie Time* appeal. It is also why the carelessness of the young victim's father in *Street Smart* was not understood to diminish the employer's culpability.

[118] Although it could be argued that the actions of Mr [redacted] and [redacted] were the primary cause of this accident, that fact cannot excuse the defendant if it is found it breached its obligations under the HSWA.

Onus and standard of proof

[119] As set out by Mr Finn, it is the obligation of WorkSafe New Zealand, having brought these charges against the defendant, to prove each and every element of those charges beyond reasonable doubt.

[120] I remind myself that the defendant does not have to prove anything. There was no obligation on the defendant to call evidence and the fact that it did call evidence does not alter the onus and standard of proof.

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[9] Above n 2 at [52].

Analysis

[121] Although I heard a considerable amount of evidence, a great deal of it was essentially background evidence and does not help me to determine the two issues I need to determine. I only intend to focus on the evidence I find of assistance in that determination.

[122] I have been referred to a number of sections of the HSWA. Ultimately there is no dispute here about the applicable law, but rather the interpretation of that law as it relates to the facts.

Section 36 charge

[123] It is clear from the wording of the two charges that the words, "so far as was reasonably practicable" assume great importance. In that regard I am referred first to s 22 of HSWA which reads:

> **22 Meaning of reasonably practicable**
>
> In this Act, unless the context otherwise requires, reasonably practicable, in relation to a duty of a PCBU set out in subpart 2 of Part 2, means that which is, or was, at a particular time, reasonably able to be done in relation to ensuring health and safety, taking into account and weighing up all relevant matters, including—
>
> (a) the likelihood of the hazard or the risk concerned occurring; and
>
> (b) the degree of harm that might result from the hazard or risk; and
>
> (c) what the person concerned knows, or ought reasonably to know, about—
>
> (i) the hazard or risk; and
>
> (ii) ways of eliminating or minimising the risk; and
>
> (d) the availability and suitability of ways to eliminate or minimise the risk; and
>
> (e) after assessing the extent of the risk and the available ways of eliminating or minimising the risk, the cost associated with available ways of eliminating or minimising the risk, including whether the cost is grossly disproportionate to the risk.

[124] I was also referred to *WorkSafe New Zealand v Department of Corrections*. In that decision the then Chief District Court Judge stated:[10]

> [33] The test of what is reasonably practicable is objective. It is not a question of whether the defendant actually foresaw the relevant circumstances, or whether it deemed the practicable steps submitted by the prosecutor to be reasonable, but whether it was objectively reasonable to predict the relevant circumstances and take those steps. In *Department of Labour v Solid Timber Building Systems New Zealand*, Baragwanath J commented:
>
> > I construe the definition of "all practicable steps" as essentially one of objective fact, viewing the matter at a stage shortly before the injury through the eye of an employer conducting the respondent's operation and with the knowledge that such an employer could reasonably have been expected to possess as to the nature of prospective harm…"

[125] The first issue I need to determine is whether the defendant failed, as far as was reasonably practicable, to consult, cooperate with, and coordinate activities with all other PCBUs who had a duty in relation to the same matter, namely HTL, TSSL, and [redacted] JB Contracting.

[126] There is no doubt that the defendant sent a considerable quantity of generic material to TSSL. In the evidence given by Mr Wayne Williams it is clear that the defendant sent to them a document headed 'Contractor Health and Safety Agreement' and the defendant required that it be read by all members who came onto the defendant's site.

[127] There is no doubt that HTL was also sent safety documents but I accept the submission of Mr Finn that the most crucial document, namely the Bluff Operating Procedures, was not provided at any time.

[128] During the course of his evidence Mr McLellan accepted that the Bluff Operating Procedures document was never sent to either HTL or TSSL. Mr McLellan also accepted that the Bluff Operating Procedures was the most substantial health and safety document governing how work in Shed 4 was to be done, including by their workers.

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[10] *WorkSafe New Zealand v Department of Corrections* [2016] NZDC 18502 at [33].

[129] In the statement made by Mr Horrell and read into the record, he said:[11]

> 15. I don't know anything about the structure of McLellan Freight or how it operates, all I know is that the general manager is Alex McLellan.
>
> 16. I had not seen the policy and procedure documents for how McLellan operates their half of the shed. I don't know the procedure for toolbox talks in the McLellan half of Shed 4.
>
> 17. I received a contractor health and safety agreement in October 2016 from McLellan. It was a generic contractors agreement, it wasn't site specific. It was the first one I had seen.
>
> 18. I was not aware of what the drivers were doing in the shed and how they were operating. We thought McLellan Freight would conduct the same protocols as what we do at Herbert's Transport.
>
> 19. I hadn't been down to Shed 4 to meet with anyone from McLellan to discuss what my workers were doing. There was word that there was going to be a toolbox meeting conducted though.

[130] I accept that the defendant did provide both companies with generic health and safety documentation. However, the evidence proves that the Bluff Operating Procedures were never sent. I consider that it was vital that the Bluff Operating Procedures were circulated because both companies ought to have been involved in a discussion with a representative of the defendant to ensure that these procedures were sufficient to keep all workers safe.

[131] To send the Bluff Operating Procedures to HTL, TSSL, and [redacted] JB Contracting was something that was reasonably practicable to do. Given that it was never sent to any of these three entities, they had no opportunity to discuss the procedures and familiarise themselves with any differences between the defendant's procedures and procedures adopted by other organisations. They had no opportunity to comment on the procedures or express their views.

[132] Given this failure, I am satisfied beyond reasonable doubt that the defendant, who had a duty in relation to workers undertaking the loading, unloading, and transportation of PKE at ADM New Zealand Ltd's facility, failed to consult, cooperate, and coordinate the activities of the other involved PCBUs. Accordingly, the defendant will be convicted on the charge under s 36.

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[11] Statement of Mr W R Horrell at paragraphs 15-19, NOE at p 102.

Section 34 charge

[133] I now turn to consider the charge under s 34.

[134] The allegation is that the defendant failed to ensure so far as was reasonably practicable, the health and safety of workers including Mr [redacted], and that failure exposed Mr [redacted] to a risk of serious injury arising from vehicles used while loading and unloading PKE.

[135] I accept that the defendant was somewhat constrained by the requirements of MPI. However, the defendant was obliged to do everything that was reasonably practicable to ensure the safety of workers whilst complying with the MPI rules.

[136] In the statement of Mr George, which was read into evidence, he said:[12]

> The only way to make the operation totally safe is that you are not allowed out of your truck while inside the shed.

[137] In the evidence given by Mr C G Hansen he said:[13]

> ... that night I was actually blowing the trucks and that down but the loader would get a bit behind because there was a hold up for some reason and so I jumped on a loader and pushed it up.
>
> Q. So was it normal to have somebody there blowing the PK off the truck?
>
> A. Yes
>
> Q. Thank you very much
>
> A. That's normal procedure, yeah

[138] In the evidence of Mr C G Hansen, some questions that I asked are recorded, as are the answers:[14]

> Q. If you had been there as spotter on the night when this truck was in that position you would have instructed him to move forward wouldn't you?
>
> A. Yes. I saw this out the window of the loader.
>
> Q. Yes

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[12] Statement of Mr R George at paragraph 48.
[13] NOE p 70 line 32 - p 71 line 6.
[14] NOE p 81.

A. And I was going to address the issue right there and then as I said in my statement but it was too late.

Q. Which really emphasises the need for a spotter doesn't it?

A. Well yes but now we don't like, this here, the whole incident now and no truck stops in the shed like that at all now.

[139] It also became clear from the evidence that the truck being driven by Mr [redacted] was equipped with a remote which would control the tray tipping process and also secure the pins at the rear of the truck. In answer to questions that I asked, it became apparent that because Mr [redacted] had a remote there was no need for him to get out of the truck at all, provided there was a spotter.[15]

[140] Mr C G Hansen also commented that since the accident no one gets out. Mr C G Hansen also confirmed that as part of the rules of procedure the spotter never went behind the truck because he could use the compressor to blow the excess PKE off the tail door of the vehicle whilst standing at the side of the vehicle.[16]

[141] We know that this accident occurred whilst Mr [redacted] was standing at the back of his badly parked truck with his back to the operating loader. I have absolutely no doubt that the risk of an accident such as this was obviously foreseeable. Indeed, some time earlier a loader had backed into the back of a truck causing some minor damage.

[142] In his written submissions, Mr Finn submitted that during the PCBU interview and during his evidence Mr McLellan, on more than one occasion, focused his attention on the failures of the workers.

[143] Mr McLellan was asked in evidence whether, as a result of the earlier accident I have just referred to, he reviewed the process or system operating in the shed. Mr McLellan replied that he most certainly did and he changed the loader driver. Mr McLellan said that he did not believe there was a process or system risk.[17]

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[15] NOE p 84.
[16] NOE p 83 lines 16-20.
[17] NOE p 258.

[144] I heard a great deal of evidence about toolbox meetings and what was and was not discussed during those meetings. There is a question as to whether or not there was a toolbox meeting prior to this accident, as it is noted that there are no signatures on the document.

[145] However, whether or not there was a toolbox meeting attended by Mr [redacted] prior to the accident is not, in my view, of great importance. The toolbox meetings were held to remind drivers of the procedures that they were to follow and of course the Bluff Operating Procedures formed the basis of those briefings. The weakness of the system operated by the defendant was an over-reliance on workers not making a mistake.

[146] The earlier accident caused by a loader backing into a truck should have rung warning bells as to the procedures. Changing the driver was not the correct solution. Because MPI insisted that the PKE be blown off the back of the truck before exiting the shed, that required very careful management to ensure the safety of anyone not in or on a piece of machinery.

[147] I accept that there was a traffic management plan. All of the drivers were obliged to obey the strict speed limits on South Port when they were travelling between the ship and Shed 4.

[148] I accept that once approaching Shed 4 the maximum speed permitted dropped from 30 km/h to 15 km/h. Once at Shed 4, the driver removed the cover from the load and any safety pins from the tailgate and was then obliged to wait until there was eye contact with the loader driver. The truck would not enter the shed whilst another truck was in the process of dumping its load and if there was any doubt, the truck driver could contact the loader driver using the CB radio.

[149] After dumping the load, the truck would then proceed to the exit door and would drive out of the exit door stopping at a point which ensured that the tail end of their vehicle remained inside the shed so that the excess PKE could be blown off before the truck proceeded any further.

[150] The Bluff Operating Procedures provided that if there was a spotter present the truck driver was not to exit the vehicle and was to keep the truck stationary until the spotter had completed the cleaning off of the tray and, if necessary, securing the tail door.

[151] The Bluff Operating Procedures provided that if there was no spotter the driver himself was responsible for cleaning off the excess PKE by standing to the side of the vehicle and not behind the vehicle. The Procedure also provided that if the driver had to go behind the vehicle, he or she must have first made sure that the path is clear.

[152] It is clear that this traffic management plan worked but was heavily reliant on the truck driver not making any mistakes. This was particularly true if there was no spotter.

[153] I am very firmly of the view that there should have been a permanent spotter tasked with the responsibility of blowing off the PKE. I note the submission of Mr Harris that had there been a permanent spotter struck while blowing down the rear of a truck, WorkSafe would have questioned the need for a spotter to be involved at all.

[154] Obviously that submission requires speculation, because until we knew details of the hypothetical accident and what the spotter was doing at the time of the accident, it is impossible to know what the reaction of WorkSafe would be.

[155] It is clear from the evidence that the truck driver, loader driver, and spotter were all able to communicate with each other by radio. We know from the evidence of Mr C G Hansen that had he been the spotter he would have immediately told Mr [redacted] to move his truck into the correct position. Mr C G Hansen would then have blown off the PKE using the wand and standing at the side of the truck. Mr [redacted] would not have needed to get out of his truck at all.

[156] We know that Mr [redacted] did not comply with procedures, he left his truck in a dangerous position, and for some reason he went to the rear of the truck where he was struck. However, just because he did not follow the rules does not absolve the

defendant from ensuring so far as was reasonably practicable the health and safety of workers in Shed 4.

[157] Mr Finn, in his written submissions, set out a number of forms of control that were available and were either known or should have been known to the defendant. I view as the most important available control the provision of a dedicated spotter. The problem with the system that required truck drivers to get out of their cab to clean off the PKE was that this required the drivers to concentrate on several different things at once. If there had been a dedicated spotter, it would have been that person's job to ensure the truck was parked in the correct place and to blow off the PKE while standing at the side of the truck. In that position the spotter could not only comply with the MPI requirements but could keep a very careful eye on vehicle movements. A system such as this would have prevented the need for a truck driver to get out of his cab at all.

[158] I am satisfied beyond reasonable doubt that this was an available measure, as were other measures and in particular I refer to a stop line or safety cone to assist drivers to know exactly where to stop, and the use of a reversing camera on the loader.

[159] I do not accept that a dust problem would mean that a reversing camera was not of assistance. Dust can always be wiped off. Additionally, all measures would work in tandem, not necessarily requiring them all to be operating with perfectly.

[160] A photograph of the loader which struck Mr [redacted] demonstrates quite graphically the difficulties the loader driver would have in spotting something directly behind him. A reversing camera would have been of real value.

[161] However, putting aside other suggestions, I am satisfied beyond reasonable doubt that by not having a dedicated spotter, the defendant failed as far as reasonably practicable to ensure the health and safety of workers including Mr [redacted] and that this failure exposed him to risk of serious injury. I accept that there were also other practical steps that could and should have been taken, as set out in Mr Finn's submissions.

[162] Accordingly, I am satisfied beyond reasonable doubt that the prosecution have proved the elements of the charge, and the defendant will be convicted.

Outcome

[163] I find the defendant guilty on both charges.

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Judge D G Harvey
District Court Judge | Kaiwhakawā o te Kōti ā-Rohe
Date of authentication | Rā motuhēhēnga: 08/09/2023