EDITORIAL NOTE: CHANGES MADE TO THIS JUDGMENT APPEAR IN [SQUARE BRACKETS].

ORDER PROHIBITING PUBLICATION OF NAME(S), ADDRESS(ES), OCCUPATION(S) OR IDENTIFYING PARTICULARS OF WITNESS/VICTIM/CONNECTED PERSON(S) PURSUANT TO S 202 CRIMINAL PROCEDURE ACT 2011. SEE http://www.legislation.govt.nz/act/public/2011/0081/latest/DLM3360349.html

SUPPRESSION ORDERS EXIST IN RELATION TO ASPECTS OF THIS JUDGMENT PURSUANT TO S 205 CRIMINAL PROCEDURE ACT 2011: SEE PARAGRAPH [75]. http://www.legislation.govt.nz/act/public/2011/0081/latest/DLM3360354.html

IN THE DISTRICT COURT
AT AUCKLAND

I TE KŌTI-Ā-ROHE
KI TĀMAKI MAKAURAU

CRI-2021-004-006221
[2023] NZDC 26957

MARITIME NEW ZEALAND
Prosecutor

v

PORT OF AUCKLAND LIMITED
Defendant

Hearing:	1 December 2023
Appearances:	T Bain & L Eastlake for the Prosecutor G Gallaway & S Riley for the Defendant
Judgment:	1 December 2023

NOTES OF JUDGE M-E SHARP ON SENTENCING

Introduction

[1] Port of Auckland Limited appears for sentencing because it entered a guilty plea to two charges under s 36(1)(a) and 48(1) and (2)(c) of the Health and Safety at

Work Act 2015. Those charges were lodged in the Court following a tragic fatal accident on 30 August 2020 in which a container fell from a crane at the Fergusson Container Wharf fatally injuring [name deleted – victim 1] who was only aged 31 years.

[2] The defendant has, as its counsel submits, accepted responsibility for that accident through its guilty pleas acknowledging that it should have implemented the specific practicable steps alleged in the charges in order to reduce the risk to its workers.

[3] Appended to these sentencing notes should be the agreed summaries of fact which I do not propose to traverse right now because they are so very lengthy. I will, however, attempt to summarise the most important aspects of them.

[4] Port of Auckland Limited, represented today by its Chief Executive and another senior executive, is a limited liability company, the only (as I understand it) shareholder of which, is the Auckland Council.

Investigation

[5] As a result of the death of [victim 1], an investigation into his death took place by Maritime New Zealand. The accident in which he died occurred at 2 am on Sunday 30 August 2020 aboard the container vessel MV Constantinos P which was berthed at Port of Auckland's Fergusson Container Terminal. Port of Auckland workers were discharging containers from this ship when [victim 1], who was a stevedore lasher, was crushed and killed by a falling container.

Facts

[6] One of Port of Auckland's cranes was lifting pairs of containers off the Constantinos when a third container below the two being targeted by the crane was accidentally lifted as well. It detached, fell and struck [victim 1] who was working in the walkway adjacent to the bay of containers being discharged by the operating crane.

[7] As the summary of facts records, Port of Auckland's business is concerned with port operations. It is a port company within the meaning of the Port Companies Act 1988 involved in a range of services including passenger services, marine services and those marine services include pilotage and harbour control. Its services also include multi cargo, bunkering, engineering and container handling. That is the loading and unloading containers from container vessels.

[8] The Port is - as we all know on - Waitemata Harbour, configured into two main terminals and additional multi cargo wharves. The Fergusson Container Terminal is Port of Auckland's main container handling terminal equipped with cranes capable of loading and unloading containers from container vessels onto the shore.

Stevedores/Lashers

[9] [Victim 1] was 31 years of age when he died. He had been working at Port of Auckland since April 2020 before which he had no stevedoring experience. He was trained and started on the day shift as a stevedore lasher but switched to the night shift in late July 2020. He was working in a pair with [victim 2] who is another victim in this matter.

[10] There are many lashers employed at the Fergusson Container Terminal by Port of Auckland and the agreed summary of facts records that all were affected by what occurred, as is completely understandable. I do not propose to outline stevedoring operations and in particular the roles of lashers, as [victim 1] was, save to say that they enter the individual walkways between the bays in which containers are kept on the container vessel and they unscrew the screws and metal bars which secure containers whilst they are in transit. They must be unlocked before containers may be discharged. Lashers are also involved on the wharf side container handling operations.

[11] Before the COVID-19 pandemic plan (to which I will refer again soon) lashers were supervised by a lash leading hand. In addition there were crane operators who manoeuvred cranes to pick up and drop containers to and from vessels, the lashing platform and the wharf. Crane operators do not have good visibility of the walkways between the bays of containers on the container vessel as those walkways may be narrow and dark and they are generally focussed on discharging or loading containers

accurately rather than looking at the walkways for the presence of lashers. Accordingly the lash leading hands, which role was in existence prior to the change of operations occasioned by the COVID-19 pandemic plan, were the eyes and ears for cranes operators.

[12] There were of course a number of other roles occupied by different employees of Port of Auckland such as ship leading hand, straddle drivers, ship supervisors, shift operator's manager and there were lashing standard operating procedures in which lashers were trained before they began their work. However, whilst the standard operating procedures for lashers were documented in training manuals and assessment guides there was no stand alone document. There was a three container width rule or exclusion zone which provided that lashers were not to work within three containers widths of an operating crane. That rule was documented in same places. However, there was no method by which lashers should and in fact were able to estimate the actual width of three containers within the particular zone concerned.

[13] So as I see it the policies and procedures which were in place prior to the pandemic were seriously deficient and did not take into account in the way that they should have let alone to the full extent of the real health and safety aspect and risk to lashers. That error was seriously compounded when the existing (if I can call them) rules around lashers working in proximity to ships whilst unloading containers, when Port of Auckland decided to change its practices and its policies in this regard as a result of the COVID pandemic plan: it did away, amongst other things, with the role of lash leading hand documented.

[14] In addition there had been very little compliance with what policies and procedures existed for lashers and lashing, for those who conducted the night shift. That was a major flaw in the way in which Port of Auckland operated and is certainly one of the major reasons that this terrible accident occurred. Because there was, seemingly, a lack of compliance with the three container width policy during the night shift and there was no active supervision, observation, monitoring carried out during the nightshift.

Pandemic

[15] Then happened COVID-19 and the global pandemic. It is well known that the New Zealand Government's response of imposing controls to reduce social movement and interaction with the aim of reducing spread led to - as we are now realising and experiencing - high level systemic failures economically, financially, in business, socially, educationally and in almost every way that could be imagined. Whilst I do not criticise the Government overtly for its responses given that it was generally considered that COVID-19 was extremely serious (in fact could be a killer and the New Zealand Government wished to keep its citizens safe) it would not surprise me if the outcome of the current COVID-19 enquiry was to suggest that the New Zealand Government's response was misguided in its severity.

[16] In any event, apart from the many deleterious consequences of that response, various businesses (and the more complicated a business the more difficult this was), were required at virtually very short notice to undertake and impose a new plan for the way in which, if they were an essential business, they would and could continue to operate whilst adhering to the Governments pandemic plan and requirements.

[17] Thus the Port of Auckland formulated a pandemic plan; it is fair to say it was done in a hurry - which certainly is not criticism of the Port of Auckland - but unfortunately its pandemic plan failed to take into account the health and safety risk factors attached for lashers in forming 13 single crane container handling stevedoring crews, each crew composed of six lashers, six straddle car drivers, two crane operators and one ship leading hand all expected to work as a bubble without interactions with other crews, in order to prevent the transmission of COVID-19.

[18] Under that plan the independent role of lash leading hand was removed and the duties formerly carried out by that person were added to the duties of the ship leading hand meaning that the ship leading hand became responsible for both directing the lashers to their point of work on the vessels but also directing the cranes to their points of work. As well, most crane operators were expected to rotate into the ship leading hand role during shifts and most crane operators were also trained in the role of shipping leading hand, meaning they would fulfil the functions of both the ship and, now, removed lash leading hand.

[19] All this, however, without Port of Auckland providing any specific training or instructions to ship leading hands or crane operators. Neither was there any update or formal review of the standard operating procedures or any revisions to the training manuals or the assessment guides for the new shipping hand role. The implementation of the pandemic plan resulted in a further reduction in the observation, monitoring and inspecting by the relevant figures within Port of Auckland, of stevedores involved in container handling operations.

[20] Those, shall I call them supervisors or inspectors, were not able to carry out their normal duties without infringing the work bubble requirement during the first lockdown in March/April 2020.

[21] All of this led really to the crisis of a perfect storm. A lack of appropriate health and safety regime for lashers prior to the advent of the pandemic, including a lack of observation and insurance that lashers were carrying out the policies that were in effect during night shifts; and after the pandemic, a serious reduction of those policies which effectively led to the death of poor [victim 1].

[22] That is all that I wish to say about the facts of this matter beyond expressing my sincere condolences to [victim 1]'s family for this shocking tragedy which should never have occurred. Sadly, I have to say it is not only fatality that has occurred at Port of Auckland. The previous one to this was not so long before poor [victim 1] died. However, I will come back to that.

Duty of care

[23] Maritime New Zealand has submitted that both sets of failures which are expressed in the two charges to which the defendant pleaded guilty are a serious departure from the duty of care that Port of Auckland owed to its workers. I agree with that submission. It was a serious departure and of course it caused a death.

Approach to sentencing

[24] I approach this sentencing on the following basis. First I explore the issue of reparation. Next I fix the amount of the fine by reference to guideline bands,

Stumpmaster v Worksafe New Zealand[1] and then having regard to personal aggravating and mitigating factors. I shall then determine whether further orders under ss 152 to 158 of the Health and Safety Work Act are required and last I will make an overall assessment of the proportionality and appropriateness of the combined packet of sanctions (as it is known) which includes reference to Port of Auckland's financial capacity and what effect that should have.

Reparation

[25] Port of Auckland has provided Maritime New Zealand with information about private arrangements that have been made to financially support [victim 1]'s family following his death. Maritime New Zealand, as prosecutor, has not been involved in this process and Maritime New Zealand has not seen the (as I understand it) Deed of Settlement that has been reached between [victim 1]'s family and Port of Auckland. That is no deterrent to the Court engaging in consideration of reparation because it is accepted in this case that the total package of reparation is one which is no less than the Court would and should have properly ordered had it not been offered.

[26] Sections 32 to 38 of the Sentencing Act 2002 deal with reparation which may be imposed in relation to loss or damage to property, emotional harm and relevant consequential loss or damage. There is no formula for fixing an amount of reparation. It is, unfortunately, an intuitive exercise based on the damage, emotional harm and/or consequential loss sustained by a particular individual. Its level, turns on the facts of the case and is a discretionary exercise at sentencing.

[27] Section 35 of the Sentencing Act directs the Court to have regard to the ability of the offender to pay a sentence of reparation. This is not a case where the Port of Auckland is in any difficulty and no submission is made on its behalf to that effect. I, therefore, consider it well able to meet reparation, as indeed the settlement that has been reached with [victim 1]'s family, indicates.

[28] A victim may be entitled to emotional harm reparation where they have suffered certain specified loss or emotional harm through or by means of an offence

[1] *Stumpmaster v Worksafe New Zealand* [2018] 3 NZLR 881 at [53].

and it is based on the assessment of the emotional harm sustained by the victim. Clearly the emotional harm suffered by [victim 1]'s family is as great as could possibly be. There is also the emotional harm suffered by [victim 1]'s work mate, his companion lasher on this occasion, [victim 2]. Port of Auckland has agreed to make an emotional harm reparation payment of $20,000 to him which I consider to be an appropriate one, given that he suffers from post-traumatic stress disorder and, it would appear, remains unable to work.

[29] So to [victim 1]'s family:- Port of Auckland entered into a private arrangement with his family whereby monetary payments and other benefits have been given, or will be given, as a form of voluntary reparation. Port of Auckland estimates the value to be approximately [details deleted] and has provided a summary of those arrangements to Maritime New Zealand. A Deed of Settlement has now been entered into and signed on behalf of [victim 1's] family which was independently represented during the negotiations. As a result of that, Maritime New Zealand does not seek any further order, submitting that the total amount of the reparation package (if I can call it that) is consistent with what the Court could have ordered, but it could not be said on a principled basis that any greater amount would be considered appropriate or within the purview of what would and should be acceptable.

[30] A major component of the arrangement is [details deleted].

[31] Maritime New Zealand makes something of the fact that the Deed expressly does not give the family any [details deleted] and that if Port of Auckland was to be placed in liquidation, or otherwise wound up, the [gift may be nullified]. In addition, something is made of the fact that the [details deleted].

[32] I acknowledge and accept all those things. Nevertheless the, in effect, gifting of [details deleted] by Port of Auckland to [victim 1's] family is extremely significant. I find it hard to imagine that Port of Auckland (which as I understand it rightly or wrongly is a very successful limited liability company) is likely to be placed in liquidation or otherwise wound up and whilst I do not have the Deed it seems unlikely that [details deleted]. So whilst I understand why Maritime New Zealand is making those submissions, they are not submissions which I find to be particularly influential, shall I say.

[33] A cash gift of [details deleted] has been given to [victim 1]'s family divided between his partner, parents and mother-in-law.

[34] In addition there have been other substantial payments made by Port of Auckland to the family. Port of Auckland has offered to pay for [details deleted]. It has paid significant amounts in [details deleted] and related costs; it agreed to that settlement for [victim 1's] family well before this sentencing took place. It was voluntary. I believe that the process of engaging in discussions about that settlement began quite early on. And it could not be said other than Port of Auckland has indicated its serious remorse, contrition and desire to make amends by a package which is reasonably generous, and which is commensurate with or greater than a reparation order that a Court in such circumstances would make.

[35] I have been concerned about the lack of ability of [victim 1]'s widow to earn an income and I have been worried about the ability of the family to support itself, especially given that one might have expected in the normal course of events, all going well, for [victim 1] to have continued to work from the age of 31 (which he was when he died) until the standard age of retirement at 65 years, on what I understand to be a reasonably healthy salary as a lasher. And to deprive the family of that amount for all of those years, as I say, is something that has greatly concerned me.

[36] I note with concern that in the victim impact statement which was very articulately composed and read by [person 1], who is the mother of [victim 1]'s widow, she indicated on behalf of the family that they would like ongoing income at a rate which reflected what [victim 1] would have continued to earn, indexed to the rate of inflation and paid on a net basis.

[37] I have, therefore, been forced to reflect on whether the reparation that has been agreed and mostly effected already, should be accompanied by a further reparation award. But having taken into account the ability of [person 2], who is [victim 1]'s widow, to obtain ongoing assistance from Accident Compensation Corporation by way of 80 per cent of the income at death of [victim 1], or to capitalise that and possibly in addition, I am not sure, to be entitled to a widow's pension (although possibly statutorily one would be inconsistent with the other) and given the reasonably generous package which has already been agreed and implemented by Port of

Auckland for reparation, I have decided that it would be unprincipled and contrary to the interests of justice to order anything further. Accordingly, and particularly noting that Maritime New Zealand does not seek a reparation order, because it accepts that what has been agreed is in law sufficient, I therefore make no further order.

Fine

[38] The next matter is to fix the amount of the fine, bearing in mind that reparation is compensatory in nature and recognises the emotional harm to [victim 1]'s family; compensates them for their consequential loss arising from the accident. In this case, there is very little difference between the prosecution and the defence as to both where this case sits in terms of culpability and what the starting point should be.

[39] Port of Auckland is said, according to the defence, to have culpability which sits near the middle of the *Stumpmaster* very high band, with a starting point of $800,000 being appropriate. The prosecution submits that the culpability of Port of Auckland in this instance sits at the higher end of the *Stumpmaster* very high culpability band, and that the starting point should be $900 to $1 million instead. As I say, very little difference between the parties.

[40] The prosecution's submission as to level of culpability and starting point is based on comparison with other relevant and comparative cases such as, for example, *WorkSafe New Zealand v Port of Auckland Limited*.[2] Because Maritime New Zealand submits that the failings of Port of Auckland are (and this is my term and not its) egregious enough to place it within the highest range, or to use its words: "Towards the top end of the high culpability band."

[41] In making his submissions on behalf of Port of Auckland, Mr Gallaway suggested (and he would not be particularly prescient to have done so), that the Court is likely to take a middle point between the two parties; that is exactly what I intend to do. I think having read all of the authorities which have been proffered by the parties, without particularly wishing to mention any one of them, this is a case where the starting point should be $850,000.

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[2] *WorkSafe New Zealand v Port of Auckland* [2020] NZDC 35308.

[42] Certainly, this was a case which fell within the highest band of culpability, and I agree that Port of Auckland's culpability fell within the higher end of that range. As bad as it was, however, it was by no means the worst that I have seen.

Personal aggravating and mitigating features

[43] I must, therefore, now move to consider the personal aggravating and mitigating factors of the defendant, Port of Auckland. The parties are in agreement that there should be an uplift for the previous unfortunate safety record of Port of Auckland.

[44] It is submitted by Maritime New Zealand that Port of Auckland has a poor safety record. This is its sixth appearance before the Court facing health and safety charges. It has five previous convictions for offending under the Health and Safety at Work Act 2015 or its predecessor legislation, including for offending twice in 2014, in 2017 and 2018.

[45] The 2018 offending resulted in the death of a straddle crane driver whose crane tipped over at 3.30 am during the night shift at the Fergusson Container Terminal. So whilst the facts were different, the effect was the same and once again that was an instance of, shall I say, poorly maintained and effected health and safety procedures and policies. That is the decision to which I referred earlier.

[46] So the prosecution says that Port of Auckland had ongoing systemic problems in respect of:

(a) Identifying appropriate controls for critical risks to health and safety that arose during the course of its business.

(b) Appropriately documenting these controls.

(c) Training its workers, stevedores in particular about critical risks to health and safety and the appropriate controls for those risks.

(d) Supervising and monitoring its workers to ensure that unsafe cultures and practices did not develop and that workers were following those documented controls and policies that did exist to address risks to health and safety.

[47] I agree with all of those submissions. In my view, they reflect the very real health and safety risks that there were, in particular for lashers within Port of Auckland and particularly on night shift.

[48] At this point I would also like to address the fact that poor [victim 1] was actually supposed to be on a day off when he was called back into work to undertake a night shift. I am not sure of the reasons but I would imagine because of staff shortages, especially given the COVID era that existed at the time. So he not only gave up his day of rest but he gave up his life.

[49] For all of these failures, Maritime New Zealand submits that an uplift of 10 per cent is appropriate and I acknowledge with gratitude that Port of Auckland does not demur from that. It accepts that an uplift of 10 per cent is appropriate and I therefore uplift the $850,000 starting point by 10 per cent.

[50] I now turn to look at personal mitigating factors. The first matter to look at is the discount that should be given for the guilty pleas. There has been quite a lot of discussion today about what that should be, either 15, 20, 25 per cent or somewhere between those, given the lapses of time that have occurred in this prosecution.

[51] The history of this matter is that the charges (these two plus two others which were later withdrawn) were laid in Court about one year after [victim 1] died and it was two years later that the defendant entered guilty pleas to these two charges, two others being withdrawn. For that, Maritime New Zealand has considered it appropriate that a discount between 15 to 20 per cent is applied, whereas Port of Auckland seeks the full discount which is available to a sentencing Court of 25 per cent.

[52] Whilst I have heard and understood Mr Gallaway's submissions on behalf of Port of Auckland as to why the full 25 per cent discount could be applied here, I am

afraid I disagree. I acknowledge that it took a very long time for charges to be laid. I acknowledge that it took a very long time for full disclosure to be made and that it was made in three tranches. I accept that negotiations over this sort of matter can take a good long time and that they did, in the end, result in two guilty pleas and two withdrawals.

[53] I acknowledge that Port of Auckland at no time indicated to the family that it would be defending the charges. It took responsibility in its representations to and with them pretty early on. However, the full 25 per cent discount has to be given for cases where the guilty pleas have been entered at the earliest possible time, and that is not two years after charges were laid, notwithstanding the matters which I have referred to, as Mr Gallaway has expressed them to me. I am prepared to give a 20 per cent discount and no more than that for the guilty pleas.

[54] There are additional discounts available for co-operation and remorse. I am convinced that Port of Auckland's remorse is real. I hope that [victim 1]'s family understands that.

[55] Maritime New Zealand submits a discount of 10 to 15 per cent is appropriate to reflect those mitigating factors, which recognises that Port of Auckland took steps to make amends to [victim 1]'s family shortly after the incident and that the amount of reparation voluntarily offered and largely given effect to is, as Maritime New Zealand submits, fair and comparable to that which would have been awarded by the Court. In addition, it has agreed to make emotional harm reparation to [victim 2] of $20,000, because he is also a victim of the offending.

[56] Under all of the circumstances, I am prepared to give a further discount of 20 per cent as Port of Auckland seeks. That means that there are total discounts of 40 per cent to be applied.

Purposes and principles of Sentencing

[57] In setting the starting point and considering what the uplift and then the discounts should be, I have taken into account, as I must of course, the purposes and principles of the Sentencing Act 2002, as I am required by the Health and Safety at

Work Act. Section 151(2)(e) of the Health and Safety at Work Act makes it clear that the safety record of the person must be paid particular regard, to the extent that it shows whether any aggravating factor is present, and that is why I have uplifted by 10 per cent.

Result

[58] Thus, from a starting point of $850,000 uplifted by 10 per cent, I reach a figure of $935,000, from which 40 per cent is to be deducted (or $374,000) reaching an end fine of $561,000, which is now what I impose on Port of Auckland Limited. There are two charges. They are different in nature but both stem from the incident in question and the failures of Port of Auckland.

[59] It was suggested, I believe, by Mr Gallaway in his submissions (or perhaps it was Mr Bain in his submissions) that I should impose that fine on one charge only, effectively treating the offending as one in total. Therefore, on CRN ending in numbers 1685, I now convict and fine the defendant, Port of Auckland, the sum of $561,000.

Ancillary orders

[60] Ancillary orders are available in cases such as this. The prosecution seeks an adverse publicity order, which is provided for in s 153(1) of the Health and Safety at Work Act. In such an adverse publicity order, an offender is required to publicise the offence, its consequences, the penalty imposed and any other related matter. The purpose is to publicly hold a defendant to account while also promoting industry awareness of workplace health and safety issues and discouraging further offending by others in the same sector or industry.

[61] There is no digression between the parties here that an adverse publicity order is appropriate. I agree, and that is because of the need to deter Port of Auckland from further health and safety related offending, given that previous sentences for breaches of the Acts have been insufficient, clearly. Also, because the impact on Port of Auckland's reputation may carry more weight by way of an adverse publicity order than continuing to impose only fines and reparation. But, most importantly, that

similar industries in this country should benefit from publication because it can be used to educate and inform relevant sectors about risks.

[62] The Port of Auckland agrees and the parties have proposed the wording for an adverse publicity order. It is attached at appendix 1 of Mr Bain's submissions from Maritime New Zealand and I agree that it is entirely appropriate. I therefore order it, as per appendix 1 which is to be attached hereto. The only other issue that arises in respect to the adverse publicity order is where it should be published and for how long.

[63] As I understand it, there is quite a difference between what the parties want and consider to be appropriate. I have decided that it should be published in the following way:

(a) On Port of Auckland Limited's Linked In profile, no more than two working days from today, and for a period of at least two months.

(b) On Port of Auckland Limited's website as a media release no more than two working days from today, and for a period of 12 months. The media release must be visible on the home page for a period of no less than two months.

(c) Five consecutive copies of the Shipping Gazette as a quarter page placement.

(d) In New Zealand Herald online NZ the equivalent to a quarter page placement, for five days.

(e) Stuff online, the equivalent to a quarter page placement for five days. I agree that comment functioning on social media or other publishing platforms should be turned off.

[64] I appreciate that the prosecution wanted substantially greater publication effected by the various different means suggested in Mr Bain's submissions but I consider that the terms that I have just imposed are more than adequate to effect the purposes that I am trying to achieve.

Costs

[65] The last matter to which I need to have recourse is costs. The parties have agreed that Port of Auckland will pay the sum of $90,000 towards the costs of prosecution. Given that this prosecution was (if you like) shared by the then and now former Chief Executive Officer of Port of Auckland, this seems to be an appropriate decision and accordingly I order that Port of Auckland should pay to Maritime New Zealand $90,000 by way of a contribution to the costs of prosecution.

Additional matters

[66] The last thing that I wish to say should have been included at an earlier stage in this judgment, however, there was a lot to say. I accept that Port of Auckland has belatedly undertaken really serious and prolonged steps to rectify all of the problems that led to [victim 1]'s death. They should, of course, have not existed and then he would not be dead today. However, it has gone to great lengths to not only address its shortcomings in that respect but to go beyond and I acknowledge that. That is one of the reasons why I have not imposed a starting point of $900,000 rather than the $850,000 that I did.

[67] In saying that, I acknowledge Maritime New Zealand has submitted that there should not be any particular recognition or discount given for the efforts made by Port of Auckland as to instituting proper safety at work policies and practices given that they are required by law. But as I see it, from everything I read, the defendant has gone beyond what is required statutorily. I appreciate it is important that I say so in this judgment.

[68] In particular I should note that immediately following the accident Port of Auckland reinstated the lash leading hand role that was temporarily suspended under the pandemic plan; it updated its risk register to identify working near cranes as one of the 10 most critical risk across the organisation and to identify key controls relating to risk that materialised in the accident. It implemented a more effective exclusion zone system to protect stevedores around cranes. It is the first port in New Zealand to develop an industry code of practice for stevedoring operations. That is significant to the Court for the simple reason that it indicates that Port of Auckland was not the only

port which may well have been deficient in its health and safety obligations for stevedoring operations.

[69] It has built on the code of practice and worked with Maritime New Zealand on doing so. It has implemented additional lifesaver critical risk training for all senior leaders and the board of directors where they focus on one critical risk per month to ensure a high level of knowledge of each critical risk. They have employed training operations specialists to ensure the standard operating procedures are being correctly performed. They have introduced a dedicated health and safety business partner for the nightshift to perform safety observations. That is particularly important and they have made training of the Port Safe Incident Reporting System for Stevedores mandatory. Last, they have become a member of the National Safety Tripartite Working Group with Maritime New Zealand, industry CEOs and unions.

[70] The very last thing that I wish to say is to acknowledge that not only various meetings (all of which could be said to be mediations of a kind) have taken place, but just very very recently a formal restorative justice conference at the Auckland District Court where [person 2] (who is [victim 1]'s wife) and her mother [person 1] (who read a victim impact statement on behalf of her daughter and on her own behalf today), participated, along with from Port of Auckland Limited, Mr Roger Grey who appears to have been employed since [victim 1]'s death in a very significant and formal role there as a result of which it appears that the health and safety culture, particularly for stevedoring has significantly improved.

[71] It might have been said previously that the culture within Port of Auckland was not particularly good for stevedores as to the risk for them. That appears to have all changed very substantially and Mr Grey appears, from the report that I have read of that restorative justice conference, to have satisfied [victim 1]'s family with the personal commitment that he has made to the importance of safety within the work place and the necessity to fix Port of Auckland's operations at its two wharves, culturally, operationally and in a transformative way. It seems to me that Port of Auckland has gone above and beyond the call of duty by employing Mr Grey to make such important cultural and safety changes and to have him appear at that restorative justice conference on behalf of the Port.

Summary

[72] In summary I have imposed a $561,000 fine on one charge. On the other I have imposed an order for $90,000 costs to be paid towards the costs of prosecution and I have ordered publication of an adverse publicity notice mandatory on the terms that I have mentioned.

[73] It remains only to wish [victim 1]'s family all the very best for the future. I know it is a future that they face without their loved one and I wish that we could bring him back.

[74] To you [person 1] who appears to have become the rock for your family I understand, I think, what a toll this must be taking on you and I hope that some of the grief and the distress which is being experienced may lessen in years to come.

[75] All the details of the reparation package which has been agreed for [victim 1]'s family with Port of Auckland Limited, are permanently supressed and that means that my sentencing notes, whilst a public document, will have those details redacted.

M-E Sharp
District Court Judge

MARITIME NEW ZEALAND v PORT OF AUCKLAND LIMITED
CRI-2021-004-006221

PORT OF AUCKLAND LIMITED	
Charge 1	On or about 30 August 2020, at Auckland, being a PCBU, having a duty to ensure, so far as is reasonably practicable, the health and safety of workers who work for the PCBU, including [redacted] and [redacted], while the workers are at work in the business or undertaking, did fail to comply with that duty, and that failure exposed [redacted] and [redacted] to a risk of death or serious injury, namely to the risk of being struck by objects falling from an operating crane.
	Particulars: It was reasonably practicable for Ports of Auckland Limited to not direct or permit [redacted] and [redacted] to work in close proximity to a crane, while that crane was in operation lifting shipping containers.
Sections:	Health and Safety at Work Act 2015, ss 48(1) and (2)(c), and 36(1)(a)
Maximum penalty:	A fine not exceeding $1.5 million
CRN:	21004501686
Charge 2	Between 31 May 2019 and 31 August 2020, at Auckland, being a PCBU, having a duty to ensure, so far as is reasonably practicable, the health and safety of workers who work for the PCBU, while the workers are at work in the business or undertaking, did fail to comply with that duty, and that failure exposed its workers, namely lashers working at the Fergusson Container Terminal, to a risk of death or serious injury, namely to the risk of being struck by objects falling from operating cranes.
	Particulars: It was reasonably practicable for Ports of Auckland Limited to: 1. provide and maintain a safe system of work by developing and clearly documenting adequate and effective exclusion zones around operating cranes; 2. provide effective training and instruction to workers on working safely around operating cranes; 3. carry out effective supervision, monitoring, and audits to ensure that workers were complying with established safe systems of work and not developing unsafe work cultures; 4. conduct an appropriate risk assessment relating to the removal of the lash leading hand role in response to the COVID-19 pandemic; and/or 5. provide effective training, instruction, and supervision to ship leading hands and crane operators when requiring them to assume the responsibilities of lash leading hands.
Sections:	Health and Safety at Work Act 2015, ss 48(1) and (2)(c), and 36(1)(a)
Maximum penalty:	A fine not exceeding $1.5 million
CRN:	21004501686

SUMMARY OF FACTS

INTRODUCTION

1. The defendant in this case is Ports of Auckland Limited (**POAL**). Anthony Gibson, POAL's chief executive officer (**CEO**) from February 2011 until the end of June 2021, has also been charged in connection with these events.

2. The charges arise out of an investigation by Maritime New Zealand (**Maritime**) into an incident which occurred at around 2.00 am on Sunday 30 August 2020, aboard the container vessel *MV Constantinos P*. The vessel was berthed at POAL's Fergusson Container Terminal. POAL's workers were discharging containers from the *Constantinos* when a stevedore "lasher", [redacted], was crushed and killed by a falling container. One of POAL's cranes was lifting pairs of containers off the *Constantinos* when a third container below the two being targeted by the crane was accidentally lifted as well. The third container detached and fell. It struck Mr [redacted], who was working in the walkway adjacent to the bay of containers being discharged by the operating crane.

3. Maritime's investigation into that incident and POAL's wider health and safety practices in relation to its container vessel stevedoring operations identified offending by POAL against the Health and Safety at Work Act 2015 (**HSWA**).

BACKGROUND

The defendant (and other relevant parties)

POAL's business and key personnel

4. POAL is a limited liability company, incorporated on 27 September 1988.

5. POAL's business is concerned with port operations. It is a port company within the meaning of the Port Companies Act 1988. POAL is involved in a range of services, including passenger services, marine services (for example, pilotage and harbour control), multi-cargo, bunkering, engineering, and container handling (loading and unloading containers from container vessels).

6. The port itself is on Waitemata Harbour and is configured into two main terminals and additional multi-cargo wharves. The Fergusson Container Terminal is POAL's main container handling terminal. It is equipped with cranes capable of loading and unloading containers from container vessels on to the shore. The Bledisloe Multi-Purpose Terminal is also

equipped with some cranes, but is not primarily used for container handling.

7. POAL's container handling business operates seven days a week, 24 hours a day. For stevedoring operations, two shifts were usually run per day, switching at 7 pm and 7 am.

8. The sole shareholder of POAL is the Auckland Council.

The deceased and other victims

9. Mr [redacted] was 31 years old at the time of his death on 30 August 2020. He had been working at POAL since April 2020. He had no prior stevedoring experience and was trained and started on the dayshift as a stevedore lasher. He switched to the nightshift in late July 2020.

10. [redacted] was another stevedore lasher who was working in a pair with Mr [redacted] at the time of the incident.

11. POAL employs many other lashers at the Fergusson Container Terminal, all of whom were affected by the conduct in issue.

MV Constantinos P

12. The *MV Constantinos P* is a container ship built in 2011 which is registered to the Marshall Islands and the port of Majuro.

13. The vessel arrived from Brisbane on 29 August 2020. Its next stop after the Port of Auckland was Lyttelton.

14. The vessel was berthed at the Fergusson Container Terminal on 30 August 2020.

POAL'S OPERATIONS

Container vessel stevedoring operations generally

15. Stevedoring operations can be described by reference to the roles of different workers:

    15.1. **Lashers —** enter the individual walkways between the bays in which containers are kept on the container vessel. The containers are secured to the deck of the vessel and to each other by metal bars, which are tightened and secured by screws. Containers are also secured to each other by securing mechanisms (sometimes referred to as "cones" or "twist locks"). The screws and metals bars need to be unscrewed, then the securing mechanisms need to be unlocked before containers may be discharged. This is normally done by the lashers, who likewise connect and secure the screws, metal bars, and securing mechanisms when containers are loaded on the vessel. These

processes are referred to as “unlashing” and “lashing” (respectively). Lashers are also involved on the wharf-side container handling operations. Once a container is unloaded from the ship it is usually deposited onto a lashing platform on the wharf-side, where lashers are tasked with detaching or attaching locks or cones to the bottom of each of the containers. Before the COVID-19 Pandemic Plan (see below), lashers were supervised by the lash leading hand (when the vessel was being worked by multiple cranes and there were multiple pairs of lashers on board, on lash platforms and on breaks).

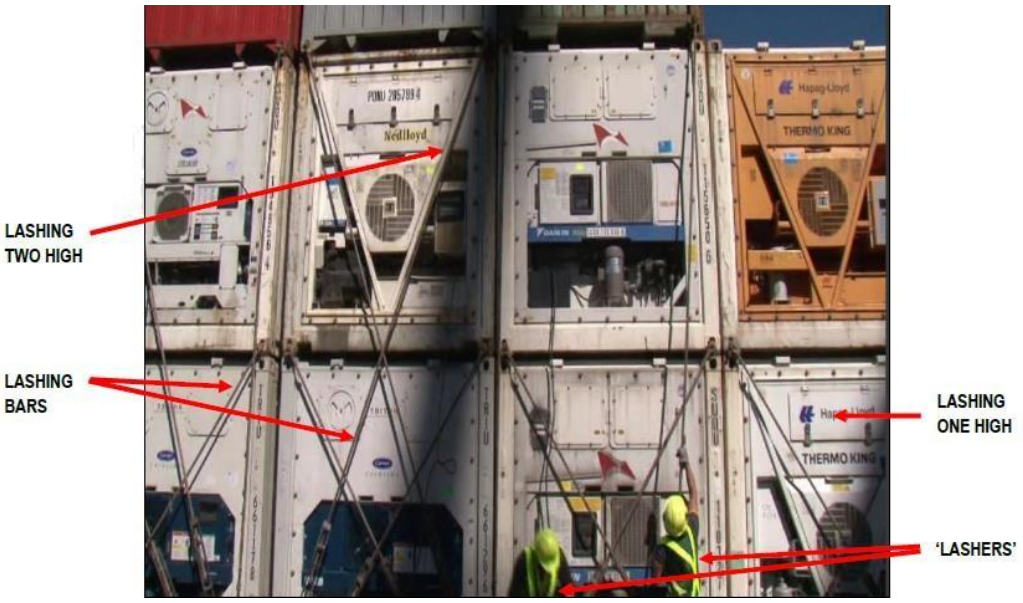

Figure 1: Lashing containers one (container) high and two (containers) high

Figure 2: lashers working in pairs showing the components of the lash

15.2. **Lash leading hand or the "lashman"** — prior to the implementation of the Pandemic Plan lashers on the vessel were supervised by a lash leading hand, who directed the lashers around the vessel and to their points of work. The lash leading hand could be responsible for up to 24 lashers over four different cranes. The lash leading hand communicated the lashers' position to the ship leading hand using a radio. (Individual lashers do not have radio communication while working on the vessel.) The lashers directly reported to the lash leading hand. At the time of the incident in August 2020, following the implementation of the Pandemic Plan, the lash leading hand role had been discontinued and its role and responsibilities were added to the duties performed by the ship leading hand (see below).

15.3. **Crane operators** — manoeuvre the crane to pick up and drop the containers to and from the vessel, the lashing platform and the wharf.[1] Crane operators sit in a cabin from where they have visibility of the spreader. Crane operators do not have good visibility of the walkways between the bays of containers on the container vessel, as those walkways may be narrow and dark. The crane operator is also focussed on discharging or loading containers accurately rather than looking at the walkways for the presence of lashers. This is another reason why crane operators rely on the ship leading hand to be their "eyes and ears".

[1] The crucial part of the crane which actually grabs onto the container is called the spreader. The spreader is attached to the crane, and when in operation locked to the top of either one 40 foot container or two 20 foot containers at once (called a "twin lift").

Figure 3: an example of a view looking from crane cab (not incident site)

15.4. **Ship leading hand or "foreman"** — acts as "the eyes and ears of the crane operators" and has radio communication with the crane operator and (prior to the implementation of the Pandemic Plan—see below) the lash leading hand. The ship leading hand informs the crane operator about their points of work and where to manoeuvre to load and unload containers. The ship leading hand is required from time-to-time to enter "personnel cages" — a 20 foot container sized work platform attached to the crane spreader, which are used to transport people and sometimes equipment between high and low work situations— both as part of routine duties and to troubleshoot issues which cannot be readily accessed from the deck of the vessel. Most crane operators are also trained in the role of ship leading hand and would from time-to-time be allocated to the role of ship leading hand. At all times (including during the Pandemic Plan) the ship leading hand is in control of the crane operations and associated work area. They have the ability to stop operations at any time, for any reason.

15.5. **Straddle drivers** — once the locks or cones have been removed from the containers at the lashing platform, the containers are deposited on to the wharf in marked rows where they are picked up by straddle cranes operated by straddle drivers and driven away to their next destination.

16. The following two roles are involved in a supervisorial capacity in container handling stevedoring operations:

16.1. **Ship supervisor** — primarily works from an office, but will visit the worksite approximately twice during a 12 hour shift. The supervisor is tasked with carrying out an inspection of the vessel when it first comes in. This would mean that they spent several hours at the worksite prior to returning to their office. They are also tasked with dealing with incident reporting by other stevedores.

16.2. **Shift operations manager** — works from an office with the ship supervisor but is usually a more senior role responsible for vessel and terminal obligations (including employees), and to a lesser degree dealing with rostering and administration of stevedoring labour. A shift operations manager works primarily in the office, but also visits the worksite. The shift operations manager reports to the senior shift operations manager and the stevedoring manager.

Risk registers

17. POAL kept risk registers, one of which was a high level document for senior management, used for identifying critical risks and controls for those risks.

18. At the time of Mr [redacted]'s death, the critical risk register acknowledged the risk that containers could fall and strike lashers while being loaded or discharged by operating cranes. It recognised that additional containers sitting below any container being targeted by an operating crane could inadvertently be picked up.

19. The critical risk register lists "exclusion zones" as an existing control for these risks.

20. There was no prioritisation of risks within this critical risk register, and no prioritisation of critical controls. That is, the critical risk register did not clearly differentiate hazards which would expose workers to the risk of serious injury or death from other risks to health and safety, and did not highlight the most important controls to respond to those risks and did not highlight those controls which could become a part of the critical risk management system.

21. POAL's other risk registers did not address the risk of falling containers.

Lashing standard operating procedures

Documented policies and procedures

22. At the time Mr [redacted] was employed lashers were trained for two weeks. There is a theoretical and practical component. They are then assessed in accordance with a lash assessment guide. On passing the assessment, lashers can begin work, but must wear a white hat for their first

160 hours. This identifies them to other stevedores as someone freshly trained. They are then given a green hat.

23. While working, white hats are always paired with a green hat. Both Mr [redacted] and Mr [redacted] had green hats.

24. Even when fully trained "green hats", lashers were required to work in pairs.

25. The standard operating procedures for lashers were documented in the training manuals and assessment guides for lashers. There was no stand-alone document.

26. POAL had a "three container width" rule or exclusion zone, providing that lashers were not to work within three container-widths of an operating crane: When interviewed, all of the lashers knew of this rule. The rule was also documented in places:

    26.1. The Lash Assessment Manual, in respect of the standards to be met while unlashing, requires lashers, the lash leading hand and the ship leading hand to "maintain a 3 container width gap from crane spreader".

    26.2. The *Lash Leading Hand Training Manual* (July 2020) recorded at one point that "lashers are not to work within 3 container widths of a working crane".

    26.3. The *Ship Leading Hand Training Manual* (August 2018) similarly had a reference to the rule.

27. None of these manuals, however, contained any diagrams, details or other exposition about the rule and how it was to be applied. The manuals did not record the rule in sections on safety rules. In addition:

    27.1. The *Standard Operating Procedures, Ship Leading Hand* (May 2019) manual did not set out any policy that stevedores are to be three container widths away from any container being operated on by a crane. Instead, it said that lashers should be instructed to "keep a safe distance".

    27.2. No other training manuals, including the *Lash Training Manual* (August 2018), recorded a policy of lashers working three container widths away from a container being operated on by the crane.

    27.3. None of the assessment guides for any of the container-handling stevedoring positions contained any assessment requirement regarding the three container width rule or

any other form of exclusion zone rule for working in proximity to cranes operating on containers.[2]

28. The documented procedures, training manuals, and assessment guides did not define how the three container width policy was to be applied. Where individual lashers tried to apply the rule, they were required to make unaided visual assessments about whether they were three container widths away from an operating crane.

Compliance with policies and procedures

29. As at 30 August 2020, it was common on the nightshift for lashers to carry out their tasks by themselves (not in pairs) and/or while in closer proximity than three container widths away from an operating crane.

30. One possible reason for this was that stevedores were paid for a full nightshift even if they completed work early (known as "cop jobs"). This provided an incentive for workers to increase productivity without incorporating parameters that promoted health and safety compliant lashing behaviours such as working in pairs and at an appropriate distance away from operating cranes.

31. Until the start of August 2020 (prior to the incident), POAL also paid certain workers (including lashers) a bonus for achieving a certain volume of work. This was theoretically tied (in part) to their compliance with health and safety obligations. However, in practice the bonus was often paid even where health and safety issues had been flagged.

32. There was better compliance with the three container width policy during the dayshift.

33. This lack of compliance with the requirement to work in pairs and no closer than 3 container widths on the nightshift was common knowledge among the lashers interviewed by Maritime. When interviewed, a ship leading hand also said that he had seen lashers not working in pairs previously.

34. CCTV cameras were also operating on the worksite, which supervisorial staff (such as the ship supervisor and shift operations manager) could review at any time.

Observations, monitoring, and inspection of container vessel stevedoring operations

35. Operational performance coaches (**OPCs**) were employed by POAL and tasked with inducting all employees, taking them through the necessary trainings, overseeing assessments,

[2] Except the *Lash Assessor Guide (May 2018),* which refers to a three container width gap from the crane spreader—but only in relation to lashing containers three high.

supervising tasks on a day-to-day basis, and identifying corrective upskilling following reported incidents.

36. The OPCs were the main means of observing, monitoring, and inspecting container vessel stevedoring operations to ensure compliance by stevedores with POAL's documented standard operating procedures. However, OPCs mostly worked standard business hours: Monday to Friday, from 7.00 am to 3.00 pm, despite POAL carrying out its container handling stevedoring operations seven days a week, 24 hours a day.

37. Stevedores generally worked either day- or night-shift. Those who worked nightshift had less contact with, observations or monitoring by OPCs to ensure compliance with standard operating procedures. By way of example, while 11 OPC observations were carried out overnight shift in July 2020, 22 were carried out over day-shift. The OPC inspections did not take place after 10:30 pm or before 5:00 am.

Reporting and responding to incidents and health and safety auditing

38. POAL's main system of incident reporting from October 2015 to 30 August 2020 was software called CMO, also known as the "Portsafe" system.

39. Once incidents were logged on PortSafe, they could be viewed by supervisorial and management staff. The action points for responding to incidents could be followed up and tracked.

40. Stevedores working as lashers, lash leading hands, ship leading hands, and crane operators were not trained on how to use PortSafe. Instead, they were expected to report incidents and near misses on paper forms which they would give to supervisory staff. Those staff would then enter the information onto PortSafe.

41. The training manuals and assessment guides for most roles did not contain any standards or policies relating to reporting accidents, near misses and hazards. However, the *Lash Training Manual* (August 2018) said that all such incidents were to be reported and recorded using paper or electronic forms, and gave the location where the paper forms were kept. The *Lasher Assessment Guide* contained a question asking why it was important for incidents to be reported.

42. POAL had been advised that its reporting systems were not working well. POAL contracted the consultancy firm KPMG to carry out internal audits. The most recent (prior to the incident) was delivered August 2018. KPMG's report identified that the rate of near miss reporting was low, and that there was inconsistency in how hazard reporting and incident reporting functioned in

practice. The report also recorded that corrective actions logged onto PortSafe were not being actioned properly.

43. This was not a new issue. A previous report from 2016 had warned of inadequate monitoring of health and safety performance. The 2016 report flagged inadequate reporting as a "high risk" factor. The 2018 report noted some improvement, but still identified this as a "medium risk".

The COVID-19 Pandemic Plan

44. The onset of the COVID-19 global pandemic and the New Zealand government's response (imposing controls to reduce social movement and interaction, with the aim of reducing spread) led to POAL implementing a "Container Terminal Operations Stevedoring Pandemic Plan" (the **Pandemic Plan**) on 19 March 2020.

45. The Pandemic Plan had the effect of forming 13 single crane container handling stevedoring crews—each crew was composed of six lashers, six straddle car drivers, two crane operators and one ship leading hand. The crew was expected to work as a "bubble", with no interactions with other crews to prevent the transmission of COVID-19.

46. Under the Pandemic Plan, the independent role of lash leading hand was removed and the duties that were formerly carried out by the lash leading hand were added to the duties of the ship leading hand. This meant that the ship leading hand became responsible for both directing the lashers to their points of work on the vessels, and also directing the cranes to their points of work. As well, most crane operators were expected to rotate into the ship leading hand role during shifts. Most crane operators were also trained in the role of ship leading hand. This meant that they would fulfil the functions of both the ship and (now removed) the lash leading hand.

47. POAL did not, however, provide any specific training or instructions (refresher or otherwise) to ship leading hands or crane operators before requiring them to undertake the additional responsibilities of a lash leading hand.

48. Neither was there any update or formal review of the standard operating procedures, or any revisions to the training manuals or the assessment guides for the new ship leading hand role.

49. The implementation of the Pandemic Plan resulted in a further reduction in the observation, monitoring and inspecting by OPCs of stevedores involved in container handling operations. The OPCs were not able to carry out their normal duties without infringing on work "bubbles" during the first lockdown in March/April 2020. OPCs returned to work in May 2020 operating

as their own bubble, and wearing PPE and maintaining distance from other bubbles as a COVID-19 control.

THE INCIDENT ON 30 AUGUST 2020

50. On 30 August 2020, Mr [redacted] was working the nightshift as a lasher at the Fergusson Container Terminal. His lashing pair partner for the night was lasher Mr [redacted]. Also working was a ship leading hand, and two crane operators. Two other lashers were also working that shift.

51. The crew was discharging containers from the *Constantinos P*.

52. The ship leading hand had received training to be a ship leading hand in 2018. He was never trained to perform the role of lash leading hand. He had started stevedoring at POAL in 2010 as a lasher and had been trained at that time on lashing. He had been away for three weeks during the period in which POAL implemented the Pandemic Plan. On arrival back at work, he was instructed to perform both the ship and lash leading hand roles. He did not receive training to support this.

53. The crane operator at the time of the incident also did not receive any updated training on performing the role of ship leading hand with the additional lash leading hand duties for the implementation of the Pandemic Plan.

54. Messrs [redacted] and [redacted] started their shift at around 7.00 pm. They worked in one hour rotations: one hour on the lashing platform, one hour lashing on the vessel, then a break. At 2.00 am, they began their third rotation for the night of lashing on the vessel. The other two lashers were starting their rotation on the lashing platform.[3]

55. Before going onto the vessel Messrs [redacted] and [redacted] approached the ship leading hand to direct them to their point of work. The ship leading hand either directed or permitted them to go into the walkway between bays 5—7 and 9—11 to lash up the containers in bay 7 which had been mistakenly unlashed by the dayshift.

[3] The crane involved in this incident was called "CRI". An inspection of the CRI crane involved in the incident was conducted by Plant & Building Safety Limited. The report of that inspection concluded that the crane was operating correctly and there was no indication of malfunctioning at the time of the incident. The crane had been properly maintained, inspected, and certified for use.

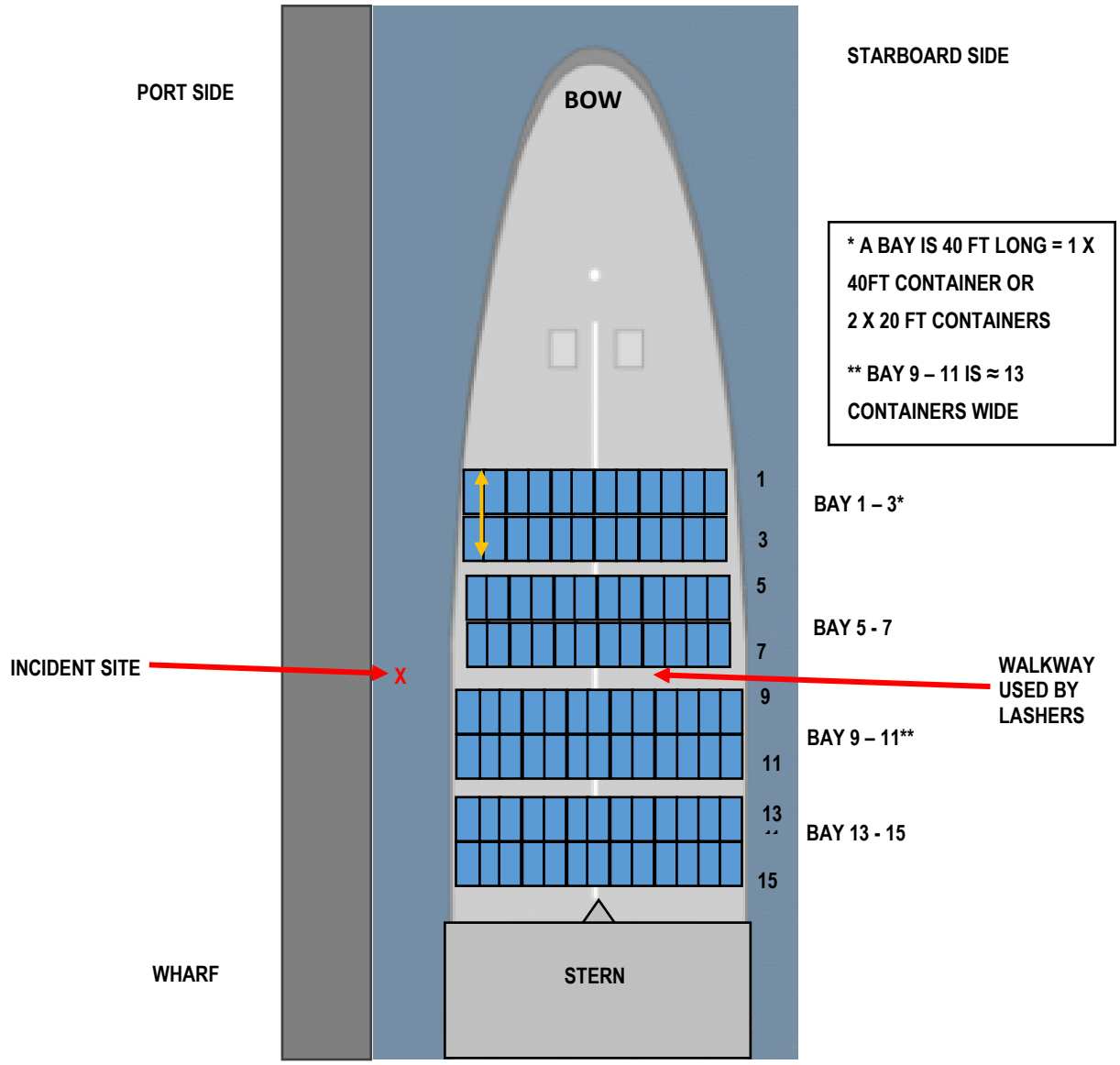

Figure 4: location of the incident and adjacent bays

56. At the same time, the crane operator was working on bay 9—11. The ship leading hand knew this. The ship leading hand knew about POAL's policy that lashers should not be within three container widths of an operating crane. However, the policy did not prohibit lashers from working in a bay adjacent to an operating crane. As a result, the ship leading hand did not ensure that Messrs [redacted] and [redacted] were not working adjacent to the crane.

57. While in the walkway between bays 5—7 and 9—11, Messrs [redacted] and [redacted] worked from opposite ends, lashing the containers that were in bay 7.

58. Although required to carry out their task of lashing each and every container in pairs, Messrs [redacted] and [redacted] were working in separate parts of the bay – thereby effectively carrying out their tasks alone but in the same bay on the vessel.

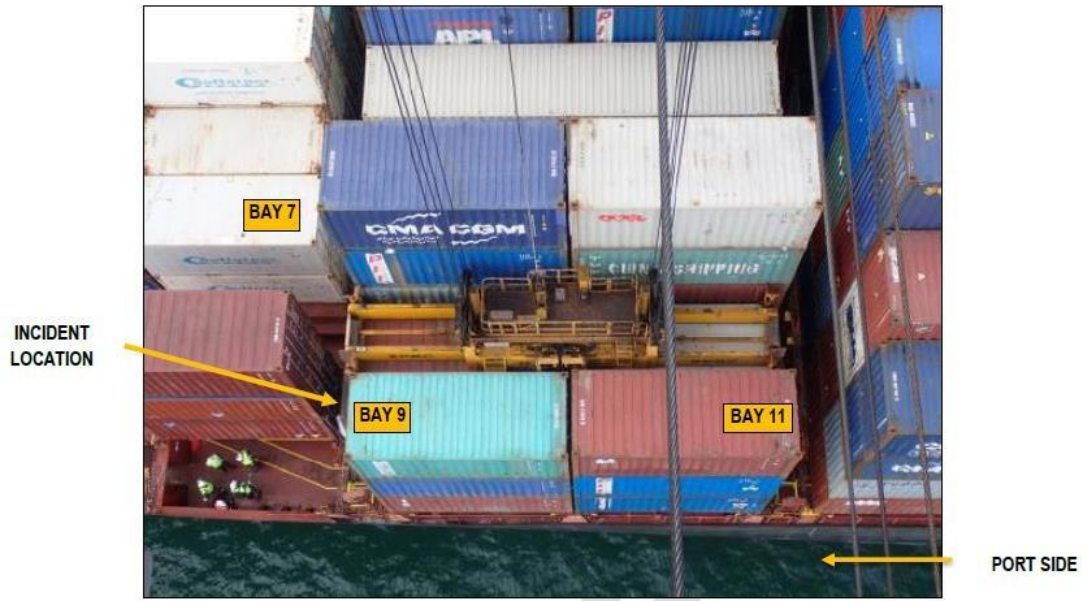

Figure 5: incident scene from above

59. The crane was operating behind them. The crane operator did not know that the lashers were in the walkway adjacent to where he was operating the crane, and was not able to see them on the crane cameras.

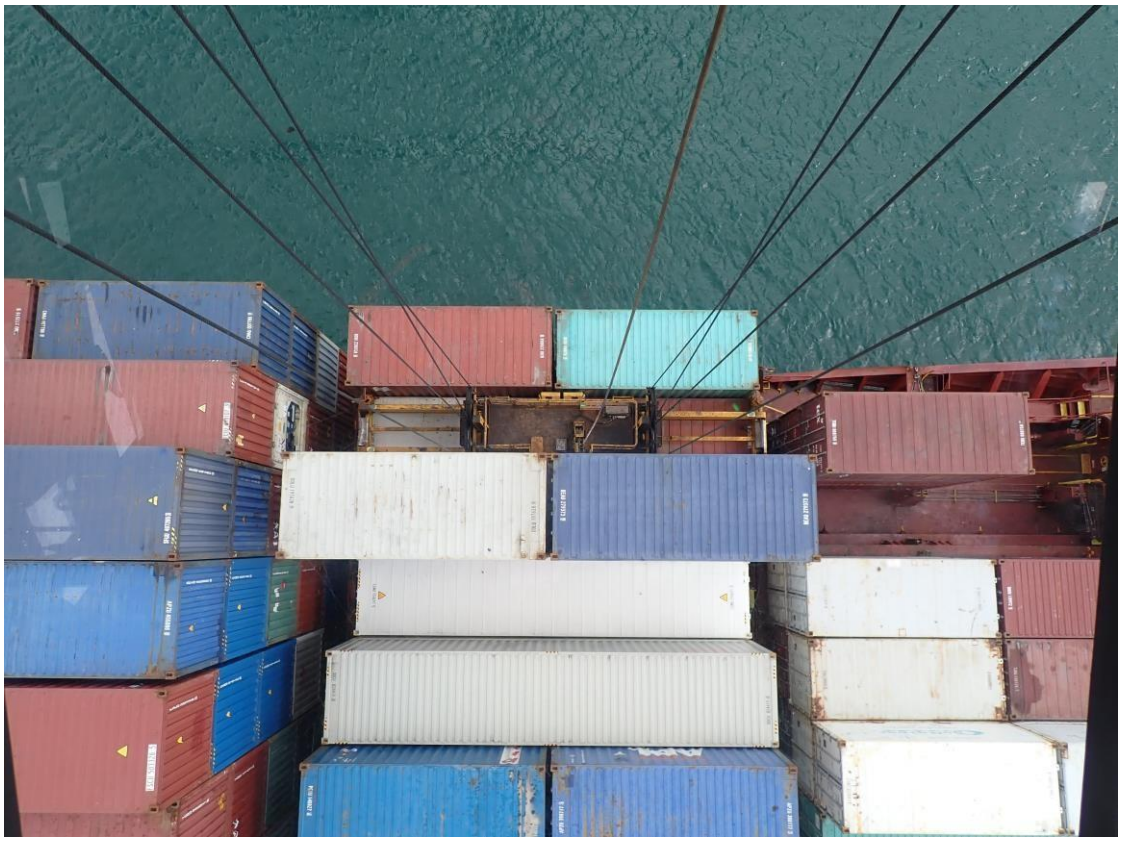

Figure 6: the view from the crane operator cabin

60. The crane operator conducted a twin-lift of the two containers in the penultimate row of containers on the seaward side of bay 9—11. The containers being lifted were in the second layer up from the platform of the walkway on which Messrs [redacted] and [redacted] were standing.

61. Unbeknownst to the crane operator, one of the containers he was lifting remained partially connected to the container below it. This third container was also lifted.

62. The containers remained connected because one of the twist-locks was not opened prior to the lift commencing. It is not uncommon for twist-locks to fail to properly open. This can be caused by equipment failure (a result of corrosion or wear), human error (a lasher missing this particular twist-lock as they moved through unlocking containers), or the twist-lock simply becoming jammed by the weight of containers moving around at sea.

63. The crane operator realised that something was wrong. However, before he could take corrective action, the bottom container that had been partially connected fell, moving downwards and laterally towards Mr [redacted] who was lashing a container in bay 7. The container crushed and killed Mr [redacted].

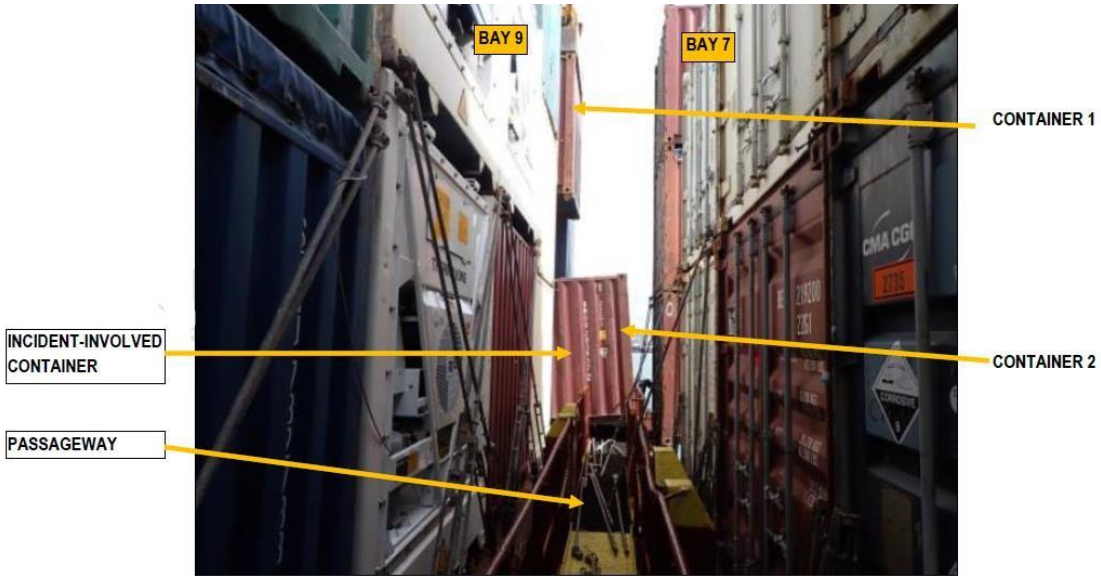

Figure 7: incident site at walkway level

64. Maritime was notified of Mr [redacted]'s death by POAL and commenced its investigation.

FAILURES TO COMPLY WITH HEALTH AND SAFETY DUTIES

65. The HSWA imposes a number of duties relating to health and safety at work. The relevant duties are outlined below.

66. POAL failed to comply with its duties, as set out below.

POAL's failures

67. As at 1 June 2019, and until 30 August 2020 (inclusive), POAL was a person undertaking a business or undertaking (**PCBU**) as defined by s 17 of the HSWA.

The primary duty of care

68. Pursuant to s 36(1) of HSWA, POAL had a duty to ensure, so far as was reasonably practicable, the health and safety of workers who work for the PCBU, while the workers were at work in the business or undertaking.

69. This was a duty that POAL owed to all the lashers working at the Fergusson Container Terminal including Messrs [redacted] and [redacted].

Relevant regulations

70. Section 35 of HSWA provides that duties under other enactments inform duties under HSWA.

71. Regulation 24 of the Health and safety at Work (General Risk and Workplace Management) Regulations 2016 (**HSWA Regulations**) imposes a mandatory duty on PCBUs to manage, in accordance with regulations 5—8, risks to health and safety associated with work being done under any object that has been raised or lifted by any means. If it is not reasonably practicable to eliminate the said risk, the PCBU must minimise the risk by, so far as is reasonably practicable, providing supports or other devices to be placed or used under the raised object so that the object cannot fall or be lowered while a worker or other person is under it.

72. Regulation 25 of the HSWA Regulations imposes a mandatory duty on PCBUs to manage, in accordance with regulations 5—8, risks to health and safety associated with a falling object if the object is reasonably likely to fall on and injure a person. If it is not reasonably practicable to eliminate the said risk, the PCBU must minimise the risk by providing and maintaining a safe system of work that includes:

    72.1. measures for preventing an object from falling freely, so far as is reasonably practicable; or

    72.2. if it is not reasonably practicable to prevent the object from falling freely, a system to arrest the fall; or

    72.3. if it is not reasonably practicable to either prevent an object from falling freely or provide a system to arrest its fall, by providing an exclusion zone that persons are prohibited from entering.

73. Regulation 5 imposes a duty on PCBUs to identify hazards that could give rise to reasonably foreseeable risks to health and safety.

74. Regulation 6 applies if it is not reasonably practicable for a PCBU to eliminate risks to health and safety in accordance with s 30(1)(a) of the Act. In such circumstances, PCBUs must implement control measures in accordance with the regulation to minimise risks to health and safety. It provides a hierarchy of control measures which includes substituting wholly or partly the hazard giving rise to the risk with something that gives rise to a lesser risk; isolating the hazard giving rise to the risk to prevent any person coming into contact with it; and implementing engineering controls. If the risk remains after that, the PCBU must minimise the remaining risk, so far as is reasonably practicable, by implementing administrative controls. If, even after that, the risk remains then the PCBU must minimise the remaining risk by ensuring the provision and use of suitable personal protective equipment (**PPE**).

75. Regulation 7 imposes a duty on PCBUs to ensure that any control measure to eliminate or minimise risks to health and safety is effective and is maintained so it remains effective, including by ensuring that the control measure is and continues to be fit for purpose, suitable for the nature and duration of the work, and is installed, set up, and used correctly.

76. Regulation 8 imposes on PCBUs a duty to review and revise control measures implemented under regulations so as to maintain so far as is reasonably practicable a work environment that is without risks to health and safety. It provides a list of non-exhaustive circumstances in which reviews and revisions must take place.

POAL's failures on 30 August 2020

77. On 30 August 2020, POAL directed or permitted Messrs [redacted] and [redacted] to work in close proximity to a crane, while that crane was in operation lifting shipping containers.

78. It was reasonably practicable for POAL not to do so. By taking this course, POAL failed in its duty to ensure, so far as reasonably practicable, the health and safety of Messrs [redacted] and [redacted].

POAL's systemic failures

79. In the period leading up to 30 August 2020, and specifically in the period between 1 June 2019 and 30 August 2020 (inclusive), POAL failed to comply with its duty to ensure, so far as was reasonably practicable, the health and safety of lashers working at the Fergusson Container Terminal.

80. Specifically, POAL failed to carry out the following reasonably practicable actions:

80.1. **POAL failed to provide and maintain a safe system of work by developing and clearly documenting adequate and effective exclusion zones around operating cranes:**

(a) POAL identified critical risks (that is, those that create a risk of death or serious harm) in some of its health and safety documentation but failed to consistently identify, implement and verify critical controls that responded to those critical risks.

(b) The "three container-width" rule was inadequate to protect workers, due to it not being readily auditable, clearly communicable, readily supervised and enforced, and being able to be readily compromised when work pressures compete with health and safety outcomes. Thus it had the effect of bringing persons in close proximity to operating cranes. It was also ineffective because it relied on unaided visual assessments. POAL should have developed an adequate and effective exclusion zone system — for example, by closing off walkways adjacent to operating cranes using physical barriers.

(c) POAL should have clearly documented its exclusion zone policy and procedure. Existing documentation did not always identify exclusion zones as important; where exclusion zones were mentioned, they were not highlighted as important.

(d) POAL should have regularly reviewed the documentation using an agreed-upon process relating to exclusion zones, to ensure that their policies and procedures established sufficient safeguards for restricting access by workers to areas where they would be at risk from falling objects and to ensure that the documentation remained cogent and useful to workers. The reviews of documentation for critical tasks should have involved people experienced in the roles under review and subject-matter experts meeting at agreed-upon frequencies (for example, annually).

(e) POAL should have revised and updated the documentation as necessary to reflect changing work practices and changing levels of risk.

80.2. **POAL failed to provide effective training and instruction to workers on working safely around operating cranes:**

(a) POAL should have specifically trained lashers in relation to the risk of working under suspended objects and the importance of exclusion zones.

(b) POAL should have verified that lashers understood the existing policies and procedures relating to exclusion zones, or the need for them, as part of its in-house training assessments.

80.3. **POAL failed to carry out effective supervision, monitoring, and audits to ensure that workers were complying with established safe systems of work and not developing unsafe work cultures:**

(a) POAL should have implemented an appropriate program of supervision and engagement, on both day- and night-shifts, and both weekday- and weekend-shifts, to ensure that lashers were working in compliance with effective exclusion zones around operating cranes.

(b) POAL should have implemented an appropriate program of both informal and structured observations, on both day- and night-shifts, and both weekday- and weekend-shifts, to monitor that lashers were working in compliance with effective exclusion zones around operating cranes.

(c) POAL failed to implement an internal and external audit system with respect to lashing which explored to a level of detail as to what was occurring and what was not occurring in the lashing task. For example, POAL should have ensured that (any) external auditors were explicitly directed to evaluate compliance with exclusion zones around operating cranes when considering critical health and safety risks.

80.4. **POAL failed to conduct an appropriate risk assessment relating to the removal of the lash leading hand role in response to the COVID-19 pandemic:**

(a) POAL should have implemented a structured and risk-based change management process associated with the introduction of the COVID-19 Pandemic Plan, including with a focus on the removal of the separate lash leading hand role in container vessel stevedoring operations.

(b) As a result, POAL did not weigh alternatives to the removal of the role or take appropriate steps to manage change in such a way that identified risks were eliminated or minimised.

80.5. **POAL failed to provide effective training, instruction, and supervision to ship leading hands and crane operators when requiring them to assume the responsibilities of lash leading hands:**

(a) POAL should have developed appropriate documentation for ship leading hands (and crane operators who would act as ship leading hands) about the changes to their requirements and responsibilities, specifically with regard to assuming the responsibilities of lash leading hand as a part of the Pandemic Plan;

(b) POAL should have ensured that ship leading hands understood their new responsibilities before undertaking work in accordance with the Pandemic Plan;

(c) POAL should have ensured appropriate supervision of ship leading hands and crane operators to ensure that they were competently carrying out the role of lash leading hands.

Exposure to a risk of death or serious injury

81. POAL's failures, both those that were systemic and those on 30 August 2020, exposed stevedores at the Fergusson Container Terminal to a risk of death or serious injury. Specifically, stevedores were exposed to the risk that they would be struck by objects falling from an operating crane.

82. Mr [redacted]s death on 30 August 2020 was a manifestation of that risk, and was caused or contributed to by POAL's failures.

STEPS TAKEN SUBSEQUENT TO 30 AUGUST 2020

83. POAL has now also updated its risk register to propose additional controls relating addressing the risks which materialised in the incident of 30 August 2020.

84. For example, POAL has implemented a much more effective exclusion zone system to protect stevedores working around operating cranes:

84.1. The exclusion zone is now larger—it prohibits lashers and other stevedores from entering into walkways which are directly adjacent to a bay being loaded or unloaded by an operating crane.

84.2. This exclusion zone policy is more appropriately and effectively communicated. The policy now has its own documents which describes in more careful detail what an

exclusion zone is and describes, using diagrams, what the risks are in an operational area.

84.3. Access was initially restricted through the use of road cones, but now there is a policy of the ship leading hand putting up signage at relevant entry points (and detailed rules concerning the procedure for the placement and removal of such signage).

84.4. There is a staggered process for operations so that the crane operator is, in effect, stood down while lashing activities occur in what would be the exclusion zone.

84.5. There is more oversight required of the ship supervisor regarding the exclusion zone.