IN THE DISTRICT COURT
AT TOKOROA

I TE KŌTI-Ā-ROHE
KI TOKOROA

CRI-2020-077-000059
[2022] NZDC 2033

WORKSAFE NEW ZEALAND
Prosecutor

v

METALLIC SWEEPING (1998) LIMITED
Defendant Company

Hearing:	4 February 2022
Appearances:	T Braden for the Prosecutor C Shannon for the Defendant
Judgment:	4 February 2022

NOTES OF JUDGE G C HOLLISTER-JONES ON SENTENCING

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[1] Metallic Sweeping has pled guilty to one charge under ss 36(1)(a), 48(1) and 48(2)(c) of the Health and Safety at Work Act 2015 that at on or about 5 January 2019, having a duty so far as reasonably practicable to ensure the health and safety of workers, including Matthew Papara, failed to comply with that duty arising and that failure exposed an individual to a crushing hazard created by a Hiab loader crane to lift a recycling cage.

[2] Metallic Sweeping accepts that it was reasonably practicable for it to ensure that the Hiab loader crane was maintained in a safe condition and that it failed to do so.

[3] Metallic Sweeping is in the business of collection, processing and disposal of refuse and recycling. As at January 2019, it had 101 workers. Matthew Papara was one of those workers. He started working for the defendant company on 24 July 2018 and he was seriously injured at work on 5 January 2019.

[4] Mr Papara suffered serious injury as a result of what occurred on 5 January 2019. Mr Papara died at home on 4 July 2020. His passing has been deeply felt by his whānau who are here today, and I have heard a victim impact statement from them.

[5] The Court approaches this sentencing on the basis of a summary of facts filed. The summary of facts contains a statement that Matthew Papara's death was not related to the incident that the Court is concerned with. I understand that the whānau have difficulty accepting that statement, but the Court will proceed on the basis that that is the correct position. So, whānau, you will have to excuse me proceeding on the basis that your partner and father did not die directly as a result of what occurred. In saying that, I will not be devaluing the impact of that accident on him.

[6] The essential facts of this are that a Hiab crane was mounted on the back of a Nissan truck. The Hiab was set up on the truck in October 2016. An independent engineering firm undertook that setup for Metallic Sweeping. The crane was used by Metallic Sweeping to lift and rotate recycling cages at the recycling centres it serviced. A recycling cage, empty, weighs 250 kilograms which is a significant weight.

[7] On 5 January, Mr Papara was working with a driver and they started work at about 6 o'clock that morning. At 10.00 am, Mr Papara and the driver arrived at the Tirau recycling depot. The driver lifted an empty cage off the truck with the Hiab and placed it on the grass next to the recycling centre. One of the issues with the recycling centre was that on two sides, it had a 2.5 metre high fence. This meant that on occasions, the crane was lifting a recycling cage over that 2.5 metre fence.

[8] After lifting the empty cage off the truck, the driver then lifted a full cage of cardboard out of the recycling area and placed it onto the truck. That was done with the crane. The driver's next step was to lift an empty cage into position where the full cage had previously been. This involved raising the empty cage over the 2.5 metre

high fence. During this lift, the hook on the Hiab detached from the crane and the cage fell.

[9] Mr Papara was standing nearby and this cage went through the air and he was not able to get out of its path. It hit him in the head and shoulder, knocking him off his feet and trapping him beneath it. Fortunately, there was a full nylon bag of glass bottles that took some of the weight. Mr Papara was pinned underneath this cage with his legs folded underneath him and that would have been both painful and frightening. The driver managed to lift the cage sufficiently for Mr Papara to get out from underneath it and he was driven to Tokoroa Hospital.

[10] Mr Papara was diagnosed as having multiple compression and stress fractures to his cervical and thoracic vertebrae. That is the key parts of his back and lower neck. He also suffered damage to the ligaments of both knees and deep bruising to his legs, head and body. He also had a fractured left ankle and a fractured rib. Mr Papara was in hospital for three weeks and on discharge from hospital, he had an Aspen collar which is a rigid collar around the neck. He was on bedrest for some weeks and his left ankle required surgery to fit a plate and pins to repair the fracture and bone fragments had to be removed. His knees also required ongoing medical attention. It is clear that the effects of the injuries were ongoing and significant for some time.

[11] Metallic Sweeping notified WorkSafe of the accident in a timely way but did not fully inform WorkSafe of the extent of Mr Papara's injuries. It was not until 16 January, which was 11 days later, that WorkSafe learnt that the injuries to Mr Papara were more serious. After learning that, WorkSafe commenced an investigation.

[12] One of the difficulties with this investigation was that 11 days had passed, and this hampered the ability of WorkSafe to fully understand what occurred. What WorkSafe did find out was that the Hiab was operating without a current LT400 Certificate of Inspection and that the hook did not have a safety catch on it. Cranes such as the one on the Hiab are required to have a current LT400 Certificate of Inspection. The engineering firm that set the Hiab up on the Nissan truck did not provide a LT400 certificate which is what they should have done. Had that

certification occurred, it would have been loaded into the New Zealand Transport Agency system and an updated certificate would have been required for the annual certificate of inspection of the truck. It is accepted that the lack of a LT400 certificate did not cause the accident. It is also accepted that the lack of a safety catch on the crane did not cause the accident. This is because the reason for the cage coming off was not that the cage slipped off the hook but because the hook itself disconnected from the crane.

[13] I have been provided with a photograph of the hook that was found by WorkSafe and a photograph of a new hook. What is missing from the one that was found was a thrust washer and a securing catch which would normally be screwed against the thrust washer to ensure that the hook remained in place. There were other issues with the Hiab that were subsequently picked up, but they were not causative of what occurred.

[14] Metallic Sweeping had a monthly checklist for the Hiab which included a check for all securing hardware - cotter pins, snap rings, hairpins and pin keepers. There was no specific reference to the hook on the monthly checklist. Furthermore, the monthly checklist was not in accordance with the manufacturer's manual for the Hiab. This meant that the monthly check did not examine all the components of the hook in sufficient detail. The defendant's drivers and operators of the Hiab were supposed to check the hook prior to use, although that did not pick up the lack of safety catch, and I shall come to that. Following the accident, the truck and Hiab underwent repair and it has since been made compliant with the LT400 specifications and a replacement swivel latch lock hook has been placed on the crane.

[15] The defendant company obtained a report from an expert who is a chartered professional engineer and his opinion was that whatever the cause of the hook falling off the Hiab, the defendant company's maintenance procedures did not pick up the issue and it is uncertain what, if anything, would have been apparent on further visual inspections. What is clear is that the hook failed and as a result, the cage fell on Mr Papara who suffered serious injury.

[16] Metallic Sweeping has been in business for at least 20 years and has no adverse history with WorkSafe.

[17] Following the entry of guilty plea, a restorative justice meeting was held. Mr Peters, the managing director of Metallic Sweeping, attended and there were a number of whānau members present at that meeting, including Ms Ngatai, Mr Papara's partner and Tristian and Regan who have been present at today's hearing.

[18] Mr Peters, on behalf of Metallic Sweeping, apologised and accepted responsibility for what occurred. He told the meeting that the company had provided Mr Papara with top-up over and above his ACC entitlements and had also made additional payments, including $2,000 towards funeral expenses.

[19] The whānau spoke about the impact of what had occurred, and they also relayed their disappointment with the offer of $52,000 in emotional harm compensation from Metallic Sweeping. The whānau were anticipating a sum in the region of $800,000. The reason for that was so that a home could be purchased for the current whānau and future mokopuna. Because of the disappointment over the offer, the meeting concluded.

[20] I have heard from the whānau today and whilst they would have preferred and felt that they should have had a lot more money, they have accepted the payment of $52,000 and provided their bank account details to Metallic Sweeping. I am informed that a payment of $52,000 will be made to this bank account within 14 days of today and the sentencing is proceeding on that basis.

[21] I have received extensive written submissions from counsel for WorkSafe and counsel for Metallic Sweeping. I will briefly summarise the two competing positions.

[22] Ms Braden, on behalf of WorkSafe, deals first with the issue of reparation which is routinely one of the first steps in a sentencing of this nature. Pursuant to the Sentencing Act 2002,[1] the Court may impose a sentence of reparation if a person has suffered emotional harm. The person who suffers the emotional harm must fall within

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1 Sentencing Act 2002, s 32(1)(b).

the definition of "victim" in s 4 of the Sentencing Act. The definition of "victim" as far as it concerns this case is, "A member of the immediate family of a person who, as a result of an offence committed by another person, dies" as a result of what occurred.

[23] In this case, very sadly, Mr Papara died about 18 months after the incident and as I indicated in the introduction, the sentencing proceeds on the basis that there is no evidence that his death was caused by the incident. This means that legally, there is no victim in terms of the definition in the Sentencing Act. However, the whānau have agreed to accept the offer of $52,000 from Metallic Sweeping and the sentencing will proceed on the basis that that money is paid and that it is an offer to make amends in terms of the relevant provision of the Sentencing Act.

[24] Ms Braden submits that the defendant company's culpability sits in the middle to upper band of the medium range as set out by the full court of the High Court in *Stumpmaster v WorkSafe New Zealand.*[2] The medium culpability range is a starting point for fine of between $250,000 to $600,000. The prosecution submits the Court should fix a starting point of $450,000. As to discounts for mitigating factors, the prosecution accepts that discounts are available to the defendant in the range of 55 per cent. Finally, the prosecution seeks costs of $2,398.39.

[25] The final issue to be addressed is the capacity of the defendant company to pay but for reasons I shall come to, the Court cannot finalise that issue today.

[26] Mr Shannon, on behalf of the defendant company, has relayed his condolences to Mr Papara's whānau and has made it clear that the defendant company is very sorry for what occurred to Mr Papara. The defendant company accepts that its maintenance procedures did not pick up the issue with the hook. The defendant company also accepts that there were problems with its maintenance procedures, but submits it is uncertain what, if anything, would have been apparent had there been further visual inspections. The defendant company also submits that the failure of the engineering company who set up the Hiab to issue an LT400 certificate has not helped and that failure did not put the defendant company into the best position to pick this issue up.

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2 *Stumpmaster v WorkSafe New Zealand* [2018] NZHC 2020.

However, the defendant company accepts that it was its responsibility to understand the legal and operating requirements for the Hiab crane.

[27] Mr Shannon accepts that the defendant company's culpability sits within the medium band, but places the starting point lower than that advocated by WorkSafe. Mr Shannon submits the range for starting point should be between $350,000 and $380,000. Counsel accepts that the Court should follow the suggested discounts of 50-55 per cent acknowledged by the prosecution and finally, there is the issue of financial capacity. The defendant company's position is that it is facing financial headwinds which result in an ability to only pay a fine of $50,000 over three years.

Approach to sentencing

[28] The Court must have particular regard to the purposes of the Health and Safety at Work Act ("HSWA") as set out in s 3:

> **3 Purpose**
>
> (1) The main purpose of this Act is to provide for a balanced framework to secure the health and safety of workers and workplaces by—
>
> (a) protecting workers and other persons against harm to their health, safety, and welfare by eliminating or minimising risks arising from work or from prescribed high-risk plant; and
>
> (b) providing for fair and effective workplace representation, consultation, co-operation, and resolution of issues in relation to work health and safety; and
>
> (c) encouraging unions and employer organisations to take a constructive role in promoting improvements in work health and safety practices, and assisting PCBUs and workers to achieve a healthier and safer working environment; and
>
> (d) promoting the provision of advice, information, education, and training in relation to work health and safety; and
>
> (e) securing compliance with this Act through effective and appropriate compliance and enforcement measures; and
>
> (f) ensuring appropriate scrutiny and review of actions taken by persons performing functions or exercising powers under this Act; and
>
> (g) providing a framework for continuous improvement and progressively higher standards of work health and safety.

(2) In furthering subsection (1)(a), regard must be had to the principle that workers and other persons should be given the highest level of protection against harm to their health, safety, and welfare from hazards and risks arising from work or from specified types of plant as is reasonably practicable.

[29] Furthermore, s 7 of the Sentencing Act provides that the sentencing must:

(a) hold the offender accountable for the harm done by the offending and promote in the offender a sense of responsibility for the harm;

(b) to provide for the interests of the victims, including reparation; and

(c) denunciate and deterrence both in relation to the offender in general.

[30] Similarly, the Court is to consider the principles under s 8 of the Sentencing Act. Those of particular relevance are:

(a) the gravity of the offending and the degree of culpability;

(b) the seriousness of the type of offence, as indicated by the maximum penalty prescribed; and

(c) the ongoing effect on the victim.

[31] Finally, and most importantly, the Court must follow the sentencing approach as set out by the High Court in *Stumpmaster* which is a four-step process:

(a) The first is assessing the amount of reparation, which I have already dealt with;

(b) fixing the amount of fine by reference to the guideline bands and then make adjustment for aggravating and mitigating factors;

(c) determining whether further orders are required;

(d) making an overall assessment of the proportionality and appropriateness of imposing the sanctions under the first three steps.

Setting a starting point

[32] Counsel are agreed that the defendant company's failure to take the practicable step referred to falls within the medium band of *Stumpmaster* which has a band for the starting point of a fine between $250,000 and $600,000. *Stumpmaster* endorsed the factors in *Department of Labour v Hanham & Philp Contractors Ltd*[3] as being relevant to sentencing and I will work through each of those operative acts or omissions at issue and the practicable steps it was reasonable for the offender to have taken in terms of s 22 of the HSWA.

[33] The reasonably practicable step not taken by the defendant company is set out in the particular of the charge. In relation to the offence, it was reasonably practicable for Metallic Sweeping to ensure that the 2015 Hiab loader crane, including the crane hook, was maintained in a safe condition. The prosecution submits that a post-accident investigation has highlighted several issues with the hook and the Hiab itself that are indicative of a lack of maintenance. I refer to the missing safety latch from the hook and the faulty slew valve on the Hiab.

[34] The defendant company emphasises that neither of these issues were causative of the accident. The defendant company submits that it was not in the crane business and it relied on third parties to maintain the Hiab, including all its parts. The Hiab was set up by a third party engineering firm who did not issue it with an LT400 certificate. Had that occurred, then it would have been subject to an annual check by a certified engineer. That check would have been connected to the annual issue of a certificate of fitness for the vehicle. Had that certificate been issued and had there been an annual check by an engineer, it would have increased the likelihood of detection of a longstanding issue with the hook. However, the defendant company accepts it was its ultimate responsibility to know about LT400 certification. This is a requirement under the relevant regulations for operating a crane such as the one that the Court is concerned with.

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[3] *Department of Labour v Hanham & Philp Contractors Ltd* (2009) 9 NZELC 93,095.

[35] The defendant company had a monthly checking regime for the Hiab but it was insufficient as it did not address all the components of it. In particular, there was no reference to the hook on the monthly checklist, nor did the defendant company have a daily checklist procedure for the hook that was in accordance with the manufacturer's manual. The defendant company had a duty to operate the Hiab in accordance with the manufacturer's instructions and it failed in that duty. It is not known whether the driver who was working with Mr Papara on the day of the accident checked the hook before the lift in question.

[36] Of concern, the defendant company has provided information about the checks another driver undertook. That driver was aware that the hook did not have a safety latch but did not report it. The lack of a safety latch and the failure of the driver who noticed it to report it is an example of the lack of appropriate procedures that the defendant company had in place concerning the hook.

An assessment of the nature and seriousness of the risk of harm occurring as well as the realised risk

[37] The Hiab was operating at a recycling centre where the likelihood of other persons being present was high. The risk of serious harm from a load falling off the hook was obvious.

Degree of departure from standards prevailing in the relevant industry

[38] The manufacturer's manual recommended that hooks are checked before every lift. As I have already stated, the checks on the hook were not mentioned at all on the defendant company's monthly checklist. I have already referred to the lack of LT400 certification which the defendant company takes ultimate responsibility for. The defendant company accepts that its checks were not in accordance with the Hiab manufacturer's operating manual.

[39] Whilst I accept that the defendant's main business was not cranes, it had a responsibility to familiarise itself with the manufacturer's manual for this crane and to ensure it had systems in place in line with that manual.

Obviousness of hazard

[40] The hazard posed by an improperly maintained crane hook which is lifting heavy and large loads is obvious. An example of the failure to notice an obvious hazard on the hook is the failure to notice there was no safety latch.

Availability, cost and effectiveness of the means necessary to avoid the hazard

[41] The identified failure was a maintenance issue and there is no availability or cost issue associated with full compliance. However, without knowing how the accident exactly occurred, it is difficult to say more about this factor.

Current state of knowledge of the risks, nature and severity of the harm of the means available to avoid the hazard or mitigate the risk of its occurrence

[42] The risk of loads falling from cranes is well known, as are the consequences of a failure. The Hiab was recorded as a hazard on the defendant company's hazard register. Although what caused the load to come off has not been determined, the defendant company failed to have a system of checking that complied with the manufacturer's recommendations for the crane. Had that been in place, it would have mitigated the risk of the hook disconnecting.

Overall assessment of culpability

[43] The risk of a load coming off the hook of the Hiab crane operated by the defendant company was obvious, as was the consequence of serious injury or death to someone standing nearby. Whilst the defendant company lacked expertise on the operation of a crane, having a system of daily and monthly checks in accordance with the manufacturer's recommendations and the relevant industry standards would not have been difficult. It is clear that the hook had not been carefully checked in recent times otherwise the lack of a safety latch would have been picked up. Whilst the exact cause of the failure is not known, I accept that systematic checking of the hook would have increased the likelihood of the issue with the hook being detected.

[44] Mr Papara suffered serious injuries, spent three weeks in hospital and underwent a long and difficult recovery period. There would be no doubt that his injuries would have worn him down. Those injuries also created instability for the whānau which I have heard about and that has been ongoing. My assessment of the defendant company's culpability is that it is in the mid-range of the medium culpability band.

Comparison with other cases

[45] I have been referred to several sentencing decisions in the mid-range of the medium culpability band. The most relevant are *WorkSafe New Zealand Ltd v McRae.*[4] That case concerned a dairy farm worker who died when the tractor he was driving jack-knifed and rolled on top of him. The direct cause of the rollover was not known, but the rollover protection system on the tractor was severely corroded which meant it was unable to support the victim. The Court found that it was the defendant's responsibility to check that rollover system and, if needed, repair it. The defendant company's culpability was placed at the upper end of the medium band.

[46] *WorkSafe New Zealand Ltd v Agricentre South Ltd*[5] involved the brakes on a tractor that the defendant company received as a trade-in. The tractor was delivered to the victim's husband and it was known to have issues with its brakes. The defendant company returned to the victim's farm and carried out further work on the brakes but failed to reconnect a mechanism which would have provided a warning light when the brake fluid got too low and it failed to check whether its repairs had fixed the issues. The brakes failed on the tractor, it jack-knifed and the victim, who was the driver's wife, suffered a fractured C5 vertebrae in her neck, fractured right humerus, fractured right wrist and other injuries. She required several operations. In that case, a starting point of $425,000 was taken by the Court.

[47] The other case referred to me is *WorkSafe New Zealand v Ritchies Transport Holdings Ltd*.[6] In that case, Ritchies failed to have an adequate and safe system in

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4 *WorkSafe New Zealand Ltd v McRae* [2018] NZDC 22096.
5 *Worksafe New Zealand Ltd v Agricentre South Ltd v Worksafe* [2019] NZDC 3498.
6 *WorkSafe New Zealand v Ritchies Transport Holdings Ltd* [2019] NZDC 18495.

place for the dry hire of buses so that drivers of dry hire buses were aware of the brake system on the bus they were hiring and also what to do if there were issues. That case is different to this in that the driver of the bus was directly responsible for the crash that killed three passengers and permanently injured another. In that case, the Court took a starting point of $400,000.

[48] The prosecutor submits that this case is more serious than *Agricentre South* as it was within the defendant company's sole sphere of influence to maintain the hook and Hiab properly and that it had the sole responsibility for their condition. The defendant company submits that this case is less serious than *Agricentre South* because the brake issues in that case were known to the defendant company.

[49] Whilst I accept that it was the defendant company's sole responsibility to maintain and check the hook of the Hiab and its failure to do so would most likely have picked up the issue with the hook, the lack of information about the exact cause of the accident means the Court has to exercise a degree of caution in setting the starting point. However, the Court can take into account the lack of a safety catch on the hook as being indicative of a failure to take the hook seriously as a hazard. I also take into account the serious injury caused to Mr Papara and the ongoing effects of that on him and his whānau. Taking all these matters into account, the Court sets a starting point for fine of $400,000.

Mitigating factors

[50] The defendant company cooperated with the investigation and the Court will provide a five per cent discount for that. The defendant company has no prior WorkSafe convictions and has one conviction in 2004 under the Land Transport Act 1998 relating to a logbook offence. Essentially, it has prior good character and there will be a five per cent discount for that.

[51] The defendant provided ongoing support to Mr Papara by way of ACC top up and then attended a restorative justice conference. I have read the minutes of that conference and I accept that the defendant company is remorseful for what occurred.

The managing director visited Mr Papara and its approach appears to have been genuine.

[52] There will be a five per cent discount for remorse and there will be a 10 per cent discount for the offer to make amends in the sum of $52,000. I emphasise that should there be any issue with the payment, there will need to be a re-sentencing.

[53] The defendant company is entitled to a 25 per cent discount for guilty plea.

[54] Following the incident, the defendant company ensured that its systems were fit for purpose, including appropriate checklists for the Hiab crane and it also obtained ISO certification. The prosecution submits those actions were those that a responsible employer would undertake anyway and that does not entitle the defendant company to credit. However, the defendant company has obtained Site Safe accreditation and will have its health and safety practices audited annually by Site Safe. It has also obtained an annual compliance certificate for safety by prequalifying its health and safety systems with local authorities through SHE Pre-Qual. The prosecution accepts that a further five per cent discount is applicable for those extra steps.

[55] The total discounts amount to 55 per cent which results in an end fine of $180,000.

[56] The Court awards the prosecution legal costs under s 152(1) of the HSWA in the sum of $2,398.39.

[57] The final issue is capacity to pay the fine. The defendant company provided financial information to WorkSafe on or about 24 January and today I was provided with an affidavit from a forensic accountant engaged by WorkSafe which questions the claims of the defendant company regarding inability to pay a fine. I am going to have to adjourn this aspect of the sentencing until 31 March.

[58] The defendant company is directed to file a further affidavit by 28 February annexing the 31 December 2021 management accounts and also addressing the interparty debts to it. Metallic Sweeping has the onus of satisfying the Court on the

inability to pay issue and full disclosure is encouraged in order for Mr Shaw to have the full picture. WorkSafe are to file any further affidavit from Mr Shaw within a further 14 days. The court will allocate a 45-minute hearing on 31 March before me in Tokoroa.

[59] I direct that the summary of facts can be released with redactions regarding the name of the engineering firm that set up the Hiab and the names of the driver on the day in question and the other driver who provided information regarding checks he undertook of the hook.

[60] There may need to be subsequent orders regarding financial information, but they do not arise from today's hearing or from the summary of facts.

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Judge GC Hollister-Jones
District Court Judge | Kaiwhakawā o te Kōti ā-Rohe
Date of authentication | Rā motuhēhēnga: 23/02/2022