SUPPRESSION ORDERS EXIST IN RELATION TO ASPECTS OF THIS JUDGMENT PURSUANT TO S 205 CRIMINAL PROCEDURE ACT 2011: SEE PARAGRAPHS [20]-[31] inclusive.
http://www.legislation.govt.nz/act/public/2011/0081/latest/DLM3360354.html

IN THE DISTRICT COURT
AT CHRISTCHURCH

I TE KŌTI-Ā-ROHE
KI ŌTAUTAHI

CRI-2021-009-008434
[2024] NZDC 27062

WORKSAFE NEW ZEALAND
Prosecutor

v

UNITED STEEL LIMITED
Defendant(s)

Hearing:	1 November 2024
Appearances:	R C Woods for the Prosecutor F Pilditch KC and S Crosbie for the Defendant
Judgment:	13 November 2024

SENTENCING NOTES OF JUDGE J A FARISH

Introduction

[1] United Steel Limited ("USL") is a manufacturer and distributer of steel products who operated a steel storage and distribution facility at 22 McAlpine Road, Wigram, Christchurch. On 23 November 2020, Franchesco James Bunge-Krueger was working as a storeman at that facility. Mr Bunge-Krueger was sweeping between

racks, loaded with bundles of steel weighing approximately nine tonnes, when the rack collapsed and Mr Bunge-Krueger was crushed, sustaining fatal injuries.

[2] USL was subsequently charged under ss 36(1)(a), 48(1) and 48(2)(c) of the Health and Safety at Work Act 2015 ("HSWA").

[3] The charge reads that USL:

> Being a PCBU, having a duty to ensure, so far as was reasonably practicable, the health and safety of workers who worked for the PCBU, including Franchesco James Bunge-Krueger, while the workers were at work in the business or undertaking, namely United Steel Limited's Christchurch steel distribution facility, did fail to comply with that duty and that failure exposed Franchesco James Bunge-Krueger to a risk of serious injury or death, arising from the collapse of ladder racks used for steel storage.
>
> **Particulars**
>
> It was reasonably practicable for United Steel Limited to:
>
> a. Ensure that its ladder racks were effectively braced and fixed, so as to be stable when used for their intended purpose;
>
> b. Develop and implement an effective process of regular inspections of its racking systems, including routine in-house inspections to identify wear and damage which might compromise the structural integrity and stability of the racks, and annual inspections by a competent person to confirm the racks' ongoing fitness for purpose and safe operation;
>
> c. Develop, implement and monitor a safe operating procedure for the use of the ladder racks, including in relation to the appropriate configuration of loads of steel stacked in the racks;
>
> d. Implement signage and markings on or near the ladder racks, identifying the correct usage of the racks, including demonstrating appropriate stacking configuration.

[4] The maximum penalty for this offence is a fine not exceeding $1,500,000.[1]

[5] USL has pleaded guilty to the charge and now appears for sentence.

[1] Health and Safety at Work Act 2015, s 48(2) [**HSWA**].

The ladder racks

[6] USL uses various types of racks to store steel products, including pallet racks, ladder racks and toast racks. USL used ladder racks to store long sections of steel at their premises. These ladder racks were made to order, by steel fabricators, to a design supplied by USL. They have been used without issue for 25 years.

[7] No bracing was fitted to the ladder rack that collapsed ("the Rack"). It was also not fixed to the floor at the time of the incident. The experts have agreed that it was the loading of the rack (top heavy) which caused the instability and hence its fall.

The incident

[8] On 23 November 2020 at about 11am, Bunge-Krueger started work for the day. He was working alongside another storeman, Mr Moeloa.

[9] It was the job of the storemen to move steel to facilitate an incurring steel delivery. This required the use of a gantry crane to lift bundles of steel from racks and move them to the necessary location. On occasion, it was necessary to remove steel from higher levels of the racks to gain access to product in lower levels. At the time of the incident the ladder racks were almost empty due to chain of supply issues.

[10] Between approximately 1:32pm and 1:53pm, Mr Moeloa moved various bundles of steel held on the Rack. These stock movements depleted the steel stored at the base of the Rack.

[11] As space became free at the base of the Rack, Mr Bunge-Krueger retrieved a yard broom and told Mr Moeloa that he intended to sweep out the area beneath the racks. Mr Moeloa advised Mr Bunge-Krueger against doing this, but Mr Bunge-Krueger proceeded to do so. While Mr Bunge-Krueger was still inside the frame of the Rack, Mr Moeloa used the gantry crane to move a bundle of steel onto the Rack from an adjacent rack. About one minute later, the Rack collapsed and the stacked steel fell onto Mr Bunge-Krueger, crushing him. The steel stacked on top of the Rack weighed approximately nine tonnes. While his workmates managed to lift

the steel off Mr Bunge-Krueger and extract him from the pile of steel, Mr Bunge-Krueger died of his injuries at the scene.

The WorkSafe Investigation

[12] The WorkSafe investigation identified:

(a) the ladder rack that collapsed was not braced, despite being made to have cross-bracing fitted;

(b) the ladder rack that collapsed was not bolted to the floor;

(c) some (but not all) other ladder racking at the premises was braced and/or bolted to the floor;

(d) the ladder racks relied on an amount of weight to be maintained at their base, for stability;

(e) the instability of the Rack at the time of the incident was likely caused by the "top heavy" configuration of the steel that was stacked on it; and

(f) when stacked in the manner seen immediately prior to the incident, very little force would be required to destabilise the ladder rack.

The purposes and principles of sentencing

[13] Section 151 of the HSWA instructs the Court to apply to Sentencing Act 2002. It also requires that the Court have particular regard to:

(a) sections 7 to 10 of the Sentencing Act;

(b) the purpose of the HSWA;

(c) the risk of illness, injury, or death that could have occurred;

(d) whether death, serious injury, or serious illness occurred;

(e) the safety record of the person;

(f) the degree of departure from prevailing standards in the person's sector or industry; and

(g) the person's financial capacity to pay any fine.

[14] The purpose of the HSWA relevantly includes:[2]

(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

(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

(g) providing a framework for continuous improvement and progressively higher standards of work health and safety.

[15] As a person conducting a business or undertaking ("PCBU"), it is USL's primary duty of care to ensure, so far as is reasonably practicable, the health and safety of its workers.[3]

[16] Against that background, sentencing under the HSWA will generally require significant weight to be given to the ordinary sentencing purposes of denunciation, deterrence and accountability.[4] I also consider providing for the interests of the victim, and providing reparation to be relevant purposes in the circumstances of this case.[5]

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[2] HSWA, s 3(1).
[3] Section 36.
[4] *Stumpmaster v WorkSafe New Zealand* [2018] NZHC 2020 at [43].
[5] Sentencing Act 2002, s 7(1).

[17] Of the sentencing principles listed in the Sentencing Act, I consider the most relevant principles in this case to be the culpability of the offender; the seriousness of the offence; the general desirability of consistency; the effect of the offending of the victim.[6]

Sentencing approach

[18] *Stumpmaster v WorkSafe New Zealand* sets out a four-step approach for offences under the HSWA:[7]

> (a) assess the amount of reparation;
>
> (b) fix the amount of the fine by reference first to the guideline bands and then having regard to aggravating and mitigating factors;
>
> (c) determine whether further orders under ss 152-158 of HASWA are required; and
>
> (d) make an overall assessment of the proportionality and appropriateness of the combined packet of sanctions imposed by the preceding three steps.[8]

Step one: reparation

[19] Reparation may be imposed for the loss of or damage to property, emotional harm, and other consequential loss or damage.[9] However, in the present case, no award of reparation for consequential loss is sought.

[20] Before I begin this inquiry, I note this Court has had the benefit of a joint victim impact statement from Mr Bunge-Krueger's family, which includes statements from: [redacted]

[21] I do not purport to do their statements justice, but I have summarised parts of them below.

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[6] Section 8.
[7] *Stumpmaster v WorkSafe New Zealand*, above n 4, at [3].
[8] This includes consideration of the defendant's ability to pay and whether an increase is needed to reflect the defendant's financial capacity.
[9] Sentencing Act, s 32.

Victim impact statements

[22] [redacted]

[23] [redacted]

[24] [redacted]

[25] [redacted]

[26] [redacted]

Emotional harm

[27] Fixing a monetary award for emotional harm is a challenging task, as this is not something that can be easily quantified. No sum of money will be able to properly compensate Mr Bunge-Krueger's family for the impact of his death. Nevertheless, payment of reparations for emotional harm is appropriate. The Court must aim "to strike a figure which is just in all the circumstances".[10]

[10] *Big Tuff Pallets Ltd v Department of Labour* (2009) 7 NZELR 322 (HC) at [19].

[28] [redacted]

[29] [redacted]:[11]

(a) [redacted]

(b) [redacted]

[30] [redacted].[13]

[31] [redacted]

(a) [redacted]

([redacted]

Step two: fine

[32] When determining a starting point for the fine, the following guideline bands are to be used:[14]

low culpability: $0 to $250,000

[11] See Schedule A of *Ocean Fisheries Limited v Maritime New Zealand* [2021] 3 NZLR 443, which sets out a review of the awards of reparation to different relations in previous cases.

[12] [redacted]

[13] See *Ocean Fishes Ltd v Maritime New Zealand* [2021] NZHC 2083, [2021] 3 NZLR 443 at [135]; and *Oceana Gold (New Zealand) Ltd v WorkSafe New Zealand* [2019] NZHC 365, [2019] 3 NZLR 137 at [88].

[14] *Stumpmaster v WorkSafe New Zealand*, above n 4, at [4].

medium culpability:	$250,000 to $600,000
high culpability:	$600,000 to $1,000,000
very high culpability:	$1,000,000 to 1,500,000

[33] Specific guidance for assessing culpability can be found in s 151 of the HSWA. However, the High Court in *Stumpmaster* held that this guidance is sufficiently encapsulated within the well-established culpability assessment factors identified in *Hanham*:[15]

(a) The identification of the operative acts or omissions at issue.[16]

(b) An assessment of the nature and seriousness of the risk of harm occurring as well as the realised risk.

(c) The degree of departure from standards prevailing in the relevant industry.

(d) The obviousness of the hazard.

(e) The availability, cost and effectiveness of the means necessary to avoid the hazard.

(f) The current state of knowledge of the risks and of the nature and severity of the harm which could result.

(g) The current state of knowledge of the means available to avoid the hazard or mitigate the risk of its occurrence.

[15] *Department of Labour v Hanham and Philp Contractors Ltd* (2008) 6 NZELR 79 (HC) at [54] cited in *Stumpmaster*, above n 4.

[16] This will usually involve the clear identification of the "practicable steps" which the Court finds it was reasonable for the offender to have taken in terms of s 22 of the HSWA.

Starting point

[34] After considering the above factors, the prosecution submits that a starting point of $700,000 is appropriate. This places USL at the lower end of the high culpability range. USL submits that its culpability falls within the medium band, and so a starting point of $450,000 to $550,000 is appropriate. USL makes several points to support this position, in particular noting that their culpability is decreased because:

(a) the ultimate cause of the ladder rack collapse is that it was stacked top-heavy; and

(b) it is uncertain whether bracing would have prevented a ladder rack that is stacked top-heavy from collapsing; and

(c) USL had trained their staff on health and safety matters, and staff were made aware that ladder racks should not be stacked top-heavy; and

(d) despite not having a formal process for ensuring compliance with the safe operating procedure, USL had regular onsite supervisors who would check for unsafe work practices; and

(e) inspections were infrequent. However, the racks collapsed due to top-heavy loading, and not wear, tear and damage.

[35] I address USL's culpability by referring to the *Hanham* factors discussed above:

(a) *Operative acts or omissions.* No system for the routine inspections of racks was implemented to determine whether the racks remained fit for purpose. USL failed to implement a safe operating procedure for the stacking of racks that outlined either the risks of a top-heavy configuration or details of the preferred configuration. The risks of a top-heavy configuration were expressed verbally during the training of each worker by their 'buddy', but there was no documentation or monitoring of this training.

(b) *Nature and seriousness of the risk of harm and the realised risk.* The steel was large and heavy. If it were to fall on or strike a worker, there would be a very real risk of serious injury or death. Workers were required to work in close proximity to the racks, and so they were routinely exposed to this risk. The realised risk, being death, was as serious as it could be.

(c) *Degree of departure from prevailing standards.* There were no guidelines specifying the need to brace ladder racks or have them routinely inspected. However, it should have been obvious to USL that their ladder racks needed to be fit for purpose. The design contemplated that the racks would be braced—it included lugs to be used for bracing—and other racks in the same facility were braced. I accept however that the lack of bracing was not an operative cause of the accident.

(d) *Obviousness of the hazard*. The hazard—the collapsing of racks, causing the heavy loads of steel on them to fall in the immediate vicinity of workers—was obvious. There were no prior collapses to alert USL. Nonetheless, USL should have recognised the importance of ensuring these racks were stable.

(e) *Availability, cost and effectiveness of means to avoid hazard*. It would also not be a major imposition for USL to make amendments to the safe operating procedure to clarify safe methods of stacking steel, or to monitor the training of their employees.

(f) *The current state of knowledge of the risks, the potential harm, and the means available to avoid the hazard or mitigate the risks*. This is a well-understood hazard, and there were safety and preventative measures that USL could have adopted.

[36] To assist me in my determination of the starting point, counsel have referred me to a number of cases. These cases are *WorkSafe New Zealand v Peter Fletcher*

Transport Ltd,[17] *WorkSafe New Zealand Ltd v Metrapanel Ltd*,[18] *WorkSafe New Zealand v Sequal Lumber Limited,*[19] and *WorkSafe New Zealand v Adam Campbell Building Ltd.*[20]

WorkSafe New Zealand v Peter Fletcher Transport Ltd

[37] The defendant (PFTL) was storing steel pipes at their premises for a customer.[21] The pipes were stacked using wooden bearers. After de-stacking and re-stacking the pipes to fulfil an order, the victim started cleaning around the area. The stack collapsed forwards, leading the pipes to fall onto, and fatally crush, the victim. There were no guidelines available for the stacking of steel pipes, but information was readily available about how to prevent the pipes from collapsing. PFTL was charged based on a failure to undertake an effective risk and hazard assessment and develop safe working methods in relation to the storage, stacking and de-stacking of pipes. It was further alleged that PFTL had failed to regularly inspect the stacked pipes or provide adequate information, training, or supervision to its workers.

[38] In fixing a starting point of $700,000, Judge Neave accepted WorkSafe's argument that "the offending in this case is serious, given that it involves an obvious risk of death arising out of a dangerous hazard which was not controlled according to industry practice".[22] On this basis, WorkSafe considers it a suitable comparator to the present case.

[39] USL argues that the storage system used by PFTL was more "amateur" and therefore more obviously hazardous than the storage system in USL but any instability was only noticeable when steel was placed on the racks in a top-heavy configuration, whereas the pile of steel pipes at PFTL's premises looked inherently unstable. While the risk in PFTL was *visually* more obvious, the relevant question when assessing obviousness in *Hanham* is "the obviousness of the thing that can cause harm".[23] In

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[17] *WorkSafe New Zealand v Peter Fletcher Transport Ltd* [2019] NZDC 14449 [**Peter Fletcher Transport**].
[18] *WorkSafe New Zealand Ltd v Metrapanel Ltd* [2016] NZDC 25945, [2017] DCR 454 [**Metrapanel**].
[19] *WorkSafe New Zealand v Sequal Lumber Limited* [2021] NZDC 22700 [**Sequal**].
[20] *WorkSafe New Zealand v Adam Campbell Building Ltd* [2019] NZDC 2342 [**ACB**].
[21] *Peter Fletcher Transport*, above n 17.
[22] At [24].
[23] *WorkSafe New Zealand v ABC Aluminium Ltd* [2023] NZDC 23126 at [54].

the present case, "is it obvious that if the staff are not trained or reminded on proper stacking, it could detach and cause harm?" The answer to this is clearly yes.

[40] Despite this, I consider USL to be less culpable than PFTL, justifying a lower starting point. This is because USL was aware that training of team members was occurring, whereas there was no evidence that training related to de-stacking and re-stacking occurred under PFTL. More should have been done in the present case by USL to make sure that the training was occurring, and that it was thorough. The importance of proper stacking should have also been emphasised in safe operating procedures or in signage throughout the facility. However, PFTL demonstrated a greater departure from prevailing standards which, in my view, justifies a lower starting point for USL.

WorkSafe New Zealand Ltd v Metrapanel Ltd

[41] In this case, a worker was fatally crushed when a wall panel fell onto him from a mobile racking frame that was designed to hold construction panels.[24] This panel frame was newly commissioned by Metrapanel for the purpose of holding panels during painting and drying. Metrapanel undertook a risk assessment of the mobile frame based on hazards relevant to the static frame, and provided training to workers about its use, but failed to identify certain risks associated with the frame's mobile nature. The Court noted that there was ample guidance on the risks associated with storing and handling construction panels and found that the hazard of panels falling and causing injury or death was obvious. The Court concluded that the appropriate starting point was within the medium culpability band and provided a starting point of $95,000.[25] Scaled to reflect the increased bands in the HSWA, this amounts to roughly $565,000.

[42] *Metrapanel* investigated potential hazards and risks and attempted to mitigate them. Their error was not recognising a hazard in the process of this investigation. In

[24] *Metrapanel*, above n 18.
[25] *Metrapanel* was determined under the earlier legislation, the Health and Safety in Employment Act 1992, which provided for a maximum penalty of $250,000. Under the earlier legislation, the medium culpability band fell between $50,000 and $100,000.

the present case, no ongoing assessment of risks was undertaken. USL knew that the hazard existed; they knew that top-heavy stacking could result in the racks collapsing.

[43] Further, the newness of the panels meant that Metrapanel had less time to consider the hazards associated with their use and take steps to reduce their risk. Neither of these factors led to a reduction of culpability in that case.[26] However, I consider that USL's high level of familiarity with the braces that they designed, as well as their knowledge about the hazards and risks of top-heavy stacking without providing in-depth training, justify a higher starting point in this case.

[44] I have considered the other authorities referred to me by both prosecution and defence, but they involve material differences that make them less helpful for my analysis.[27]

WorkSafe New Zealand v Sequal Lumber Limited

[45] In *Sequal*, the victim was doing stencilling work while standing next to stacked packets of timber.[28] A ground bearer supporting the stack behind her broke and the timber fell onto the victim. WorkSafe concluded that the accident was the direct result of a rotten bearer which triggered the movement of the stack and broken straps. In fixing a starting point of $450,000, the Court noted that Sequal had a hazard identification system and a system for re-stencilling stacked packs, that it trained and monitored staff, and that the victim deviated from known procedure.

[46] The present case justifies a higher starting point for the following reasons:

(a) USL clearly omitted to take extra precautions when it knew that the Rack was not braced or fixed to the floor. Sequal had a process for inspecting hazards and, it seems, failed to notice the existence of the rotten bearer. USL states that they did have an inspection process, but the lack of bracing is something that USL already knew about.

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[26] At [23].
[27] *WorkSafe New Zealand v Adam Campbell Building Ltd* DC Greymouth CRI-2018-018-000125, 8 February 2019; *WorkSafe New Zealand v Sequal Lumber Ltd* [2021] NZDC 22700.
[28] *Sequal*, above n 19.

(b) USL did not have a process for monitoring training related to stacking.

[47] For these reasons, I consider that a higher starting point in the present case is appropriate.

WorkSafe New Zealand v Adam Campbell Building Ltd

[48] The defendant, ACB, was undertaking the re-piling of a remote bach property.[29] During this process, the bach was lifted. The victim was under the house when it fell from the supports, and he was fatally crushed. A starting point of $900,000 was fixed. Some factors distinguishing ACB from the present case are that:

(a) the work was inherently dangerous;

(b) ACB involved an inexperienced and vulnerable victim;

(c) the likelihood of the risk being realised was high;

(d) guidance and information about how to address the hazard was readily available; and

(e) ACB was not well-versed in lifting buildings and so should have sought expert input before carrying out this work on its own.

[49] For these reasons, ACB is not a suitable comparator and the starting point in the present case should be considerably lower.

[50] In an attempt to reduce their own culpability, USL have brought up the conduct of the victim and Mr Moeloa immediately prior to the incident. Duffy J in *Department of Labour v Eziform Roofing Products* stated:[30]

> A victim's intentional or wilful disregard for safety practices may well mitigate otherwise seriously culpable conduct on the part of an employer. But guarding against workplace accidents that result from the foolish carelessness of employees is part of the role of the Health and Safety in Employment Act.

[29] *ACB*, above n 20.
[30] *Department of Labour v Eziform Roofing Products Ltd* [2013] NZHC 1526 at [52].

> So, to allow such carelessness to minimise an employer's culpability would undercut one of the policy objectives of the legislation.

[51] And further:

> Yet the community has no means of monitoring workplace safety, other than through the Health and Safety in Employment Act. Particularly in light of the accident compensation scheme's no fault principle, the fines imposed under this Act must act as a real deterrent on employers to avoid workplace accidents, including those involving the foolishness and carelessness of employees. Unless employers are influenced by the means of this Act to change the culture of employees who display a cavalier attitude towards safety precautions, the community will continue to bear the cost of the harm that results. It would be wrong, therefore, to permit employers to rely on an injured employee's foolishness or carelessness to mitigate the employer's culpability. It follows that in matters of workplace health and safety, to attach little, if any, weight to a victim's carelessness will not be inconsistent with the requirement in s 9(2)(c) of the Sentencing Act.

[52] USL argues that not giving weight to an employee's tactics would be inconsistent with s 9(2)(c) of the Sentencing Act which states that the Court *must* consider the victim's conduct. Where an employee is simply careless, *Eziform* argues that this should be given such little weight as to consider it negligible in the assessment of employer culpability. This necessarily involves consideration of the victim's conduct, determining whether it is careless and therefore a neutral factor, or whether it is something more—an "intentional or wilful disregard for safety practices"—that would justify a reduction in the employer's culpability. In the present case, USL did not provide information in the safe operating procedure or on signage around the premises about the risks of top-heavy stacking, instead they presumed that information was passed by an employee through the "buddy system". The fact that top-heavy stacking had not been an issue since they started operating 25 years ago does not extinguish the existence of the hazard. The conduct of Mr Moeloa or Mr Bunge-Krueger on the day of the incident does not reduce USL's culpability in this case. Rather it highlights why a SOP for the ladder racks was essential as notices identifying the safe stacking of these racks.

Conclusion on starting point

[53] Having regard to the cited cases and my own assessment of the *Hanham* culpability factors, I consider **$600,000** to be an appropriate starting point for USL.

That places the offending towards the bottom of the high culpability band in *Stumpmaster*.

Aggravating and mitigating factors

[54] Both WorkSafe and USL submit that there are no aggravating factors that justify an uplift of the starting point. I agree.

[55] The parties agree that the following discounts should be awarded:

(a) *Co-operation with the WorkSafe investigation* – 5 per cent.

(b) *Remorse* – 10 per cent. It is evident that USL is remorseful. The fact that they have already paid over $38,000 to Mr Bunge-Krueger's family is "tangible and demonstrable evidence" of remorse justifying a 10 per cent discount.[31]

(c) *Willingness to pay reparation* – 10 per cent.

(d) *Guilty plea* – 15 per cent.

[56] USL seeks a further five per cent discount for their prior health and safety record, stating that they have no prior convictions. While it is true that they have no convictions, WorkSafe submits that USL has had "various interactions with WorkSafe, including eight improvement notices". I agree that the defendant is entiled to credit for not having any prior convictions. The company has been in business for 43 years. Before this incident they had shown a commitment to Health & Safety and the incident has led to a more nuanced approach to health and safety. The prosecution could not date or provide any information with respect to the improvement notices. I therefore add another 5 per cent to the mitigation.

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Judge JA Farish
District Court Judge | Kaiwhakawā o te Kōti ā-Rohe
Date of authentication | Rā motuhēhēnga: 13/11/2024

[31] *WorkSafe New Zealand v Trade Depot Ltd* [2024] NZDC 16025.