The Safe Side

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Developments in health and safety from New Zealand and around the world

October 2024 | Issue 62

In this month's issue, we look at two recent sentencings under the Health and Safety at Work Act (HASWA) that resulted after the deaths of young people on excursions run by PCBUs. The first came about after 15-year-old Karnin Petera was drowned at Abbey Caves while on a school trip; the second followed the death of a young woman on a fun day out on the water. We also cover the settlement of the first case that used the Criminal Proceeds (Recovery) Act 2009 to seize assets gained from offending against health and safety or hazardous substances legislation. Finally, we briefly touch on the new requirements for Police checking on staff at limited-attendance childcare centres.

School Board sentenced after tragic death of 15-year-old student in Abbey Caves

Whangārei Boys' High School Board (the Board) has been ordered to pay reparations of over $500,000 after being sentenced on two charges under HASWA. Details of the reparation payments were suppressed by the Court. No fine was imposed.

The prosecution arose after the tragic death of a 15-year-old school student, Karnin Petera, who drowned in floodwaters in Abbey Caves on 9 May 2023. Sixteen other students on the caving trip and their two supervisors were lucky to survive the incident.

A full day before the group ventured into the cave, MetService had issued an orange weather warning forecasting heavy rain. Karnin's parents contacted the school multiple times to express their concerns about the weather in the lead-up to the trip, but were told it would go ahead as the school didn't expect heavy rain until later.

A Radio New Zealand article describes how the group entered Organ Cave earlier than planned because of the forecast rain and waded through normal knee to waist high water. They then took a junction at 150m in, and went through a dry passage to a glow worm chamber where they spent about 20 minutes. In the meantime, the water in the cave system had risen markedly.

When returning, the trip leader decided it was safer to try to walk out of the cave than wait out the flood in the upper passage, because he did not know how long the water would take to subside, and he had no way of communicating with the outside.

The students got into the water but it was deeper and swifter than anticipated, and an emergency quickly developed. With the water mostly above their heads, the group floated down the cave. Many were dragged down by their gumboots or overalls or by other students, and despite linking arms, they were separated.

When they eventually reached the entrance, they saw a large volume of water rushing around either side of a large rock. Students who reached the left-hand side of the rock managed to get out relatively easily; those who were sucked to the right had a lot more difficulty. One student recalled seeing Karnin's foot become trapped between rocks. Karnin was eventually located around 7pm that night when the water had subsided enough for a rescue team to enter the cave.

WorkSafe's investigation uncovered multiple failures that contributed to the teenager's death. It found there was no shared understanding among organisers and decision-makers of exactly what heavy rain meant, or when trips would be cancelled. WorkSafe also found that the Board had ineffective oversight of high-risk activities and critical decisions, and its emergency planning failed to identify the risk of rising water trapping students while caving.

After sentencing, WorkSafe said that while outdoor education plays a crucial role in providing students with valuable, real-world learning experiences that enhance their overall education, there must be "gold standard" risk management whenever schools take rangatahi into the great outdoors. Every school board should ensure that its oversight of outdoor education is robust – and if they are unsure, they should get an expert involved.

Education Outdoors New Zealand's chief executive, Fiona McDonald, also recommended that the person responsible for Education Outside the Classroom (EOTC) in each school is registered on the EOTC coordinators database and participates in ongoing professional development. Further guidance, including a toolkit and safety management plan templates, can be found on the Education Outdoors New Zealand website.

Updated guidance on vetting workers at limited-attendance childcare centres

Updates have been made to the Health and Safety at Work (General Risk and Workplace Management) Regulations 2016 (Regulation 51) which means that Police vetting must be completed for non-teaching and unregistered employees at unlicensed childcare centres before the person begins work. This vetting must be used to assess any risks to the safety of children. WorkSafe has updated their guidance to reflect this.

Auckland business and its owner forfeit $4m to Police following asset recovery proceedings

On 15 September 2015, there was a large explosion inside a 96,000-litre tank at an oil recovery business in Wiri, Auckland. Twenty-four-year-old Jamey Bowring, who was performing hot work on top of the tank, was thrown 130 metres into a nearby car yard and killed.

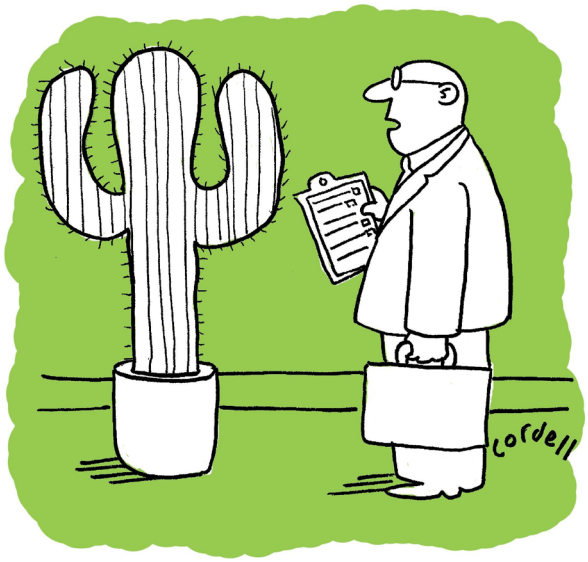
A WorkSafe investigation found numerous failings by the company and its managing director under both the Health and Safety in Employment Act 1992 (HSE) and the Hazardous Substances and New Organisms Act 1990 (HSNO). The company and managing director subsequently pleaded guilty to six charges each under the Acts. The charges included the rarely used and most serious offences available under HSE for *knowing* that the failure to take certain actions was reasonably likely to cause serious harm to any person; as well as for repeatedly breaching a prohibition notice put in place after the explosion.

At sentencing, the Judge found that the level of culpability sat in the extremely high culpability range and that the offending for breaching the prohibition notice was belligerent and flagrant. The company was fined a total of $258,750 and combined reparations of $128,074.21 were ordered to be paid by both parties. The managing director was fined $25,000 and sentenced to 4½ months home detention. The maximum fines under HSE were significantly less than under the current HASWA.

In a move that alarmed many, the Commissioner of Police (the Commissioner) then began proceedings against the company, shareholders and associated trusts under the Criminal Proceeds (Recovery) Act 2009 (CPRA) in 2019. This legislation is often used to recover assets gained through offending such as drug dealing or money laundering. This was the first time it had been used for HSE or HSNO offences. The Commissioner alleged that the respondents had unlawfully benefited from significant criminal activity and made a forfeiture order for close to $11 million.

A seven-week trial began this month, however, the parties entered settlement discussions shortly after the Commissioner opened his case. The High Court in Auckland then approved a settlement that will see the company and managing director jointly forfeiting $4 million.

After the settlement was announced, Financial Crime Group Detective Inspector Lloyd Schmid said that Police were aware of concerns within the business community about the application of the CPRA in these circumstances, but that Police had no intention to use the CPRA routinely for offences against HASWA. He said the case, largely brought on the basis of breaches of regulations relating to hazardous substances, had some unique features and aggravating circumstances, including the tragic death of a young man. "Police will however consider any future cases on a case-by-case basis," Detective Inspector Schmid said.



"I'm from Health & Safety... I wonder if I might have a word..."

Failure to follow safety procedures leads to tragedy on the water

What should have been a fun day out on the water resulted in tragedy when a 25-year-old-women fell overboard and was fatally struck by a charter vessel. The victim and her work colleagues were guests on board the boat for a trip around the Hauraki Gulf in April 2021. She had gone up to the bow of the vessel with another passenger and was heading back inside when she slipped and fell overboard.

Maritime NZ said the company failed to ensure its Maritime Transport Operator Plan (MTOP) was followed on the day of the victim's death. The MTOP identified the hazard of passengers being on the bow of the vessel while it was underway, but this was not implemented and enforced. Some crew members were unaware it was a policy for the vessel, and it was not covered in the safety briefing for passengers. Neither were there any physical barriers indicating the "no-go" passenger areas on the vessel.

At sentencing, the Judge ordered emotional harm reparations of $140,000 to be paid, but due to the limited financial means of the company, no fine was imposed.

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