IN THE DISTRICT COURT
AT QUEENSTOWN

I TE KŌTI-Ā-ROHE
KI TĀHUNA

CRI-2020-059-000535
[2023] NZDC 17056

WORKSAFE NEW ZEALAND
Informant

v

NZSKI LIMITED
Defendant

Hearing:	17, 18, 19, 20, 21, 26 and 27 April 2023
Appearances:	Ms K Hogan and Ms A Simpson for the Informant Mr J Rapley KC and Ms H Bennett for the Defendant
Date of Decision:	15 August 2023

RESERVED DECISION OF JUDGE G A REA

Background

[1] The Defendant is the operator of the Coronet Peak Ski Field near Queenstown. That ski field has a significant number of "trails" or "runs" that allow skiers of all levels of ability to have somewhere appropriate to ski.

[2] This case deals with one of those "trails" or "runs" which is named Sugar's Run. Sugar's Run is designated as a "red" trail or run which means it is suitable for advanced skiers.

[3] In 2008 the Elephant Pit Reservoir was constructed by the Defendant at the base of Sugars Run in order to hold water that would be used for snow making purposes during the ski season.

[4] The reservoir itself is a man-made hazard. It was recognised as an "extremely high" hazard because of the possibility that skiers could ski into it and have considerable difficulty getting out of it. To prevent that from occurring the Defendant instructed what has been described as a "deer fence" which completely encircled the reservoir. This fence was constructed of tall wooden posts with strained wires between the posts. In 2019 the fence was heightened because the Defendant was concerned that a build up of snow against the existing fence could create ramp like conditions which could mean a skier went right over the top of the existing fence and into the reservoir.

[5] The heightening of the fence was done by attaching further wooden posts and strained wire to the existing fence by bolting them on. Some parts of some of the bolts protruded from the wooden posts and represented a hazard in themselves.

[6] The erection of the deer fence, both before it was heightened and afterwards, represented its own hazard to skiers. If it was recognised that skiers could end up in the reservoir if the fence was not there, then it is obvious that skiers could ski into the fence as well because it was even closer to the Sugar's Run Trail than the reservoir was.

[7] The correct way to finish off skiing Sugar's Run is to make a right hand turn and ski along a groomed area parallel with the deer fence. Some of the deer fence posts at the base of the run were padded as a safety precaution but others further along from where the right hand turn should properly be made were not padded in the apparent belief that they would not pose a hazard to the skiers. None of the wire between any of the posts had any padding or anything else that would prevent a skier from colliding with it or mitigate any damage if he/she did hit it.

The Incident

[8] On the morning of 21 September 2019 Ms Anita Graf-Russell was skiing with a group of friends at Coronet Peak. It was a beautiful morning for skiing and Ms Graf-Russell had skied a number of runs or trails. She was a very accomplished skier who could ski on various trails and runs without any difficulty.

[9] The group that she was with were meeting for breakfast/brunch at a café on the mountain but before doing so she decided to ski Sugar's Run.

[10] Ms Graf-Russell was observed by others to come down Sugar's Run and as she came to the end of the run she moved to her right. Instead of completing the right hand turn and continuing on her way she skied into one of the deer fence posts and collapsed. Medical assistance, including a doctor, arrived reasonably quickly and found her in a state of unconsciousness. After a period of time her breathing ceased and despite all the medical attention she was given, including CPR, she died at the scene.

[11] A post-mortem examination was carried out by Dr Lennard Wakefield. Dr Wakefield concluded that Ms Graf-Russell's death was caused by blunt force trauma, cardiac tamponade (obstruction to the flow of blood) and cardiac lacerations. He determined the manner of death as a presumed accident.

[12] Dr Wakefield gave evidence at the trial and said that the injuries he documented were as a result of Ms Graf-Russell's impact with the fence.

The Charge

[13] As a result of this incident a charging document was laid against the Defendant by the Informant for a breach of the Health and Safety At Work Act 2015 ("the Act"). That charge alleges as follows:

"**Date of offence:***	on or about 21 September 2019
Offence location:*	Coronet Peak, Queenstown

Offence description: Being a PCBU who controls or manages a workplace, namely Coronet Peak Ski Field, Queenstown (the **Ski Field**), failed to ensure so far as was reasonably practicable, that the workplace was without risks to the health and safety of any person, including Anita Maureen Graf-Russell, and that failure exposed Anita Maureen Graf-Russell to a risk of serious injury or death, arising from collision with a fence post that was part of a double height deer fence surrounding a water reservoir, at the base of the Sugar's Run ski trail, at the Ski Field

Particulars: It was reasonably practicable for NZSKI Limited to have:

(a) Conducted an adequate risk assessment to identify the hazards and risks associated with the deer fence on the Sugar's Run ski trail.

(b) Installed safety catch-net fencing along the full length of the turn at the bottom of Sugar's Run ski trail.

Legislative reference:*Sections 37(1), 48(1) AND 2(c) of the Health and Safety at Work Act."

[14] Pursuant to s 3 the main purpose of the Act is to provide for a balanced framework to secure the health and safety of workers and work places by protecting workers and other persons against harm to their health, safety and welfare by eliminating or minimising risks arising from work and work places. In furtherance of that purpose 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.

[15] What is "reasonably practicable" is defined in s 22 of the Act:

> 22 Meaning of reasonably practicable
>
> In this Act, unless the context otherwise requires, reasonably practicable, in relation to a duty of a PCBU set out in subpart 2 of Part 2, means that which is, or was, at a particular time, reasonably able to be done in relation to ensuring health and safety, taking into account and weighing up all relevant matters, including—
>
> (a) the likelihood of the hazard or the risk concerned occurring; and
>
> (b) the degree of harm that might result from the hazard or risk; and

(c) what the person concerned knows, or ought reasonably to know, about—

(i) the hazard or risk; and

(ii) ways of eliminating or minimising the risk; and

(d) the availability and suitability of ways to eliminate or minimise the risk; and

(e) after assessing the extent of the risk and the available ways of eliminating or minimising the risk, the cost associated with available ways of eliminating or minimising the risk, including whether the cost is grossly disproportionate to the risk.

[16] It is accepted in this case that the Defendant is a Person Conducting a Business or Undertaking ("PCBU").

[17] Section 37 of the Act sets out the duty of a PCBU who manages or controls a workplace:

37. Duty of PCBU who manages or controls workplace

(1) A PCBU who manages or controls a workplace must ensure, so far as is reasonably practicable, that the workplace, the means of entering and exiting the workplace, and anything arising from the workplace are without risks to the health and safety of any person.

(2) Despite subsection (1), a PCBU who manages or controls a workplace does not owe a duty under that subsection to any person who is at the workplace for an unlawful purpose.

…

(4) In this section, a PCBU who manages or controls a workplace—

(a) means a PCBU to the extent that the business or undertaking involves the management or control (in whole or in part) of the workplace; but

…

[18] Section 48 of the Act is the offence provision section and it provides as follows:

48 Offence of failing to comply with duty that exposes individual to risk of death or serious injury or serious illness

(1) A person commits an offence against this section if—

(a) the person has a duty under subpart 2 or 3; and

(b) the person fails to comply with that duty; and

(c) that failure exposes any individual to a risk of death or serious injury or serious illness.

[19] As noted in the charging document, the Informant has set out two separate particulars that it says were "reasonably practicable" ways that the Defendant could have reduced or eliminated the risk of serious injury or death to any person, including Ms Graf-Russell, those particulars are:

(a) It was reasonably practicable for the Defendant to have conducted an adequate risk assessment to identify the hazards and risks associated with the deer fence on the Sugar's Run Ski Trail; and

(b) It was reasonably practicable for the Defendant to have installed safety catch net fencing along the full length of the turn at the bottom of Sugar's Run Ski Trail.

[20] To find the Defendant guilty of the charge it is not necessary for the Informant to prove that both of the particulars were reasonably practicable ways of preventing death or serious injury. It is sufficient if it is able to prove either one of them beyond reasonable doubt.

[21] The particulars stipulated in the charging document as to what the Informant alleges were reasonably practicable steps for the Defendant to take are extremely important and provide the foundation to the charge. It is clear from the Court of Appeal decision in *Talleys Group Limited v Worksafe New Zealand*[1] that they are the very "pith and essence" of the charge. As a result it is my obligation to determine the charge based on what is alleged against the Defendant in those particulars and not to stray outside them.

[22] Before the Defendant can be found guilty of this charge there are five separate elements each of which must be proved beyond reasonable doubt by the Informant.

(1) The Defendant was a person carrying out a business or undertaking (PCBU).

[1] *Talleys Group Limited v Worksafe New Zealand* [2019] 2 NZLR 198 at [41]

(2) The Defendant was managing or controlling a workplace, namely The Coronet Peak Skifield.

(3) Ms Graf-Russell was not at the workplace for an unlawful purpose.

(4) The Defendant did not ensure, so far as is reasonably practicable, that the workplace, was without risk to the health and safety of any person.

(5) That the failure set out in (4) exposed any person to a risk of death or serious injury.

[23] The Defendant accepts that the first three elements have been proved beyond reasonable doubt but strongly challenges the fourth and fifth elements.

[24] What amounts to "reasonably practicable" steps has been the subject of a number of decisions in this country and in Australia. The approach taken is consistent and is encapsulated in the comments of Collins J in *Waimea Sawmillers Limited v Worksafe New Zealand*[2]*:*

> "[36] The Act does not require an employer to ensure complete protection of an employee. Rather, the Act imposes an obligation on an employer to take all reasonably practicable steps to guard against potential hazards. Whether a practicable step has been taken cannot be determined with the benefit of hindsight or on what was known after the event. The relevant point in determining what is practicable is a point in time immediately prior to the incident."

[25] In *Worksafe New Zealand v Ministry of Social Development*[3] Doogue CDCJ (as she then was) in applying what Collins J said in *Waimea* said as follows:

> "[3] The task before the Court is to assess what security arrangement was appropriate at the defendant's Ashburton office on 1 September 2014. It is crucial to avoid applying the benefit of hindsight. We know now that employees did in fact face a lethal hazard. However, the appropriate question in this case is to determine whether the hazard of client initiated violence was reasonably predictable, and if so, whether the defendant took all practicable steps to address that hazard, given the knowledge available prior to the incident."

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[2] *Waimea Sawmillers Limited v Worksafe New Zealand* [2016] NZHC 915
[3] *Worksafe New Zealand v Ministry of Social Development* [2016] NZDC 24649

Issue (1) – Failure to undertake adequate risk assessment to identify hazards and risks

[26] On 30 January 2020 Mr Jason McDonald the health and safety inspector in charge of the investigation interviewed Mr Paul Anderson the Chief Executive Officer of the Defendant and Mr Logan Miller the Group Health and Safety Manager for Trojan Holdings Limited which is the company that owns the Defendant. The interview took place in the presence of a solicitor acting for the Defendant. It was confirmed at the start of the interview that both Mr Anderson and Mr Miller were authorised to speak on behalf of the Defendant.

[27] Early in the interview Mr Anderson outlined in some detail the Defendant's commitment to health and safety saying it was its first priority. Mr Anderson emphasised the importance of worker participation around thoughts and ideas about health and safety and how it was important to the Defendant to also get anecdotal feedback from guests and staff which could be used to improve health and safety practices.

[28] Mr Anderson put it on the basis that the company had hundreds and thousands of eyes and ears during the ski season and that feedback was really valuable. He said that in terms of making changes, recommendations were made to the Board but lower level things would be acted on immediately and staff were empowered to make the changes immediately to reflect changing conditions. He was able to say that in his time as CEO no health and safety recommendations made to the Board had ever been declined.

[29] Mr James Lazor gave expert evidence for the defence on the Defendant's health and safety systems for the Coronet Peak ski area. In his evidence he said that the Defendant's health and safety vision prioritised safety over business pressures and gave staff the ability to speak up to stop unsafe behaviour, reporting incidents, including near misses and communicating with employees and contractors to manage hazards on site. He said that the Defendant's corporate culture with a vision of safety was clearly spelt out in its health and safety policy.

[30] In 2019 Sugar's Run was realigned as a result of a new chairlift being put in and as stated previously the deer fence around the reservoir was heightened. During the course of the investigation the only document from the Defendant to reference and assess the risk posed by the deer fence was a 2014 document entitled "Padding Hazard Register Grid A2". That document was produced as Exhibit 11 at the trial.

[31] The first entry in that document states as follows:

> "Elephant Pit Reservoir. 28 fence posts, metal deer fencing and strainers very likely to be skied into at high speed. Several serious harm injuries have occurred already. Many near misses."

[32] The evidence is that the document was created by Ashley Stewart, who was a ski patrol member at the time, and was last saved on a computer on 9 October 2014.

[33] In his evidence Mr Lazor acknowledged that members of the ski patrol are highly regarded professionals. He said that a patrol department works as a team and group decisions identifying risks are the norm. He said that the Defendant's ski patrol is assigned to manage the risk assessment programme and conduct risk assessment daily. The patrol was trained in risk assessment methodology and possesses the necessary knowledge and experience to identify potential hazards and risks associated with those potential hazards.

[34] It is my understanding from the evidence that the Informant became aware of Exhibit 11 when it was supplied to it by the Defendant during the course of the enquiry that led to the current charge.

[35] Unsurprisingly Mr McDonald asked Mr Anderson and Mr Miller about this document during their interview on 30 January 2020. I consider the questions and answers are extremely significant and therefore I am setting them out in full in this judgment so that the flavour and context of that discussion can be appreciated:

> JM is Jason McDonald
> PA is Paul Anderson
> LM is Logan Miller
>
> "PA … which is really important that we get that worker participation and um, their engagement and their kind of almost I'd say unprompted thoughts and ideas about health and safety so we've tracked that over

um, the last five or six years. Um, as well as guest injury statistics so we have ah grids on each mountain and we can track where injuries are happening and then that would feed in to our works programme so we have repairs and maintenance or larger capital works …

…

PA … on the mountains, and also anecdotal feedback from guests and staff, un, is used to improve health and safety practices because we've got hundreds of thousands of eyes and ears …

…

PA …which is really important that we get that worker participation and um, their engagement and their kind of almost I'd say unprompted thoughts and ideas about health and safety so we've tracked that over un, the last five or six years. Um, as well as guest injury statistics so we have ah grids on each mountain and we can track where injuries are happening and then that would feed in to our works programme so we have repairs and maintenance or larger capital works…

PA …on the mountains, and also anecdotal feedback from guests and staff, um, is used to improve health and safety practices because we've got hundreds of thousands of eyes and ears…

…

JM … So I want to have a bit of a chat about the document that you supplied on the 25th of November and that was the 2014 fencing padding assessment document…

PA Yeah.

JM …um, do you want to, do you want to just talk about that in general to start with and then we can get in to specifics if we need to.

PA Yeah sure, um yeah so on that through this investigation we have been made aware of that detailed Risk Assessment that was undertaken by a staff member in patrol, in the Coronet Peak patrol team…

JM Yeah.

PA …um, we actually found it on um, his personal directory…

JM Okay.

PA …um, personally I was never made aware of it until after the accident as I said during, during the investigation that has followed. What I believe is that it is likely that that went to the Ski Area Manager at the time or recommendations to him were based on that Assessment…

JM Right.

PA …um, but the, but the recommendations made for budgets didn't include that post, the post in question. They included on the ten in the

fall line, um, I, I can't explain why that um, why rather than 28 posts, 10 posts were padded, um, because that knowledge rests with that departed um, Ski Area Manager, and I am disappointed that the full recommendations of that report weren't passed on um, or used in the recommendation um, because the, our Ski Area Mangers are all aware of the importance we place on safety measures…

JM Mm.

PA …and they are aware of the Board's appetite for improving such things so…

JM Yeah.

PA …um, it, it's certain that if that had been recommended it would have been approved.

JM Okay, okay, ah so you say this member of the patrol team, it was found on his personal drive, um, you say it is likely that it went to the, the Manager of that patrol team or recommendations based on that report…

PA Correct.

JM …um, the patrol team member has left…

PA Yes, yeah.

JM …the organisation…

PA Yeah.

JM …what, do you have their name?

PA Yes, I do.

JM Yeah, yeah.

LM We'll supply that, we'll send that through.

JM Yeah, I'll put a request through for that, that's all fine…

LM That's fine, we'll send that through to you.

JM Ah and what about the Manager?

PA The Manager has also left.

JM He's also left, so…

LM The Ski Area Manager…

JM Yeah.

LM …at the time has left…

JM Yeah.

LM …um so again we can send those details if you put out a request for it and we will send it through.

JM Okay.

LM I think you know the company acknowledges that obviously that Risk Assessment is quite a detailed assessment…

JM Mm.

LM …um, so there would have been a lot of time and effort put in to it by that staff member. It is unfathomable that, that somebody would have done all of that work without other Managers being aware of it…

JM Mm.

LM …and the fact that unfortunately it wasn't passed up the food chain further…

JM Mm.

PA … it is the really disappointing point.

JM Yeah, well it was good that you were able to access the personal drive I guess …

PA Yeah …

JM … um, I imagine it would have come as a bit of a shock to you as well.

PA … that was a WTF the moment yeah.

JM Yeah, yeah.

PA Yeah, for sure.

JM So that's fed in, you've been doing an internal investigation yourselves?

PA Yes we have yeah.

JM Yeah, yea, so that's all fed in to, in to your work that you are doing on that?

PA Yeah

JM Ah are you aware of the qualifications of the ah Patrol team member that wrote this?

PA Um, I'm not, not of his specific qualifications but we will have that on record…

JM Yeah, okay, I'll just add that to my request …

LM We understand that he was an experienced, ah two or three years patroller, and …

PA I know of him personally …

JM Yeah

PA … I can remember him yeah.

JM And how long ago has it been since he left the company?

LM Again we'll confirm this, but …

PA Yeah, let me confirm that.

LM … I believe it was two years post that review …

JM Okay

LM … is when he left; I think it was the '16 season was his last season …

JM '16 okay.

LM … and again we can confirm that with that request.

JM Yeah, okay ah, and you're not certain that the manager had seen that document but you are fairly confident that someone in that you know immediately above the patrol member who wrote it …

PA Yeah

JM … would have been aware of the work that was being done.

PA Yeah, yeah and the recommendation that was referred to Risk Assessment and that recommendation came from the Ski Area Manager …

JM Mm, okay.

PA So I'm assuming that was the risk assessment he was referring to …

JM Yeah, okay, so they've made a recommendation for that …

PA Yeah

LM Just to be blear on that though, so the recommendation that come through from the Ski area manager …

JM Mm.

LM … was to pad ten posts in that fence and referred to a Risk Assessment but not in detail the assessment done um, by that patroller …

JM Okay

LM … um, and it was that, that request for capital expenditure that went through to the CEO Paul and then through to the Board and was approved with no issues at all, um …

JM Okay

[silence]

JM Has there been any review of the same kind of risk assessment being done or looked at or has it been I suppose put in a formalised manner as this so the two; if I'm being a bit messy here with that …

PA Yeah

JM … um, if I'm being clear, ah has there been another risk assessment of that nature about padding of posts completed in a a, in a documented form of the Elephant Pit posts since then?

PA No, not since that we've been able to find."

[36] It is clear from that interview that the company accepts that the content of Exhibit 11 would have been made available to the ski area manager and Mr Miller accepted that it was unfathomable that somebody would have done all that work without other managers being aware of it and that it was unfortunately not passed up the food chain further. It is accepted in this interview that the company was put on notice of serious safety issues concerning the deer fence and it was not dealt with in such a way that an overall adequate risk assessment of the deer fence could be undertaken.

[37] In his original report which he read at the trial as his evidence in chief Mr Lazor, the defence expert, attempted to totally minimise the importance of Exhibit 11. He described the author of it as a junior ski patroller and he said there was no mention of this junior ski patroller handing in the information in Exhibit 11. His criticism of the "junior ski patroller" hardly aligns with his earlier evidence about the approach taken by the Defendant in giving staff the ability to speak up to stop unsafe behaviour. If a report such as Exhibit 11 detailing major safety concerns about the deer fence is not properly followed up then stating it is company policy to act on safety recommendations or suggestions from staff becomes almost meaningless.

[38] However as I understand from his evidence Mr Lazor had not been supplied with a copy of the transcript of the interview I had referred to and was not aware of the comments made by Mr Anderson and Mr Miller on this topic.

[39] During the interview Mr McDonald asked whether there had been any other risk assessments about padding on posts completed in a documented form on the Elephant Pit posts since then (since 2014). Mr Anderson replied:

> "No, not since that we have been able to find."

[40] There is one other portion of that interview that needs to be recorded verbatim in this decision. It deals with the knowledge that Mr Anderson had that there had been patrollers who had found themselves on that fence:

> "JM Okay, thanks for that. Have, have you had any previous incidents on that fence before? We kind of touched a little bit on it but I don't think we really probably did it justice.
>
> PA So, there's um, there are a few incidents, relatively small number on Sugar's run itself …
>
> JM Right.
>
> PA … that haven't identified specifically in our system whether they were on the fence …
>
> JM Okay
>
> PA … we are aware um, more through, more through our investigations that during the patrol run checks, there have been patrollers who have found themselves on that fence …
>
> JM Okay
>
> PA … that's the nature of their role, they, they would have, it might have been hard conditions that made them slide further than they expected, um, but that, that's all …
>
> LM And just to point out that there is predominantly anecdotal …
>
> JM Mm
>
> LM … from the reporting that we have got around that."

[41] During 2014 the evidence shows that the Defendant had actual knowledge of the risk posed by the deer fence. This included the identification of 28 fence posts that were very likely to be skied into at high speed. It was aware that several serious harm injuries had occurred already and that there had been many near misses. Ashley Stewart gave the risk score as 10 out of 10. While some attention may have been given to that report and some posts may have been padded as a result of it, it is quite clear that no proper assessment was done so that those responsible for safety on the

mountain could properly formulate the appropriate way to mitigate what was an obvious danger.

[42] Because the charging document refers to risk of serious injury or death arising from collision with "a fence post" that was part of a double height deer fence Mr Rapley's submissions were focused almost exclusively on what has been described as post 10, the post that Ms Graf-Russell skied into that led to her death.

[43] While it is understandable that Mr Rapley would prefer to narrow the focus to that single fence post the charge could equally be seen to referring to the fence generally. In the end whichever approach is taken it cannot assist the Defendant on the first particular. Once the company had knowledge of the dangers presented by the deer fence overall it was not only reasonably practicable for it to conduct an adequate risk assessment to identify all of the hazards and risks it was absolutely essential that they did so. Any such risk assessment would have to consider the fence overall and determine the extent of the risk at various parts of the fence and how that risk should be mitigated and/or managed.

[44] Despite being informed of the dangers posed by the deer fence in 2014 no adequate risk assessment was undertaken at that time or later. It is little wonder that Mr Anderson described it as a "WTF (what the fuck) moment when he became aware of the contents of Exhibit 11".

[45] Based on the interview with Mr Anderson, between 2014 and the time of the death of Ms Graf-Russell, the Defendant was also aware that there had been ski patrollers, the elite group directly responsible for identifying safety issues, who had found themselves on that fence. There is no evidence that any adequate risk management of the deer fence has taken place at any stage since 2014.

[46] Relying on the authority of *Maritime New Zealand v Glass Bottom Boat Limited*[4] Mr Rapley submits that a failure to perform an adequate risk assessment merely states an omission and does not identify the action (or failed action) that the

[4] *Maritime New Zealand v Glass Bottom Boat Limited* [2018] NZHC 81 at [33]

Defendant was required to take. He further submits that a result the failure to conduct an adequate risk assessment cannot support the charge.

[47] The *Glass Bottom Boat* decision was the result of a civil appeal about s101 of the Act dealing with the power of an inspector to issue Improvement Notices. The decision is confined to the statutory interpretation of that particular section. The decision has no relevance at all to the provisions of the Act upon which this prosecution is based.

[48] The whole purpose of the Act as it relates to PCBUs is to impose upon them an ongoing obligation to undertake adequate risk assessment and to address health and safety issues on that basis. I consider that if Mr Rapley's submissions on this point were correct then that would amount to an almost complete evisceration of the purposes of the Act. As Downs J said in *Worksafe New Zealand v Dong SH Auckland Limited*[5]:

> "[28] Four things about all this stand out. First, the breadth of duties created by the Act. Second, the Act's emphasis of its purpose, including through creation of the principle that workers and others should be given the highest level of protection. Third, the breadth of the concept of a PCBU. Specified exemptions alleviate a wide-ranging definition. Fourth, the Act's emphatic rejection of form in the advancement of purpose."

[49] I am satisfied beyond reasonable doubt that it was reasonably practicable for the Defendant to have conducted an adequate risk assessment to identify the hazards and risks associated with the deer fence on Sugar's Run ski trail. I am also satisfied beyond reasonable doubt that the Defendant failed to undertake any such risk assessment.

Issue (2) – Failure to install safety catch net fencing along the full length of the turn at the bottom of Sugar Run's ski trail.

[50] It is the case for the Informant that the Defendant should have installed safety catch net fencing along the full length of the turn at the bottom of Sugar's Run ski trail

[5] *Worksafe New Zealand v Dong SH Auckland Limited* [2020] NZHC 3368

after the deer fence was built. If it had, Ms Graf-Russell would have collided with that catch net fencing and been protected from the deer fence behind it.

[51] In his evidence Mr McDonald makes it clear that the Informant focused on catch net fencing as a result of an expert opinion it had received. It was as a result of the expert opinion that the Informant asserted that it was reasonably practicable for the Defendant to have installed catch net fencing. In other words the Informant has relied completely on the opinion of their expert to support one particular of the charge.

[52] The expert relied upon was Ms Sue Graham. Ms Graham read her expert opinion report as her evidence in chief at the trial and she was extensively cross-examined by Mr Rapley.

[53] The cover sheet of the report says "Expert Opinion Report for Worksafe New Zealand on the fatality at Coronet Peak Ski Field occurring on 21 September 2019 written by Sue Graham August 2020". At the end of the report it is signed by Ms Graham and dated 8 October 2020 which seems to be some weeks after it was written. The charging document in this case is dated 26 August 2020.

[54] In her report at page 5 under paragraph [6](a) dealing with foreseeability of the incident she says:

> "It is accepted ski industry practice to provide protection (by erected permanent or temporary safety nets or fences, padding and/or signage) to those areas which there is a risk of skiing, sliding or falling into a hazardous situation. The use of safety and catch nets is widespread in the ski industry and ski racing."

[55] In cross-examination Mr Rapley referred that passage to Ms Graham and asked her to give some examples of New Zealand ski fields that used safety catch nets as at 21 September 2019. Ms Graham was unable to give any examples at all.

[56] During the cross-examination of Ms Graham it became increasingly clear that she had little knowledge of the different sorts of safety catch nets that could be used for different purposes. In his submissions Mr Rapley referred to many different pieces of evidence given by Ms Graham during the course of her cross-examination which he said shows that she had no real expertise at all in the area of catch net fencing.

[57] It is not necessary in this decision to set out the various criticisms made by Mr Rapley of Ms Graham's evidence on this point. It is sufficient to say that I agree with most of them and I do not accept based on the evidence that she gave at the trial, that she can be considered an expert on catch net fencing and therefore her opinions in relation to it as it effects this case cannot be relied upon.

[58] Despite the fact that the Informant clearly included the particular about catch net fencing in the charging document based on advice from Ms Graham and despite the reliance placed on her evidence in her opening statement, Ms Hogan has now submitted that in establishing that it was reasonably practicable for the Defendant to instal safety catch net fencing the Informant is not dependant on the evidence given by Ms Graham. In her submissions she sets out a comprehensive table identifying over a number of years the use of various catch nets at Coronet Peak. She also points out that was is described as A Net Fencing was constructed by the Defendant along the full length of the turn at the bottom of Sugar's Run ski Trail after the death of Ms Graf-Russell and before the commencement of the 2020 ski season on 26 June 2020. She submits that because such a catch net was constructed voluntarily by the Defendant within months of Ms Graf-Russell's death then that sort of catch net fence would have been available prior to her death and should have been in place at the time of the accident.

[59] Mr Lazor gave comprehensive evidence about catch net fencing as well. He detailed the various types of catch net fencing that existed and what they were used for. He concluded in his view that it would not have been practical for the Defendant to instal safety catch net fencing along the deer fence as such fencing at that time had not been commonly used in the ski industry in New Zealand other than on competitive ski racing where B netting was used.

[60] In the end I am left in a situation where I do not know what type of catch net fencing the Informant considers should have been in place along the full length of the turn at the bottom of Sugar's Run ski trail. I have no evidence from the Informant as to whether any particular type of catch net fencing would actually alleviate the identified risk. In the end I have no acceptable evidence at all as to whether it would actually be reasonably practicable to instal some type of safety catch net fencing and

if so, what type. Accordingly I find that the Informant has not established that it was reasonably practicable for the Defendant to install safety catch net fencing along the full length of the turn at the bottom Sugar's Run ski trail.

Various Other Matters

(a) *Pathological Evidence*

[61] Dr Martin Sage, a very experienced pathologist was called as a defence witness. He raised the possibility of an adverse medical event occurring to Ms Graf-Russell immediately before she collided with the fence post. He also raised the possibility that some of the internal injuries recorded at post-mortem could have been caused by vigorous CPR applied to Ms Graf-Russell at the scene before she died.

[62] While there was no evidence of any prior medical event at post-mortem Dr Wakefield could not entirely rule it out because on occasion there can be issues, particularly relating to the heart, that have occurred prior to death that cannot be picked up post-mortem.

[63] There was some conflicting evidence about how Ms Graf-Russell presented to various people she spoke to or had come into contact with that morning prior to the accident. She was described as being confused and that she did not appear to remember what runs she had completed. Others who knew her well found her to be her normal happy herself enjoying her skiing on a beautiful morning.

[64] While I accept it is impossible to rule out that Ms Graf-Russell may have had some medical event immediately before colliding with the fence post there is absolutely no evidence to indicate that any such event occurred. In any event consideration of a prior medical event is largely irrelevant to what I have to determine. Medical events on the mountain must be something that are taken account of in health and safety planning bearing in mind the large number of people over all age groups that can be skiing or snowboarding on the ski field at any given time.

[65] As far as the CPR issue is concerned I believe that is best answered by Dr Wakefield who in the course of his evidence said as follow:

> A. It's my position that the injuries that are documented resulted from impact with the fence and I say that because after the impact with the fence Ms Graf-Russell was unresponsive, she made a few grunts, a few sounds, she had a heartbeat and she had some circulation and she was breathing. She had to have circulation to breathe. If she didn't have any circulation her brain wouldn't be getting blood and it wouldn't be saying take a breath, take a breath. So she had circulation and she had a heartbeat. And then, over a period of time, she progressively deteriorated to the stage at which she needed CPR. And when did she need CPR? When her injuries were such that she lost her pulse and she stopped breathing. So she'd had those life threatening injuries prior to CPR starting and CPR may have been additive to those injuries, but she already sustained them before the resuscitation, the CPR, commenced. It's a basic timeline. It's basic common sense.

[66] In addition, as Ms Hogan emphasised in her submissions, the charge relates to the "**risk"** of serious injury or death. Quite apart from the internal injuries which caused her death Ms Graf-Russell suffered serious injuries to her head and neck. These were in no way connected to CPR.

(b) *The Peak Safety Report*

[67] In August 2016 at the request of the Defendant a private company called Peak Safety Limited did a report on the ski patrol safety system at Coronet Peak. The report did not identify the deer fence at the base of Sugar's Run as a safety issue, in fact it was not mentioned in the report at all. From the Defendant's point of view this simply reinforces its position that the deer fence was not a health and safety hazard nor a risk to skiers or it would have been identified as such in the report.

[68] The report expressly recommended that the Defendant undertake "a systematic hazard assessment of the man-made structures on the resort to establish what, if any, protection would be suitable for these". No such hazard assessment was made by the Defendant of the deer fence.

[69] The principal responsibility for ensuring health and safety lies with the PCBU conducting a business or undertaking. That positive duty under the Act requires the

PCBU to make the proper safety and health assessments. That did not happen in this case.

Conclusions

[70] For the reasons I have already given I am satisfied that this charge is proved beyond reasonable doubt. I am satisfied as follows:

(a) That the Defendant was a person carrying out a business or undertaking (PCBU) at the Coronet Peak Ski Field on 21 September 2019.

(b) That the Defendant was managing or controlling a workplace namely the Coronet Peak Ski Field.

(c) That Ms Graf-Russell was not on or at the workplace, for an unlawful purpose.

(d) That the Defendant did not ensure, so far as was reasonably practicable, that the work place was without risk to the health or safety of any person. I find that it was reasonably practicable for the Defendant to have conducted an adequate risk assessment to identify the hazards and risks associated with the deer fence on Sugar's Run ski trail and that the Defendant failed to do so.

(e) That this failure exposed Ms Graf-Russell to a risk of death or serious injury by colliding with Post 10 which was part of the deer fence that was unprotected and which had not been the subject of an adequate risk assessment to identify the hazards and risks associated with it.

[71] The Defendant is convicted of the charge. A date for sentence needs to be set as soon as possible and the Registrar will liaise with Counsel and with me to identify a suitable date. I consider there would likely be some benefit in having a telephone conference to address the logistics of sentencing. Consideration needs to be given as to whether Counsel and myself should be present in person at the Queenstown District Court or whether it can be dealt with by one or more of the participants being present

by AVL. I will leave Counsel to discuss that issue and to get back to me through the Registrar with their views.

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Judge G A Rea
District Court Judge | Kaiwhakawā o te Kōti ā-Rohe
Date of authentication | Rā motuhēhēnga: …15/08/2023