

**IN THE DISTRICT COURT
AT AUCKLAND**

**I TE KŌTI-Ā-ROHE
KI TĀMAKI MAKĀURAU**

**CRI-2019-004-007831
[2020] NZDC 25308**

WORKSAFE NEW ZEALAND
Prosecutor

v

PORTS OF AUCKLAND LIMITED
Defendant

Hearing: 4 December 2020

Appearances: B McCarthy and V Veikune for the Prosecutor
J Billington QC and J Mills for the Defendant

Judgment: 4 December 2020

NOTES OF JUDGE E M THOMAS ON SENTENCING

A. The defendant is fined \$540,000.

**B. The defendant is ordered to pay total reparation of \$136,000 and
prosecution costs of \$5,000.**

REASONS

Introduction

[1] Laboom Dyer was 23 when he was tragically killed. His death has deeply affected those around him. He leaves behind grieving family and friends. His young son Noah will only ever have the barest memories of his father. Adding to the tragedy, his death was preventable.

[2] Mr Dyer was a stevedore who had worked for the Ports of Auckland since 2015. Since 2016 his role was that of a straddle driver. A straddle is a mobile crane unit used to lift and transport shipping containers. The driver sits in a cab mounted high up on the left-hand side of the straddle, 13 metres above the ground. The cabs are equipped with internal CCTV, seatbelts and a tip alarm. Drivers are directed where to do by controllers. The controllers communicate their instructions to the drivers via a display unit in the straddle cab.

[3] Obligations imposed on its drivers by the Ports of Auckland included among other things not using a cellphone while you are operating the straddle and wearing a seatbelt.

The incident

[4] Mr Dyer was working the night of 26 to 27 August 2018. Straddle drivers operate on a two-hours on, 40 minutes off rotation. Mr Dyer had already completed three two-hour stints, each of those stints involved collecting containers from a particular gantry. He began his fourth stint just after 3.30 in the morning on 27 August. As he headed to the gantry where he had been working throughout his shift, he received instructions to go to a different one. At around that time he was also on his cellphone. He did a u-turn, first by turning to the left before sharply turning to the right. He was travelling close to the Ports of Auckland imposed speed limit on the wharf for straddle drivers of 25 kilometres per hour. As he turned, the straddle tipped onto Mr Dyer's side. Mr Dyer, who was not wearing a seatbelt, fell backwards out of his seat. He suffered serious injuries. He passed away on 2 September 2018.

The offending

[5] The investigation by WorkSafe revealed the following gaps in training or processes for straddle drivers:

- (1) A lack of training around performing tight turns at low speed to avoid tipping, despite specific instructions on how that should be done being in the manufacturer's operating manual.
- (2) Not providing that manual to drivers as part of their training.
- (3) A lack of promoting awareness about tipping generally.
- (4) Insufficient training about how to respond to a tip alarm activation and in ensuring that drivers were aware that there was no automatic braking or autocorrection following an activation.
- (5) Insufficient monitoring of tip alarm activations.
- (6) Insufficient monitoring of CCTV footage for driver compliance, particularly around cellphones or seatbelts.
- (7) Operating a bonus system based on productivity which would cause drivers to feel that they had to work as fast as possible. Mr Dyer had a high tip alarm activation record. Despite that record he consistently received his bonuses.

[6] Ports of Auckland has pleaded guilty to a charge of failing to ensure the health and safety of workers and thereby exposing Mr Dyer to the risk of death. The maximum penalty is a fine of \$1.5 million. It accepts that notwithstanding any actions taken by Mr Dyer, it has failed to take the following reasonably practicable steps:

- (1) Developing, documenting, communicating and implementing appropriate training for straddle drivers in relation to the risk of the

straddle carrier tipping while turning, the operation and significance of the tip alarm and the actions to be taken if the tip alarm were activated.

- (2) Ensuring there was an effective system for monitoring and addressing tip alarm activations.
- (3) Ensuring there was an effective system for monitoring and enforcing safety policies concerning seatbelts and cellphones.
- (4) Ensuring that the bonus scheme incorporated parameters that promoted safe driving, to counter any incentive to achieve greater productivity at the expense of safety.

Reparation

[7] The approach to sentencing is well settled.¹ I turn firstly to the issue of reparation.

[8] The victim impact reports that have been filed set out the emotional harm that those connected to Laboom Dyer have suffered. That harm is significant. It is not unexpected. It is exactly what you would regrettably expect to see. I need not go through those victim impact statements here and now. I have read them and they speak for themselves. Ports of Auckland accepts the harm that has been caused. There is also some consequential financial loss that has been suffered.

[9] Both sides have referred me to cases where the courts have assessed reparation. Reparation is a largely intuitive exercise. How can you place a value on a life? How can you place a value on what it means to lose someone, what it means to lose a grandson, a nephew, a partner, a father? You cannot place any price on that. Reparation is in some ways a very unfair word. It is a token only of what people have lost.

¹ *Stumpmaster v WorkSafe New Zealand* [2018] NZHC 2020

[10] Based on the cases that the parties have referred to, I agree broadly with their assessment of what the authorities allow me to order. I assess reparation at \$130,000. \$80,000 of that will go to Noah, \$20,000 to Tua Dyer Junior, and \$30,000 to Mr Dyer's other family members. I also award \$6,000 to Ms Riley in respect of the additional expenses that you have paid for. It is particularly difficult for that sum to be limited to only \$6,000 because of the consequences of ACC. But that is regrettably how the law sees that.

Fine

[11] The failures represent a systemic failure to instil and maintain a culture of safety and to monitor compliance. It is aggravated by Ports of Auckland having some previous knowledge about tipping. It also understood that there were concerns in the industry about the bonus scheme and how it was to operate. These things were known to Ports of Auckland before Mr Dyer's death. The risk of harm was significant. The potential for serious injury or death was obvious. The tragic outcome here was reasonably foreseeable. The training provided fell well short of what was contained in the manufacturer's manual. The bonus scheme departed from the industry standard. The hazard was obvious. Ports of Auckland was aware of it, there were previous instances that they knew about from ports around New Zealand. One was at its own site in 2009.

[12] To be fair to Ports of Auckland, it had identified that risk. It had in fact dedicated significant resource to addressing the risk of tipping in 2017. There were a high number of tip alarm activations. It was concerned. It was right to be concerned. It understood that it was not doing enough to deal with the high number of activations. It put together a concerted initiative to identify the tip alarm activations and take the necessary steps, including re-education of drivers to significantly reduce those tip activations, because of the obvious risk that tipping posed. Through that initiative it did significantly reduce tip activations. However, having achieved that, it stopped the project. By the time of this fateful night, activations were back to their pre-project levels.

[13] The steps Ports of Auckland should have taken were available. They were affordable. They were effective.

[14] That combination of factors places their culpability around mid-range in the high culpability band identified by the High Court in *Stumpmaster*. Based on the cases referred to by both parties I take a starting point for the fine of \$850,000.

[15] Ports of Auckland has previous convictions for health and safety breaches. That warrants an uplift to that \$850,000 by five per cent.

[16] Since then, it has done what it can. It cooperated throughout the investigation. It did what it could to assist the family. It has expressed remorse and it has backed up remorse through its actions. It is willing to and wishes to pay reparation. It has taken the steps that it can do to remedy all defects and recognises that it needed to take those steps well before August 2018. It has pleaded guilty. Not early, however it had always signalled an intention to plead guilty to this charge. It had always accepted these failings. For that reason, it is entitled to a 25 per cent discount for the guilty plea.

[17] All the mitigating factors take the fine down to an end point of \$540,000.

Costs

[18] The prosecution is entitled to a contribution towards the costs of the prosecution. Both sides recognise that that can only be a token amount. \$5,000 is sought by WorkSafe. Ports of Auckland does not oppose that.

Proportionality adjustment

[19] Neither party argues that there should be any adjustment. I agree that that is appropriate.

Result

[20] Ports of Auckland is fined \$540,000.

[21] It is ordered to pay reparation of \$136,000. The breakdown of that reparation is:

- (a) \$80,000 to Mr Dyer's son Noah,
- (b) \$20,000 to Tua Dyer Junior,
- (c) \$30,000 to the remainder of his family, and
- (d) \$6,000 to Ms Riley.

[22] It is also to pay costs to the prosecution of \$5,000.

Judge EM Thomas
District Court Judge

Date of authentication: 05/01/2021

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