SUBMISSION OF MARITIME UNION OF NEW ZEALAND TO THE AUSTRALIAN GOVERNMENT PRODUCTIVITY COMMISSION INQUIRY INTO THE LONG TERM PRODUCTIVITY OF AUSTRALIA'S MARITIME LOGISTICS SYSTEM

1. The Maritime Union of New Zealand ("MUNZ") seeks to comment on some aspects of point 7 of the Scope of Inquiry. MUNZ is concerned that the Productivity Commission may seek to rely on material about New Zealand ports contained in the Australian Competition and Consumer Commission's Container Stevedoring Monitor Report 2020/2021.

2. MUNZ seeks to provide important contextual information about productivity and safety in the New Zealand environment that was not included in the ACCC report.

THE NEW ZEALAND PORTS

3. It is noted that the report concludes that Australian ports do not compare favorably with New Zealand ports in terms of productivity, comparing port performance from 2009/2010 to 2019/2020 using measures of containers per hour, with net ship rates, net crane rates and net labour rates compared.

4. The statistics set out are for New Zealand's three largest ports being Auckland, Lyttelton and Tauranga.

5. The statistics would suggest that the productivity at Lyttelton is very similar to that of Australian ports. As a result, this submission will focus on Auckland and Tauranga.

6. Like the Maritime Union of Australia with its national coverage of Australian ports, MUNZ has members in all containerised ports in New Zealand.

7. The ports of Auckland and Tauranga operate quite differently in terms of how stevedores are employed and the operating models.

THE PORT AT AUCKLAND

8. The containerised port at Auckland is owned by Ports of Auckland Limited ("POAL") which is a wholly owned subsidiary of Auckland Council.

9. Most of the stevedores employed in the containerised port, are members of MUNZ. There are approximately 270 stevedores employed

10. Within the containerised port, stevedores are directly employed by POAL. POAL has a collective agreement (similar to Australian Enterprise agreements) which covers stevedores employed at the port.

11. The collective agreement addresses issues such as notification, hours of work, and other work-related issues.

THE IMPACT OF CHANGED WORK PRACTICES

12. There were significant industrial disputes at Ports of Auckland in 2011/2012. At that time POAL was able to negotiate more flexible work arrangements. Over the period from 2012 to 2020 significant focus was placed by POAL on productivity, and increasing the productivity of the port. These increases were significant. They involved:

    (a) more flexible rostering arrangements;

    (b) longer shifts;

    (c) bonuses (not included as part of the collective agreement), whereby the fastest operators were incentivised with higher earnings).

13. Throughout this period MUNZ expressed considerable concerns about the work arrangements, and opposed them on the basis that they were not safe at the time of their introduction. MUNZ acknowledges that the productivity did increase through this period, and the speed at which straddle cranes particularly operated increased significantly, as did the speed of the crane operation.

14. During this period long-standing work practices that ensured the safety of employees were removed.

15. While the productivity of the port may have improved, anticipated direct safety consequences followed.

THE IMPACT OF THE CHANGES

16. At the time of the changes brought in in 2012, POAL had not ever been prosecuted over safety issues.

17. There were incidents resulting in serious injuries to workers as early as 2014, with Paul Hutton. The company was convicted under the health and safety legislation applicable at the time, following an incident that occurred in 2014.

18. A further incident occurred in October 2015, involving Neil Bower.

19. The sentencing notes of Judge SA Thorburn of 20 March 2015 (**attached**) note that POAL faced a charge was laid under the Health & Safety in Employment Act 1992, and pleaded guilty to acting in breach of a failure to comply with the requirements of the Act, to take all practical steps to ensure the safety of an employee whilst at work.

20. The notes indicate that Mr Bower was a longstanding stevedore. He was required to release a twist lock using a long pole. He lost his balance and fell off the deck of the boat and into the water, hitting objects and sustaining injuries. He had suffered multiple fractures to his body, his legs, tibia and fibula, his upper right femur, fractured vertebrae, fractured ribs, sternum, lacerated lungs and these injuries being described by the Court as the main injuries suffered.

21. The Court noted that the safety rail which should have been in place on the ship was not there, and a safety cage had not been used.

22. The Judge noted that there the company policy described as a '*desktop model while company policy had not been implemented*'.

23. The company was ordered to pay $25,000 in reparation. A fine of $55,000 was imposed on POAL.

24. These two incidents both reflected poor health and safety practice on the part of the port. They perhaps indicated the need for POAL to carefully consider its approach to health and safety. It did not.

THE FIRST FATALITY

25. The number of accidents at POAL increased. In addition, tragic results occurred including the death of Laboom Dyer on 28 September 2018 and Pala-Amo Kalati on 30 August 2020.

26. It was the Union's submission that the death of Laboom Dyer highlighted the dangers of the increases in work speed for straddle drivers.

27. Immediately following the death of Laboom Dyer, MUNZ lobbied POAL concerned that the death demonstrated the exact concerns that MUNZ had raised since the introduction of the more flexible work arrangements. POAL did not accept this position. However, POAL was charged under sections 361A, 481

and 2(c) of the Health and Safety at Work Act. The charges were laid almost one year after the incident.

THE CRIMINAL CHARGES

28. The company was charged with failing to ensure so far as reasonably practicable, the health and safety of workers who worked for POAL, including Laboom Dyer. The charge also related to a failure to ensure the health and safety of other workers at work at the container terminal at Fergusson Wharf at the time. The charge included that POAL's failure exposed Laboom Dyer to a risk of death.

29. The Summary of Facts is not attached to this submission, although MUNZ may seek the leave of the Court to provide it. The submissions below are based on the Summary presented to the Court at the time of sentencing.

30. The Summary of Facts sets out the events of the evening noting that the accident followed Mr Dyer attempting to perform a U-turn while travelling at about 25kmh the maximum speed permitted on the wharf. During that U-turn the straddle crane tipped.

31. The charges resulted from concerns that POAL had not monitored the tip alarms of the straddles operating at the port. The Summary of Facts identified that straddles had a tip alarm system. In September 2016 the Health and Safety Committee had noted that the tip alarms in the last month had exceeded 20,000 activations across the port. Work had commenced in mid-2017 to reduce the number of tip alarms.

32. The report identified that Mr Dyer in the previous months had set off thousands of tip alarms. The tip alarms had peaked in October 2017 with 2,683 in that month alone. At paragraph 48 the Summary of Facts noted:

> *"During the course of these discussions, Mr Dyer and a fellow driver expressed the view that the direction to reduce tip alarms was directly with odds with the bonus scheme, which incentivised the drivers to maximise their productivity. Despite this, Mr Dyer agreed to reduce his tip alarms throughout these discussions and in the 12 February 2018 discussion, Mr Dyer and the other drivers present were instructed that this had become a serious issue. Mr Dyer was not spoken to further despite increases in*

May and that the six hours prior to the incident he had triggered a critical tip alarm 97 times."

THE BONUS SCHEME

33. In addition, the Summary of Facts sets out the adoption and continuation of a bonus scheme adopted in 2015.

34. The bonus scheme was introduced to reward the top five per cent of straddle drivers. At the time of its introduction MUNZ had urged POAL to not adopt a bonus scheme that allowed bonuses to be paid to straddle drivers who were operating unsafely. This was rejected. The introduction of the bonus scheme whereby drivers felt the need to drive in a dangerous manner (including ignoring tip alarms) was one of the breaches of the Health and Safety Act at Work Act identified by WorkSafe. The Summary of Facts concluded it was reasonably practicable for POAL to:

    (a) develop, document, communicate and implement appropriate training for straddle carrier drivers in relation to:

        (i) the risk of the straddle carrier tipping whilst turning;

        (ii) the operation and significance of the tip alarm; and

        (iii) the actions to be taken if the tip alarms were activated.

35. There was considerable delay between the incident on 27 August 2018, and the sentencing of POAL in December 2021. POAL was fined $540,000.00 in relation to the incident.

THE SECOND POAL FATALITY

36. However, the issues were again identified in the tragic death of Pala-Amo Kalati on 30 August 2020.

37. Mr Kalati was working on a ship at the port. He died after a container fell from a crane and landed on him.

38. POAL has been charged by Maritime New Zealand in relation to this incident. In addition, the Chief Executive of POAL has also been charged as an officer of POAL. This is the first time in New Zealand that an executive of a major

corporate is to be charged personally for breaches of the Health and Safety at Work Act 2015.

39. Pleas have not yet been entered to the charges, in large part due to Court delays arising from the Covid 19 epidemic.

THE CHASNZ REPORT

40. The report is comprehensive and states clearly many deficiencies in the health and safety processes at the port.

41. The death of Mr Kalati has demonstrated very significant ongoing difficulties with health and safety at the time. The incident whereby two stevedores completing lashing duties were able to work under a container being lifted by a crane, and in addition where errors could result in the container falling, raises very serious and real issues about the company's practices at the time.

42. Following the death of Mr Kalati, the Auckland Council (as owner of the port) became increasingly concerned about the safety of the port operation and commissioned an independent health and safety review by CHANZ.

43. CHASNZ is a Charitable Trust set up with the objective of raising health and safety standards within New Zealand workplaces.

44. The commissioning of the report was encouraged and welcomed by MUNZ. A copy of the report is **attached**. It finds major health and safety deficiencies at POAL. The key findings include at 2.0.1:

> "From the detailed aspects identified in this report, it is the opinion of this review that there are systematic problems at POAL in relation to critical H&S risk management and organisational culture that relate to H&S."

45. The extent of the difficulties of POAL are identified by the report. POAL accepted is recommendations.

46. It is fair to say that a considerable part of the increased productivity at POAL over this period related directly to unsafe work practices introduced through this period

CURRENT PRODUCTIVITY

47. Recent statistics from New Zealand show a significant reduction in the productivity of ports noted in the ACCC report, with changes occurring from peaks in the second quarter of 2017 and marked reductions by the fourth quarter of 2020.

48. Productivity had reduced by the fourth quarter of 2019.

49. Some of the latest reductions in productivity result from the impact of COVID-19 which has led to difficulties with the numbers of empty boxes and a reduction in productivity.

50. However, following the clear concerns about safety identified at Ports of Auckland, the regulators being both WorkSafe (for work on shore) and Maritime New Zealand (for work onboard ships) have both become increasingly active in enforcement. Port companies appear to have become more concerned about safety issues noting the impact of some work practices upon the safety of stevedores, and the impact of that on the stevedoring workforce.

51. It is therefore fair to say:

    (a) that the increases in productivity at Ports of Auckland resulted in large part from work practices that have been found to be unsafe by the regulator and for which the company has been convicted for breaches of the Health and Safety at Work Act;

    (b) these work practices while best identified at POAL have also arisen in other ports around New Zealand;

    (c) addressing the work practices has resulted in significant reductions in productivity.

THE PORT AT TAURANGA

52. The operation of the Port at Tauranga is very different to that of Ports of Auckland Limited.

53. There are a small number of crane drivers who work at Tauranga, who are employed by the Port directly. However, the majority of the stevedoring work is

completed by stevedores who are employed by companies that contract to the Port of Tauranga.

54. The terms and conditions of employment for those stevedores, are different for each company. There is no national award covering stevedores within New Zealand, or any Code of Practice as to how work is completed within the port.

55. The stevedores employed in the container terminal are not members of MUNZ. There are small in-house unions in place.

56. The terms and conditions in those ports are substantially different to the terms negotiated by MUNZ.

57. In addition to different work practices, the layout of the Port of Tauranga is substantially different to Auckland, providing an advantage when measuring productivity.

58. Tauranga has significantly more space on the wharf. This space can be used for storing containers.

59. In addition, there is a larger amount of space close to the ship so containers can be delivered to the wharf prior to a ship arriving, and also left on the wharf when they are discharged.

60. This is very different to the Ports of Auckland operation where it is necessary to take containers further when they are discharged or to bring containers a longer distance when the ship is loading.

61. This has allowed containers to be block stacked on the berth in Tauranga. Therefore when comparing productivity, it may be that productivity is higher when the ship is in port. However, commonly in the Port of Tauranga, containers are then moved once the ship leaves port, or prior to the ship arriving.

62. This double handling of containers will not be measured in the statistics used to compare the ports.

ISUES AT TAURANGA

63. MUNZ is working to ensure that the terms and conditions for workers at Tauranga are lawful. It is the view of MUNZ that many of the terms and conditions are

inconsistent with the requirements of the law in New Zealand for hours of work. Recently for a stevedoring employer working a flexible model common in Tauranga, MUNZ has obtained Employment Court rulings that the terms and conditions are unlawful, and has obtained a compliance order (see ***Lye v ISO Limited***).[1] New Zealand does not have an enforceable Code of Practice, setting out how ports will operate. This makes it possible for companies to operate unlawfully and unsafely.

64. In addition there have been ongoing issues with stevedores at Tauranga noted in the media, suffering serious back injuries. MUNZ considers that these are contributed to by long hours of work.

65. Like the Port of Auckland, productivity in Tauranga has reduced significantly recently. MUNZ considers that this results from a new focus of the regulators on safety following the deaths, prosections and CHASNZ report at POAL, but in addition, the focus on hours of work.

66. Shift work exposes employees to increased risk of accident and ill-health.

67. MUNZ has worked to ensure that employment agreements recognise these risks and putting in place effective Fatigue Risk Management Policies. These are becoming common in the industry, but not in Tauranga.

68. There is currently an increased recognition of the impact of shift work on stevedores and other employees. MUNZ considers that this is forcing a change of approach from many stevedoring companies. This is reflected in the statistics for the port operations.

69. Tauranga does not provide a safe and sustainable model for the Australian port system.

GENERAL COMMENT

70. **Attached** to this submission is a Schedule of Incidents that MUNZ is aware of, involving serious injury or death within the stevedoring work environment since June 2010.

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[1] ***Lye v ISO Limited*** [2020] NZEmpC 231; [2021] NZEmpC 120; and [2021] NZEmpC 189

71. Some of these are addressed specifically within the submission. MUNZ has been involved with the matters referred to, and is aware of the background to the events, and has provided details where it can.

72. Other incidents have occurred within the industry, but it is accepted are not within containerised ports.

73. Overall, the schedule establishes serious issues with health and safety within the stevedoring industry in New Zealand.

CONCLUSION

74. It is difficult to make proper assessment of the productivity of ports without a full knowledge of the operation, as productivity is not only dependent on the work of the stevedores.

75. The port in Tauranga has significant advantages over other New Zealand ports, due to its layout and greater amount of wharf space.

76. Productivity did increase in New Zealand in the years 1990 – 2020.

77. Productivity has reduced significantly since that time. This is in part due to the pressures of Covid-19. However, it is clearly able to be evidenced in POAL that dangerous work practices were used to increase productivity. The issues have been a concern to all New Zealand ports, and new monitoring from regulators and awareness of the issues has led to significant changes in the way ports operate.

78. Ongoing work to ensure that the health and safety of stevedores is protected, including by way of changes in hours of work, are likely to result in changes in productivity levels at the Port of Tauranga.

79. MUNZ submits that there is a clear correlation between increased accidents, injuries and deaths, and the increased productivity within the New Zealand port environment.

Dated this 11th **day of February 2022**

C.J. HARRISON
National Secretary
Maritime Union of New Zealand

IN THE DISTRICT COURT
AT AUCKLAND

CRI-2014-004-007019
[2015] NZDC 9067

THE QUEEN

v

PORTS OF AUCKLAND LIMITED

Hearing:	20 March 2015
Appearances:	C Paterson for the Prosecutor R McIlraith for the Defendant
Judgment:	20 March 2015

NOTES OF JUDGE S A THORBURN ON SENTENCING

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[1] Maritime New Zealand has charged the Ports of Auckland with an offence against the Health and Safety in Employment Act 1992, in that it failed to comply with the requirements of the Act as an employer to take all practicable steps to ensure the safety of employees whilst at work. The maximum penalty under the Act is a fine of $250,000.

[2] 22 January was the day in which the injured person, Mr Bower, a stevedore in his 50s, and having been in that form of employment for many years, I think at least as a senior stevedore for 15, something in that range, was working on the ships for the removal of containers. The particular vessel concerned was the *Lica Maersk*, and he was on the deck facilitating the release of containers bound by a system to stop them moving, so that the crane could lift them.

[3] I do not intend to give a detailed explanation of the system but to appreciate that a twistlock is an instrument which is used to bind in the bands or the frames that keep the containers secure, and to free them for the crane, the twistlock has to be removed from the top of the containers that are being bound.

[4] Mr Bower was on the deck and, needing to release a twistlock. He used a long pole, something in the range of five metres to reach up about the height of two or three containers, and engaged it in the twistlock to release it. What happened next is the event which has given rise to the charge because he lost his balance (perhaps not unsurprisingly when one thinks about it), endeavouring to hold steady and wield an item, I am not sure exactly how much weight a twistlock is but at such a height on a long pole, lost his balance, and fell off the deck of the boat and into the water below and, of course, in that fall also hitting objects and sustaining quite considerable injuries. He was in the water for 15 minutes, rescued and then hospitalised. He sustained multiple fractures to his body, his legs, tibia and fibula, his upper right femur, fractured vertebrae, fractured ribs, sternum, lacerated lungs and tendon injuries, just to briefly name the main injuries. He was hospitalised for three months and continues now in recovery to suffer the ongoing effects of such major injuries.

[5] On the deck there was a safety rail which ought to have been put in place to prevent a fall over into the water. It was not in place. There was also a specially designed cage into which the stevedore could enter, lifted up by the crane, and somehow safely fixed to the side of the containers, to enable the stevedore to have direct access to the twistlock and release it more easily and safely and without the intrinsic risks that were obvious by using the long pole from the deck.

[6] The ship had been inspected by a man whose job was to check it as safe for the stevedores to work on, and clearly there was a failure in respect to that exercise for two obvious reasons. First, the safety rail was there but not in place and second, the use of the cage as opposed to the more precarious method adopted by Mr Bower for the twistlock was not insisted upon when the inspector checked the ship off as safe.

[7] In a vast summary of matters that have been placed before me, I know that Ports of Auckland had some months earlier appreciated the need to devise directions for the safe removing of twistlocks which, of course, would have included the placement of the safety rails at the deck and also the use of the discrete and especially designed cage for the stevedores to be lifted up to the twistlock on the top of the containers. My understanding is that, and I use this terminology advisedly, this was a desk top model for safe practice which had been devised by those who were required to look at the workplace and meet minimum standards at the very least for safety, which model would have excluded the use of the pole and insisted on the placement of the safety rail.

[8] This model had been approved and signed off, but for some reason which is unclear but has been acknowledged by the Ports of Auckland, was a failure, it did not manifest itself in a change of practice at the point of work, and I understand that upon this incident happening the officials or senior management of Ports of Auckland were somewhat taken aback that the pole practice was still continuing.

[9] The case is based upon failures enumerated on the charging document all of which are acknowledged by Ports of Auckland which has pleaded. In the submissions which have been before me in written memoranda and added to by verbal comment at the hearing, Ports of Auckland has not resorted to flight of refuge of denial or prevarication, modifications or tweaks of interpretation. Ports of Auckland, it seems to me, has frankly and candidly accepted the failures that are enumerated.

[10] That is a brief background in respect to the incident. As far as the personal effects upon Mr Bower are concerned, they are thoroughly narrated in the documents which include a victim impact statement and also a rich and full report of a restorative justice event in which senior members of the Ports of Auckland met with Mr Bower and his supporters.

[11] Ports of Auckland employs, I believe, something like 400 people in its operation. I wondered, in preparing, what the timeline of its existence was. I know from personal observation that it has been there at the container wharf, whether as

Ports of Auckland but certainly in an ongoing operation, for a long time. The point of this comment is that it is a large, very physically oriented operation down on the wharves employing a large number of people and has until now a perfect record as far as offences and prosecutions are concerned and thus, therefore, it is to be predicted, evokes some comment in respect to good character, which I will refer to later.

[12] The incident as it affects Mr Bower has been life changing and in the documents to which I have referred there is detail of how that is manifest, and it is of course more than the physical effects of broken bones and so on. There are other issues which are immeasurable and which might broadly be described as ongoing trauma and/or emotional consequences, fatigue, mood changes, impacting on things like optimism, expectations for the future, disappointments about change, frustrations about whether there will ever be any return to how he was before and, of course, relational consequences, all of which broadly speaking tuck into the generic term of emotional harm. And all that is immeasurable in a scientific or methodological way, unlike economic loss or financial factors.

[13] In the course of the communications mainly through the restorative justice event, the Court has been appraised of proactive and intentional engagement on the part of the Ports of Auckland with Mr Bower, and is aware that steps have been taken in various ways to assist and to repair where possible, and to reflect its taking of responsibility for the incident in as many practical ways as possible.

[14] All of that notwithstanding, the issue before the Court is where the incident lies in respect to the culpability spectrum and what, then, ought to be an appropriate outcome. I, in following *Department of Labour v Hanham & Philp Contractors Ltd* (2009) 9 NZELC 93,095, (2008) 6 NZELR 79 will attend to reparation now. There are clearly specifically identifiable economic losses which Mr Bower has shared with the Ports of Auckland. To date I am advised that the Ports of Auckland have addressed top ups of wages, payment for health intervention, gym memberships and so on, assisted with acquisition of a computer and broadband access and some other matters to make life a little more tolerable whilst he is recovering, such as a television and a media player.

[15] Beyond those steps there are other financial concerns somewhere in the realm of $15,000 specifically in respect to economic matters. The parties, however, have agreed as is appropriate that a final reparation decision ought to be left to the Court and Ports of Auckland will abide by that.

[16] So my decision in respect to reparation is this. Certainly there seems to me to be clearly something around the $15,000 mark in terms of identifiable financially measurable issues, but beyond that there are these other matters to which I have referred which we label as emotional harm which are unmeasurable. There will be ongoing effects in Mr Bower's life for the foreseeable future if not for his entire future, which have swept across the landscape of his life because of this event, and they will be manifest in all sorts of ways, I expect. Some emotional harm, consequences or post-event trauma are more ongoing and deeply entrenched for some people than for others. We are all wired differently and personalities are as diverse as human nature.

[17] Some folk will claim ongoing negative life changing effects through emotional trauma arising out of what many might think a fairly minor incident, and others will stoically step up to try and make something of life after major events such as Mr Bower's, and complain little. So assessing an award for emotional harm is a very discretionary thing, but I have concluded that for Mr Bower it does not matter where he is positioned, I guess, on the emotional characteristic scale. If he is extremely sensitive and disarrayed by small currents of distraction or if he is stoic and strong and trucks on and makes the best of things, it matters not. However we look at what has happened to him and whatever his nature or character, there will be obviously and logically and with the application of ordinary common sense, major changes to his life which will never be avoided and will have implications and consequences relationally and in all sorts of other ways for he and those nearest and dearest to him.

[18] And so to sort out the reparation issue now I simply determine that I will make a reparation award of $25,000.

[19] Coming to the issue of the fine, matters of culpability and where the incident is placed, *Hanham* is our lead case, and with seven league boots, quickly summarising all that is in *Hanham*, which is a tariff case, low culpability sustains fines of up to $50,000; medium, $50,000 to $100,000; and high, $100,000 to $175,000.

[20] In assessing culpability, *Hanham* has a list of seven points for attention, and in looking at them in paragraph 54 the prosecutor is right that most of them are ticked in this particular case: identification of the issue – the problem was known; assessment of the nature and seriousness of the risk was obviously known; the degree of departure from the standards prevailing in the relevant industry – I cannot comment on that; the obviousness of the hazard – when I gave my opening remarks about the actions of Mr Bower in the circumstances, the obviousness of the hazard is so apparent it deserves little more comment; the availability, cost and effectiveness of means necessary to avoid the hazard – we know about that because there was a safety fence and a cage already in existence and expected to be used; the current state of knowledge – that is arguably (and the defence have addressed this), in favour of the defendant in the sense that it thought that the practices which were safer were being embarked upon and the officials did not have knowledge that they were not but, of course, the failure to ensure that the plan for safer practice had in fact been implemented at the work face is inexcusable and has been accepted in the brief expression, "We have failed," that was made at the restorative justice meeting.

[21] So in a word the elements of culpability in *Hanham* are there and would infer high culpability. The prosecutor suggests that that is clearly the case and would promote a starting point well over $100,000, $125,000, something like that.

[22] The Ports of Auckland has been transparent and ready to acknowledge culpability and that is something which I will come back to soon again, but there is a point that has been made by counsel which I am drawn in to accept.

[23] I thank counsel for their memoranda and for the cases that have been offered. The *Hanham* points for assessing the level of culpability I believe are not conclusive. Clearly the points mentioned have to be addressed but it seems, too, to me that

culpability must surely also require an assessment of attitude, and if an employer has a cavalier or nonchalant attitude or is a procrastinator or has a parsimonious attitude to expense which is reflected in corner cutting and things like that and even, in the extreme, bad faith, those aspects if present must of course clearly speak of culpability.

[24] So turning that coin over, if on the other side there is good faith and obvious commitment to endeavouring to make the workplace as safe as possible and an ethos, attitude or ethic that is reflective of a high priority on safety, then that speaks against a finding of high culpability notwithstanding an event. And so therefore I am inclined to regard the Ports of Auckland as an organisation which because of the number of employees and because of its clearly long history in the industry of stevedoring and port work, and because it has no history of prior prosecution and because, too, the prosecutor acknowledged, there were no aggravating features that could be put before the Court in respect to the event, I accept its counsel's submission that this was a genuine and, ironically, honest failure as opposed (these are my words) to cavalier disregard for issues of safety.

[25] And I think in that regard, too, the case can be distinguished from a case such as *Department of Labour v Safe Air Ltd* [2012] NZHC 2677, (2012) 10 NZELR 198 in which there was a bizarre and utterly un-understandable abrogation that seemed deliberate but certainly was a very, very low grade commitment, of analysing the risks of a step that created or enhanced or increased the chance of something happening, and it did of course.

[26] And so whilst on the *Hanham* bullet points there are a number of matters which do speak of high culpability, I infuse into that my view of the attitude of the Ports of Auckland and give some recognition for that.

[27] And so I am going to pitch my starting point at $100,000. That means it sits on the border between high/medium culpability or lower in the range of high culpability. Clearly, of course, there is a 25 percent discount in respect to that starting point for plea.

[28] I am going to talk now about the statutory scheme of the Sentencing Act 2002 and the restorative justice conference. The statutory scheme, s 9, makes it clear that the Court has to in a mandatory way take into account nominated mitigating factors to the extent that they are applicable. There is s 9(2)(b), the plea of guilty, and I have mentioned that.

[29] The next is s 9(2)(f), remorse. Looking at s 10 the Court must take into account (s 10(1)(a)), any offer to make amends, any remedial action taken or proposed and any agreement to remedy wrong, damage or loss.

[30] Importantly in this case s 10(2) directs that any matters to which I have referred in respect to agreement to make amends has to be taken into account on the basis of whether or not it is genuine and capable of fulfilment and whether or not it has been accepted by the victim as expiating or mitigating wrong. So ss 9 and 10 are mandatory statutory directions in respect to mitigation because of attitudes of an offender to remedy or repair.

[31] Section 9(2)(g) refers as a mitigating factor to any evidence of offender's previous good character. I have mentioned good character. The defendant is entitled to credit for that.

[32] Remorse. The restorative justice conference is the key piece of material which enables the Court to evaluate whether or not remorse exists and whether or not it is genuine. It was in *R v Hessell* [2009] NZCA 450, [2010] 2 NZLR 298 that remorse was addressed and recognised as a factor for mitigation independent of the credit for a guilty plea where there is proper robust evaluation of the circumstances that demonstrate a defendant's remorse. The concern of the Courts has been of course that every day defendants are said to be remorseful by their counsel because they have pleaded guilty, but remorse is something that has to be shown to exist after a robust evaluation and soundly demonstrated as genuine, and the Act envisages that through the provisions that I have referred to.

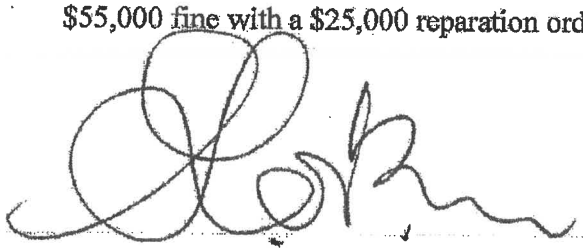
[33] Alongside the clinical and unemotional and process-driven scheme of Court business there is now the restorative justice path, and it allows a flow of

communication in a relational way about events which have happened, offences that have been committed. New Zealand leads the world in its exploration of the relevance of such processes and the Court today has got a very helpful explanation of communication in a human and relational way about the event, its consequences and what ought to be done and by whom to make things better if at all possible. And so, clearly, although it is corporate remorse, remorse is validated and expressed and has also, I think, been evidenced by the steps taken before today and even, I think, before the restorative justice meeting, by the Ports of Auckland to touch base with Mr Bower and his circumstances and do what it could to alleviate them.

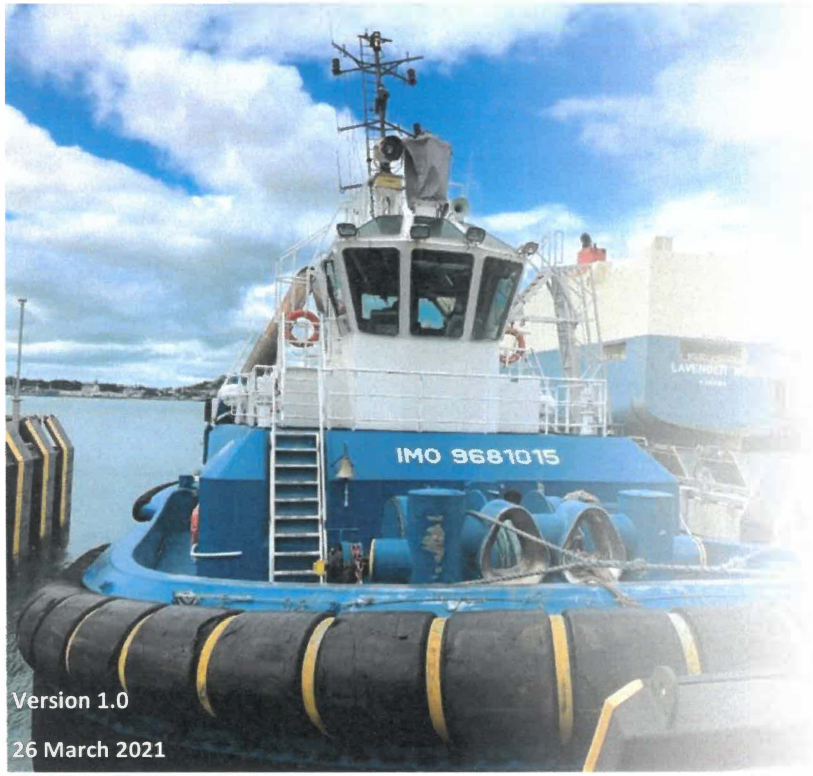
[34] Under s 8(j) the Court is obligated (it is an imperative), to take into account a restorative justice process. By collecting the following matters in a composite way I introduce a further discount on the starting point of $100,000. Remorse; good character; and steps taken such as they are to offer amends and repair and remedy the consequences by appropriate actions; remorse, albeit by corporate remorse, that I determine does exist and is genuine.

[35] I introduce another discount of 20 percent, and will thus conclude by imposing a fine of $55,000.

[36] $100,000 starting point, 25 percent discount for plea, and a further 20 percent discount for the collected other matters to which I have referred. So finally, then, a $55,000 fine with a $25,000 reparation order.



S A Thorburn
District Court Judge



Version 1.0

26 March 2021

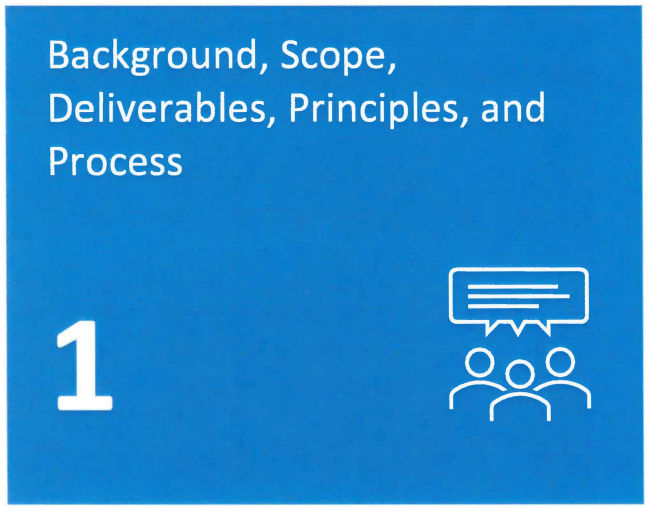
Ports of Auckland Independent Health and Safety Review

Commissioned by Auckland Council

Contents

Table of Contents

Background, Scope, Deliverables, Principles, and Process



Background, Scope, Deliverables, Principles, and Process

1.1. Background

1.1.1 **Ports of Auckland Limited (POAL)** is incorporated under the Companies Act 1993 and operates Ports of Auckland (including its inland ports, and other activities) under the Port Companies Act 1988. Its principal objective is to operate as a "successful business" in accordance with its statement of corporate intent. Operational decisions are the responsibility of the POAL Board.

1.1.2 **Auckland Council (AC)** is the unitary authority for the Auckland region established by the Local Government (Auckland Council) Act 2009. It owns 100% of the shares in POAL. Council is responsible for the appointment of directors to the POAL Board and for approving POAL's statement of corporate intent.

1.1.3 **POAL's** current and previous statements of corporate intent include outcomes and strategic objectives for "safe and empowered people", including key performance targets for zero lost time injuries, and to "achieve the target of becoming a zero-harm workplace".

1.1.4 Since 2017 there have been two deaths at POAL. Following the investigation into the first fatality, POAL pleaded guilty to offences under the Health and Safety at Work Act 2015, and the second (in August 2020) is currently being investigated by Maritime New Zealand.

1.1.5 Because of the importance of Health and Safety (H&S) to operating a "successful business", AC and POAL have agreed to an independent Review (Review) of the H&S framework and culture at POAL.

1.1.6 The Review focused on POAL's systemic management of critical H&S risks. This will help inform whether POAL's current H&S framework is fit-for-purpose and identify any systemic issues which need to be addressed.

1.2. Scope of Review

1.2.1 **Construction Health and Safety New Zealand Trust (CHASNZ)**, (The Reviewer) has been nominated by AC to lead the Review in accordance with these Terms of Reference. The Review commenced in October 2020 with a draft reporting date of February 2021.

1.2.2 The Review was conducted urgently within a short time frame, and accordingly the Reviewer prioritised making meaningful recommendations that inform improvement.

1.2.3 The Review assesses and comments on POAL's systemic management of its critical H&S risks for H&S (including hazard identification, H&S risk assessment, monitoring controls and resilience) and the H&S climate at POAL.

1.2.4 In carrying out the assessment, the Reviewer paid consideration to factors such as but not limited to the following:

a. Governance and leadership (including the accountability relationship between the Board, CEO, and senior managers of POAL in respect of H&S).

b. Continuous improvement (including due diligence and continuous improvement functions of the Board, CEO, and senior executives, implementing learnings from previous incidents and near misses).

c. Resourcing of and consideration of the H&S function in its business (including empowerment of the H&S team, relevant managers, and investment in plant and equipment).

d. POAL's training methods, methods of assessing competency, supervision and reporting regimes in relation to its critical H&S risks.

e. Culture and engagement (including modelling good practice, an integrated and holistic approach to H&S and well-being, and effective shared ownership of H&S priorities through collaboration of workers, crews, third parties, contractors and management).

f. Factors bearing on management of critical H&S risks and organisational culture (including performance management, management accountability for H&S outcomes, financial incentives, industrial relations, and workers and union engagement).

g. The adequacy of incident reporting, investigation and implementation of suggested improvements.

1.3. Deliverables

1.3.1 The main deliverable is this report on the Review's findings and recommendations, and briefings for the Council's Governing Body and POAL Board following report delivery.

1.3.2 For purposes of fact-checking and natural justice, the Reviewer has provided a draft copy of the Report to the Chief Executives of Auckland Council and POAL for comment prior to the Reviewer finalising the Report. The Reviewer has also checked specific facts with any relevant stakeholders.

1.3.3 The deliverables of the Review followed the scope, key principles and assessment process set out in the terms of reference issued by Council regarding POAL. Specifically, the assessment:

a. Assesses and comments on POAL's systemic management of its critical H&S risks (including hazard identification, H&S risk assessment, monitoring controls and resilience) and the H&S climate at POAL.

b. The terms of reference call for an assessment of H&S culture. Within the academic literature, there is no agreement as to what safety culture is and subsequently what the definition is.[1]
A universally accepted definition of safety culture, unlike that of (organisational) culture, is not available.[2]

This review has opted to use Safety Climate for the survey. There is strong agreement from academic evidence that safety climate is directly linked to employee perceptions of management's commitment to safety and that it is a good measure, because it is a predictor of injuries.[3][4]

When measuring safety climate, its important to measure the strength of agreement in the survey. In addition to calculating the average score (which will tell us its either a positive or negative climate), we have measured the variance in the scores (which provides the strength of this view).

1. Hopkins, A. (2006). Studying organisational cultures and their effects on safety. *Safety Science*, *44*(10), 875–889. https://doi.org/10.1016/j.ssci.2006.05.005

2. Strauch, B. (2015). Can we examine safety culture in accident investigations, or should we? *Safety Science*, *77*, 102–111. https://doi.org/10.1016/j.ssci.2015.03.020

3. Beus, Jeremy M., Stephanie C. Payne, Mindy E. Bergman, and Winfred Arthur. 2010. "Safety Climate and Injuries: An Examination of Theoretical and Empirical Relationships." *Journalof Applied Psychology* 95(4):713–27. doi: 10.1037/a0019164.

4. Probst, Tahira M., Linda M. Goldenhar, Jesse L. Byrd, and Eileen Betit. 2019. "The Safety Climate Assessment Tool (S-CAT): A Rubric-Based Approach to Measuring Construction Safety Climate." *Journal of Safety Research* 69:43–51. doi: 10.1016/j.jsr.2019.02.004

1.4. Key Principles

1.4.1 The Review has been conducted in accordance with the following principles:

a. The Review was conducted with respect and sensitivity acknowledging that workers are likely to be affected by the tragedy of recent events.

b. The Reviewer has acted impartially, and fairly and had complete independence in conducting the Review, formulating their findings and reporting to Council and POAL.

c. The Review has reported on key findings and provided recommendations for improvements within the scope of the Review including regarding culture, systems, accountability, performance, H&S risk/ hazard identification and mitigation.

d. The findings and recommendations are the Reviewer's own opinion, based on their professional experience and judgement based on the information and material reviewed.

e. While the Review was not an investigation into specific incidents, discussion of previous incidents have been used as examples where applicable.

f. The Reviewer relied on or referred to other reviews and reports which POAL has conducted (independently or otherwise) and did not duplicate effort for information gathering.

g. To encourage free-and-frank exchange of views and provision of information by all participants, and facilitate prompt assessment and reporting of meaningful improvement recommendations:

i. The Review was not conducted to evidential standards or for evidential purposes. Information and material relied on by the Reviewer did not need to be attributable or verifiable.

ii. The Review allowed participants to provide information and comment anonymously and on a fully confidential basis. The Reviewer informed participants of this confidentiality condition.

1.5. Review Process

1.5.1 The Reviewer liaised with the Council and POAL as to the practical process by which the Review was conducted. Subject to that, and the Terms of Reference the Reviewer conducted the Review by such process and methodology as the Reviewer considered appropriate.

1.5.2 The Reviewer had access to information and materials on the following basis:

a. POAL was asked to provide the Reviewer with all requested information and materials about its H&S framework including systems, policies, and practices, records and reporting on H&S performance and workforce engagement concerning H&S matters. POAL withheld any legally privileged material, any material the disclosure of which to the Reviewer is restricted by law or which POAL is not permitted by law or contract to disclose.

b. The Reviewer has had confidential access to POAL workers for interviews. The Reviewer received contributions from Council, POAL management and board members, unions, workers and any other person or organisation (including confidential voluntary submissions) the Reviewer considered appropriate.

c. Any information provided to or collated by the Reviewer as part of the Review process is held securely and kept confidential. Where possible information is kept anonymous to reduce the risk of any privacy breach.

d. The Reviewer engaged with Maritime New Zealand before engaging any interviewees to ensure that the Review does not in any way interfere with Maritime New Zealand's current investigation.

1.6. About CHASNZ

1.6.1. CHASNZ is registered charitable trust dedicated to improving H&S in construction and related trades. It is independent of POAL, the port industry, and AC.

1.7. Limitations

1.7.1. The Reviewers would like to make note of the following limitations:

a. The Report has been prepared at the request of and for the purposes of AC and POAL. The information contained in the Report is current at the date it is issued. To the fullest extent permitted by law, CHASNZ does not accept or assume responsibility to anyone other than Auckland Council for its H&S Review, the Report or the opinions given in the Report.

b. As per the terms of reference for this Review, the Review was not conducted to evidential standards and information and material has been relied on by the Reviewer which may not or could not have been verified.

c. The Reviewers have been contacted anonymously by a number of current and former employees. CHASNZ (The Reviewer) have committed to retaining their confidentiality.

d. Where appropriate the Reviewers have referred to "perceptions". This has been when there has been a strong theme expressed by multiple independent parties and the Reviewers have found that, in their professional opinion, this has constituted an important finding for POAL to take into consideration. The basis for the perception may not be verifiable through other means but the Reviewer has reasonable confidence that it is a view held by a fair representation of stakeholders and submit it as such.

e. This Review has been conducted in a manner that is intended to be beneficial and proactive in supporting AC and POAL in progressing towards keeping employees, contractors, and other third parties safe.

f. Recommendations provided by the Reviewer are based on findings and observations during the Review period. POAL has responsibility for interpreting and determining if the recommendations are fit for purpose.

g. This report is provided for the sole benefit of the parties (AC and POAL) and is not to be relied upon by other parties.

h. The information contained in this Report is for the sole benefit of the parties (AC and POAL) specifically for the purposes of the Council's Review into the H&S critical controls framework and safety climate at POAL. The content should not be used or relied on by any other person or for any other purpose. CHASNZ accepts no liability or responsibility whatsoever to any other person who acts or relies in any way on any of the material contained in this Report for any other purpose.

i. This report is confidential and cannot be shared, commented on or used without permission and consultation with the parties (AC and POAL).

1.8. POAL Overview

1.8.1 POAL's principal activity is to own and operate a seaport on Auckland's Waitemata Harbour.

Background, Scope, Deliverables, Principles, and Process

1.8.2 POAL provides the following services:

a. Container terminal handling services which include receipt, delivery, transit storage and shipment of a wide range of import and export cargos.

b. Vehicle, breakbulk and bulk cargo handling services via independent stevedores (multicargo).

c. Marine services which include pilotage, towage, hydrography and bunkering services – both directly and through its ownership of SeaFuels Ltd and Bunker Shipz Ltd and its half ownership of North Tugz Ltd.

d. Intermodal freight hubs in South Auckland, Waikato, Bay of Plenty and Manawatu – both directly and through its ownership of Waikato Freight Hub Ltd and its one third ownership of Longburn Intermodal Freight Hub Ltd.

e. Supply chain management services – both directly and through its ownership of Nexus Logistics Ltd and CONLINXX Ltd.

f. Other port-related activities required to manage and operate an efficient and competitive port – both directly and through its half ownership of PortConnect Ltd; and

g. Services and facilities to support the cruise ship industry.

Organisational structure

1.8.3 The CEO has ten direct reports and at the time of the Review a total of approximately 667 people working at the port.

1.8.4 The Deputy CEO & CFO - leads 56 office-based staff across the following departments:

- Finance
- Governance & Risk
- Information Security
- People Capability & Business Support
- Safety & Wellbeing.

1.8.5 The GM Container Terminal Operations - leads 337 staff, across:

- Stevedoring (300 performing operational roles)
- Rail
- Capacity & Planning
- Berthing
- Gate operations.

1.8.6 The GM Marine, Engineering & Multicargo – leads 163 staff across:

- Marine – 83 performing operational roles (includes pilots, tug & pilot crew, linesmen, harbour control, marine engineering, cruise operations)
- Engineering - 56 performing operational roles (includes mechanics, fitters, engineers, plumbing, electrical, plumbing, welding, radio technician, workshop, stores)
- Multicargo - 7 staff in supervisory roles
- Hydrography – 2 staff in operational roles.

1.8.7 The GM Infrastructure – leads 12 staff across:

- Civil infrastructure
- Property
- Electrical infrastructure
- Environment
- Security – (security operational activity is outsourced to First Security).

1.8.8 The Chief Digital Officer – leads 55 staff, mainly office-based although some staff perform IT installation and fault rectification work in the operational areas.

1.8.9 The GM Supply Chain – leads a team of 5 office-based staff.

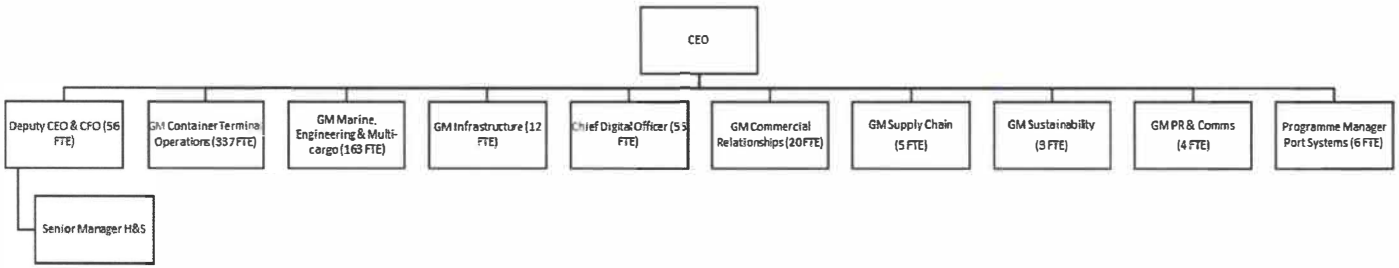
1.8.10 The GM Commercial Relationships – leads a team of 20 office-based staff.

1.8.11 The GM Sustainability – leads a team of 3 office-based staff.

1.8.12 The GM PR & Communications – leads of team of 4 office-based staff.

1.8.13 The Programme Manager Port Systems – leading POAL's straddle carrier automation project with 6 staff.

Subsidiaries operate under a Board appointed from the Executive team.



Background, Scope, Deliverables, Principles, and Process

1.9. Overview

1.9.1. Ports in general are high risk environments from a H&S perspective and require a high level of critical H&S risk management. Critical H&S risks are those that could cause fatalities or serious harm injuries. Typical critical H&S risks requiring high levels of control in the port industry include but are not limited to:

- Lifting and loading cargo on and off ships, trucks, and trains.
- Stacking of containers.
- Working at height on ships while lashing (the practice of securing containers).
- Working in and around heavy moving plant such as straddles, extended reach trucks and forklifts.
- Traffic management – interactions between pedestrians, light vehicles, heavy vehicles, and mobile plant.
- Maintenance activity involving working at height, with electricity and in confined spaces.
- Handling and storage of hazardous materials.
- Moving on and off ship from pilot boats.

1.9.2. The industry in New Zealand is comprised of independent and sometimes competing ports. Port industries overseas are often under a national port authority which increases the opportunity for consistent safety standards. The industry in New Zealand is beginning to collaborate on H&S through the Port Industry Association, the Port CEO forum and through initiatives led by Maritime New Zealand and WorkSafe. However, currently benchmarks on H&S performance are not available. This applies equally to consistent safety standards across the industry for common activities such as stevedoring which are managed and applied port by port.

1.9.3. The operational environment at POAL requires highly resilient H&S risk management systems and controls to ensure that work can be carried out with the required safety buffers in place. The board and management of POAL require a high level of assurance that the controls in place to manage critical H&S risks are appropriate for the risk being managed and working as intended.

1.9.4. A highly resilient control environment requires a strong H&S climate at its foundation. Aligning the organisation to a culture that places H&S of its workforce as highest priority is a key requirement. Without this, efforts to manage safety will be weakened as controls will be circumvented and key predictive indicators such as near miss incidents and control failures may not be reported.

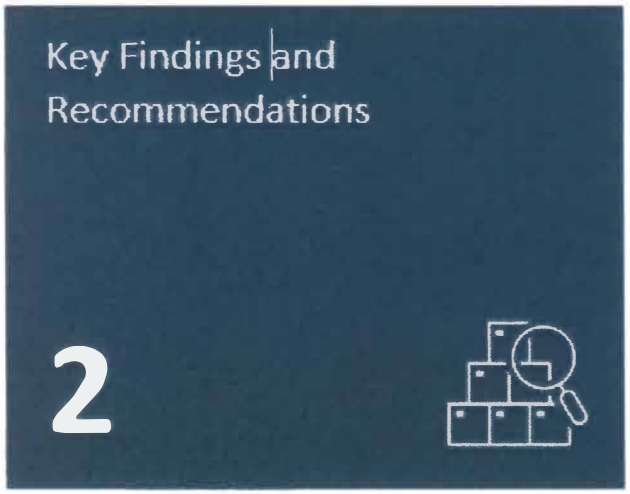
1.9.5. Key influencers of the safety climate are the CEO, senior management, and frontline supervisors. The CEO and senior management set the tone and prioritisation of H&S for the organisation and frontline supervisors enact the will of the organisation through everyday operations.

1.9.6. CHASNZ (The Reviewer) has undertaken an assessment of the critical H&S risk environment and the safety climate at POAL. The recommendations for improvement fall into four key categories and are based on our independent assessment of the current operation as reflected to us by POAL management, workers, and other stakeholders.

1.9.7. The recommendations are designed to assist POAL in the future to strengthen the control environment and improve the safety climate. The topics of Overlapping Duties and Fatigue Management have specifically been included in this assessment due to their potential to contribute to multiple risks across the ports environment.

1.9.8. CHASNZ (The Reviewer) would like to thank all stakeholders who have contributed to this report.

Key Findings and Recommendations



Key Findings and Recommendations

2.0 Key Findings and Recommendations Summary

General

2.0.1 From the detailed aspects identified in this report, it is the opinion of this Review that there are systemic problems at POAL in relation to critical H&S risk management and organisational culture that relate to H&S.

2.0.2 Although POAL are good at managing aspects of their business such as shipping movements and equipment maintenance, there is more focus needed where there is reliance on the people element, in particular, in the higher risk areas of the business.

2.0.3 In reviewing the systemic management of critical H&S risks the Reviewers have found that there is opportunity for significant improvement to ensure that POAL operates a resilient and appropriate control environment reflective of the level of inherent risk in port operations.

2.0.4 In reviewing the current safety climate, as an aspect of the overarching culture at POAL the Reviewers found that in high risk areas of the port there were inconsistent views on how workers perceived the commitment to H&S by senior management to that of what board, line and executive management felt was being demonstrated.

2.0.5 POAL do accept responsibility for their workplace culture and are working to improve it. The difficult relationship between Maritime Union of New Zealand (MUNZ) and POAL has, at times, hampered H&S improvement. For H&S to continue to improve at POAL, it is essential that all parties work collaboratively to support H&S.

Governance, Leadership and Structure

2.0.6 The role of the CEO in regard to H&S leadership should be reviewed, redefined and measured based on key requirements such as:

a. Prioritising safety over productivity and profitability.

b. Communicating regularly and proactively on safety in multiple ways (as opposed to in reaction to a safety incident).

c. Encouraging comprehensive and meaningful employee engagement in safety.

d. Helping change at risk behaviours.

e. Following up with employees and resourcing corrective actions.

2.0.7 Safety as a core value needs an increased focus for all frontline leaders and management.

2.0.8 POAL executive management needs to address perceived engagement and trust gaps between executive management and the frontline workforce regarding H&S expectations. From the observations and interviews made by this Review resolving this issue will be a significant challenge for POAL.

2.0.9 POAL needs to create consistent engagement across the workforce, based on trust, and which addresses the dysfunctional relationship between management and MUNZ. Achievement of this will require good will and positive engagement from all sides.

Critical Risk

2.0.10 POAL have made efforts to establish and document an understanding of their critical risks, although this documentation is sporadic and not consistent in terms of content. There is not an aligned view of the critical risks across the organisation and there is no safety assurance information that clearly demonstrates critical controls are either implemented and effective. This view is corroborated from the physical observations made

Key Findings and Recommendations

from visits to the operations and from independent overlapping accounts from current and former members of the H&S team.

2.0.11 In order to create a resilient H&S control environment POAL needs to:

a. Improve the Occupational Health and Safety Management System so that it is aligned to ISO 45001 (OHSMS).

b. Establish a critical H&S risk programme for the organisation with a focus on improving the communication, monitoring and reporting of critical H&S risks and their controls.

c. Develop and implement a safety assurance framework for the Automation Project.

d. Further embed the H&S policy into the OHSMS, so that it describes how and when safety assurance processes are delivered at POAL.

e. Engage human factors expertise to review operating environments and work processes for straddle carriers and cranes.

Overlapping Duties

2.0.12 POAL, as the owner of the joint operating environment that many third parties work within, should:

a. Improve relationships and cooperation between third party operators within the POAL Auckland Port footprint.

b. Improve the Common User Safety Protocols (CUSP) so as to clarify H&S expectations for the Auckland Port Footprint that aligns an approach across all organisations and individuals with regards to operations featuring critical H&S risks.

H&S Function

2.0.13 Resourcing of the H&S function requires a transformational H&S practitioner as a leader to reset the H&S strategy. During the Review the incumbent Senior Manager H&S left POAL and a new appointment was made.

2.0.14 This leader should report directly to the CEO and continue to have unfettered access to the POAL board of directors. Other capabilities required within a H&S function in a high-risk environment include driving and implementing a critical H&S risk programme, wellbeing, injury management, and health resources, a safety system team using ISO45001 which may include reporting, analytics, assurance and process safety capabilities. A business partnering approach is required to enable coaching and co-design of H&S initiatives with frontline teams.

2.0.15 The newly appointed H&S lead is currently establishing a new H&S strategic plan however this was not ready during the time of the Review.

Recommendation Table Legend

Implementation Period		
S	Short Term	Within 1 month
M	Medium Term	Within 1 year
L	Long Term	Within 3 years
Estimated Impact		
L	Low	Will improve the safety of some areas of the operation
M	Medium	Will improve structural safety management aspects
H	High	Will improve the systems and safety of work undertaken at POAL to a high degree

Please note that this table is designed as guidance only to assist with implementation and should be evaluated by POAL as a separate exercise.

Key Findings and Recommendations

2.1 GOVERNANCE

Ref	**Key Findings** (with reference to recommendations)
2.1.1	The board are engaged in safety, regularly undertake site visits and discuss H&S issues as presented by management. (2.1.6, 2.1.8)
2.1.2	The way the board specifies targets that enable the board to track the organisation's H&S performance requires significant improvement. A substantive plan that allows for measurement and review at all levels of management is needed to ensure the organisation is achieving its H&S goals. (2.1.6, 2.1.10)
2.1.3	POAL do have a general understanding of their critical risks and controls, however there is a lack of clarity and understanding over whether the critical controls are sufficient for the risk exposure and whether they are operating as expected. (2.1.7)
2.1.4	The board requires more insight into H&S issues raised by workers and whether these are being adequately addressed. (2.1.8)
2.1.5	There has not been an adequate level of independent technical safety advice delivered to the board in order for the board to be comfortable that safety risk assurance requirements for key projects and operations have been met. (2.1.9)

Ref	Recommendation	Immediate action required	Implementation Period	Estimated Impact
2.1.6	It is noted that the Board does currently review and approve H&S objectives. As an improvement action it is recommended that this becomes a formal process based around the strategic planning cycle.		S	M
2.1.7	Review and agree critical H&S risks and their controls at board level. Agree how control performance (appropriateness and effectiveness) will be measured and reported on to the board. Make the critical H&S risk control performance reporting part of regular monthly reporting. Deep dive into critical H&S risk with operational management regularly to ascertain whether the controls are meeting the organisations H&S objectives (e.g., refer to the fatigue management section). It is noted that this recommendation sits across both management and governance functions.	Yes	Establish risks within 1 month – controls 3-6 months	H

Key Findings and Recommendations

2.1.8	The POAL board do communicate with workers during site visits. When undertaking site observations, ensure there is the facility to independently and confidentially talk to workers around control effectiveness (whether what is written down and trained is actually carried out in practice).		S	M
2.1.9	Focus on verification of H&S assurance activity for key critical H&S risks and projects such as automation. The board should require evidence that appropriate safety assurance work has been undertaken by competent professionals through the form of hazard and operability studies (HAZOP), safety cases or other similar methodologies. It is noted that KPMG have been previously commissioned to conduct an external review in this area. These reports were limited in scope and not technical in nature. POAL had engaged an external specialist to carry out 'bow tie' analysis, however this work, while useful, was not fully completed at the time of the Review and is at a relatively high level.	Yes	S	H
2.1.10	The board should be consulted as key stakeholder when management formally document how the board and management will measure success in H&S performance. It is essential that management create a framework of expectations, objectives, targets, and measures from board level and down through all levels of management and operations. This also requires consultation with workers. An indication as to whether these targets are being met should be communicated to all levels of the organisation.		M	M

Key Findings and Recommendations

2.2 LEADERSHIP

Ref	**Key Findings** (with reference to recommendations)
2.2.1	Workers' perceptions of H&S leadership and commitment varied depending on what part of the business they operated within. Head office, Maritime and Engineering departments generally felt supported in H&S while Container Terminal Operations (Stevedoring) views were more negative in terms of safety leadership. (2.2.8)
2.2.2	There are gaps between executive management's understanding of H&S control procedures and the perception of frontline workers as to what operating practices are applied in reality. (2.2.8)
2.2.3	Elements of the workforce who undertake high risk roles (mainly terminal operations) believe that executive management prioritises profitability and productivity over H&S and this is reinforced at the operational leadership level. (2.2.8, 2.2.9, 2.2.12)
2.2.4	There are variable perceptions on executive management's commitment to H&S by elements of the workforce (such as stevedoring) who undertake high risk roles. (2.2.10, 2.2.11, 2.2.13)
2.2.5	Workers in terminal operations had a perception that H&S issues, if raised, were not taken seriously by the organisation and resolved adequately. (2.2.12, 2.2.15)
2.2.6	There has been a clear history of industrial dissent, that may be a barrier to the development of a future positive culture within the workforce. All parties need to work together in good faith to achieve H&S improvement. (2.2.10, 2.2.14)
2.2.7	Worker engagement processes need significant improvement. (2.2.8, 2.2.16)

Key Findings and Recommendations

Ref	Recommendation	Immediate action required	Implementation Period	Estimated Impact
2.2.8	Enhance the board down view of what effective executive safety leadership behaviours are required to achieve the H&S objectives of the POAL. Improve processes to measure, evaluate, report on and coach senior management in these leadership qualities. These should include at a minimum: • Prioritising safety over productivity and profitability. • Communicating regularly and proactively on safety in multiple ways (as opposed to in reaction to a safety incident). • Encouraging comprehensive and meaningful employee engagement in safety. • Helping change at risk behaviours. • Following up on incidents reported by the workforce and implementing corrective actions.		M	H
2.2.9	When reviewing the H&S policy (which is currently underway) include CEO and Senior Executive responsibilities.	Yes	S	M
2.2.10	The legacy of labour relations dissent is hampering the underlying organisational culture. All stakeholders should work positively to focus on creating a culture where H&S is the primary focus and minimum H&S expectations are agreed, supported and acted upon.	Yes	M	H
2.2.11	Develop and prioritise initiatives to address trust issues within the terminal operations regarding the fear of speaking up, lack of follow up of safety issues raised and perception that those who raise issues or follow safety rules will be discriminated against.		M	H
2.2.12	Embed safety and wellbeing as a core value for the organisation through specific training led by the senior executive but aimed at middle and line management that focusses on expected H&S leadership behaviours. H&S modules of core organisatonal leadership training are being developed but were not available at time of Review.		M	H
2.2.13	Ensure that senior management are trained in the expected H&S leadership behaviours. Courses such as those available from the Business Leader's H&S Forum would be appropriate as are many other commercially based training courses. POAL are currently investigating appropriate training.		M	H

Key Findings and Recommendations

2.2.14	Continue to support and contribute to the Port Industry H&S initiative (led by the PIA and supported by Maritime NZ and WorkSafe) from a leadership perspective by continuing to be an advocate and active member.		M	L
2.2.15	Create an organisation wide focus on key hazards and risks and an expedited prioritisation mechanism for any control or hazard related issues raised by workers.	Yes	S	H
2.2.16	Address the difficulty and lack of ease in reporting issues through existing systems by reviewing and investing in easy to use and visible (to workers) hazard, risk and incident reporting and resolution systems.		S	H

Key Findings and Recommendations

2.3 HEALTH & SAFETY RISK

Ref	**Key Findings** (with reference to recommendations)
2.3.1	Marine operations and Engineering operations were examples where H&S risk is being managed well. The engineering data management system was impressive and an example of industry good practice. (2.3.10)
2.3.2	POAL have invested in H&S and the lashing platforms were a clear exemplar of how POAL have made a significant investment to keep their people safe. (2.3.11, 2.3.12.)
2.3.3	POAL have provided an account of how their cranes are well-managed to levels of industry good practice. (2.3.10)
2.3.4	The POAL organisational H&S Management System does not appear to be adequately implemented and operating. Although individual H&S documents have been produced, they do not fit into a 'Plan, Do, Check, Act' cycle that would enable continuous improvement and enable commitment and involvement of top management in the overall H&S management programme. (2.3.10)
2.3.5	People working across POAL's operations do not have a consistent understanding of the organisation's critical risks and controls. (2.3.11)
2.3.6	The Reviewers were impressed by the innovative approach to straddle automation at POAL. The POAL project team highlighted a number of safety controls implemented into the project, which made it clear that safety was a priority for POAL on this project. However, the automation project is unable to make a robust safety case for the development and operation of the automated straddles at Fergusson Wharf. It would be reasonable for a major project involving a new approach to integrating automated plant into an existing manual operation to have developed a safety assurance framework to enable an appropriate case to be made about the overall system safety during design, development, and operation. (2.3.12)
2.3.7	POAL's overall approach to safety assurance requires improvement so that all major projects develop a suitable safety assurance framework and provide project governance with clearer information on how they are meeting safety objectives. (2.3.12)
2.3.8	There are many opportunities where Human Factors expertise input would help more effectively analyse usability and user interface issues with plant and other equipment linked to high-risk activities. (2.3.13)

Key Findings and Recommendations

Ref	Recommendation	Immediate action required	Implementation Period	Estimated Impact
2.3.9	Occupational Health and Safety Management System (OHSMS). Consideration of developing the OHSMS to align to ISO 45001 is recommended. Investment in an ISO 45001 scoping audit to highlight what elements of the OHSMS require improvement and assist with developing an improvement plan. A good OHSMS will provide POAL with a better mechanism for managing general H&S risks and ensuring appropriate learning and review activity around H&S risks is being undertaken.	Yes	M	H
2.3.10	Critical H&S Risk Programme – To further augment POAL's approach to critical risks, it is recommended that POAL establish a critical H&S risk programme. One key output would be a common understanding of what the organisation's critical H&S risk activities are and development of life saving rules associated with those H&S risk activities. A critical H&S risk programme would also provide focus on critical H&S risk control, with specific activity developed around assessing effectiveness of controls and development of reporting systems focused on critical risk activities and events with high potential for harm. Process safety focus is also a key element of a critical H&S risk programme and is captured in recommendation 2.3.11.	Yes	S	H
2.3.11	It is recommended that a safety assurance framework for automation (and other major projects) is developed and that competent safety engineers are engaged to develop and implement this. It will be advantageous for POAL to integrate the safety assurance framework process into the wider H&S risk management system so safety assurance can be developed and operated across all of POAL's critical H&S risk portfolio. When undertaking complex projects outside of POAL usual operations, it is strongly advised that specialist H&S capability is engaged to aid in managing the H&S risks associated the project.	Yes	S	H
2.3.12	It is recommended that human factors specialists are engaged to review the operating environments and work processes for straddle carriers and cranes to identify opportunities to improve the overall safety of related operations. Particular attention is drawn to: • Straddle training activities where improvements are needed to the safe location of tutors during practical instruction sessions. • Straddle cockpit configuration, where some operators are likely exceeding chair weight ratings, knotting ill-fitting seatbelts, and removing headrests. • Lashing platform processes, where further improvements to safety interlocks and processes might be achieved. • Control room operations across POAL.		M	M

Key Findings and Recommendations

2.4 OVERLAPPING DUTIES

Ref	**Key Findings** (with reference to recommendations)
2.4.1	POAL have demonstrated through development of the Waikato Freight Hub that they have the capacity to manage overlapping duties well; in this context in a construction environment involving overlapping projects and contractors. The design of the hub has demonstrated how POAL have considered risks to their tenants during the design phase demonstrating good practice as a client and developer. (Not linked to a recommendation).
2.4.2	POAL do undertake work to manage overlapping duties with third parties who use the port, including some collaboration forums. Current relationships between POAL and many of the third parties using the port require improvement. It is the view of this Review that POAL can and should do more to lead effective cooperation, communication, and consultation between third parties on matters of H&S. (2.4.8, .2.4.9, 2.4.10, 2.4.11)
2.4.3	Deteriorating infrastructure and poor housekeeping within the POAL Multicargo footprint are exposing third party operators to H&S risks that should be managed by POAL. The POAL team in Multicargo require increased support by POAL top management to improve the risk environment for third party operators. (2.4.9)
2.4.4	Poor traffic management (including clearly marked roadways and adequately signed infrastructure) within the POAL port footprint are presenting risks associated with site traffic and their interface with mobile plant and other vehicle operations. (2.4.11)
2.4.5	POAL have implemented a Common User Safety Protocol (CUSP) document. By way of improvement, POAL should make it consistently clear to all third parties operating on their property what the critical H&S risks are and what the 'non-negotiable bottom line' is regarding the controls for these risks. (2.4.9)
2.4.6	There is a risk that a third-party driver may be struck by exiting traffic whilst adjusting container locks in the common roadway of the Wiri freight hub, presenting the potential for death or serious injury. (2.4.10)
2.4.7	POAL do not currently receive adequate assurance from third party tenants that critical H&S risks are appropriately controlled and managed. (2.4.9)

Key Findings and Recommendations

Ref	Recommendations	Immediate action required	Implementation Period	Estimated Impact
2.4.8	Multicargo - Improve communication and cooperation between POAL and all third parties operating within the multicargo area. The Review acknowledges the existence of an inter-PCBU operational sub-group. One suggested approach would be to establish a H&S Leadership Group.	Yes	S	H
2.4.9	It is appreciated that POAL are going to some effort to engage with third parties, by way of further improvement POAL should consider creating a clear H&S expectations document that is effectively communicated to all 'third party' organisations operating on POAL property. This document should clearly align to an agreed set of critical H&S risks and controls in order to establish what is 'not negotiable' and what is expected as a minimum when operating on POAL premises.	Yes	S	H
2.4.10	Wiri Freight Hub - Work with tenants to establish a safe place of work for drivers to access their loads and trailers without being exposed to the risk of being hit by other site traffic.	Yes	S	H
2.4.11	Wiri Freight Hub - Establish a mechanism whereby POAL can gain assurance that third party tenants are managing their critical H&S risks appropriately, particularly those risks which have the potential to effect other third parties and the wider public.		S-M	M
2.4.12	Wiri Freight Hub - Consider appropriate controls (e.g., a barrier system) to prevent the fire water tank from being damaged by traffic operations.	Yes	S	M

Key Findings and Recommendations

2.5 FATIGUE MANAGEMENT

Ref	**Key Findings** (with reference to recommendations)
2.5.1	POAL use the services of Dr Matthew Thomas, who is an Associate Professor in Health Medical and Applied Sciences to develop and review bio-mathematical models of fatigue management. (No recommendation)
2.5.2	Fatigue management documentation requires improvement to ensure that it meets the intent of the implemented processes. (2.5.6)
2.5.3	Reactive and predictive information on fatigue is available within the organisation but not currently used to best effect. (2.5.7)
2.5.4	The models used to predict and govern fatigue should be peer reviewed. (2.5.7, 2.5.8, 2.5.9)
2.5.5	Worker representation from high risk areas may provide important signals around whether the workforce or individuals are fatigued. (2.5.10)

Key Findings and Recommendations

Ref	Recommendations	Immediate action required	Implem ntation Period	Estimate Impact
2.5.6	Ensure that the FRM Committee and associated FRMS is effectively maintained and operated. Board reporting should include regular updates and whether the meetings have been occurring, attended and minuted adequately. Key indicators should be reported to the Board as per the following recommendation.	Yes	S	M
2.5.7	Potential key indicators for the FRM committee, management and board include: a. Trends in fatigue and sick leave taken by reason code. b. Bio-mathematical risk scores of the roster both in forecast and historical trends by week, month, and year for seasonal analysis. c. Modelling on current and forecast workforce capacity compared to demand and potential impact on fatigue scores. An optimal workforce capacity should be modelled based on an overall targeted (lower) fatigue score. This can be compared to the actual workforce available so that management and board understand the fatigue risk profile of the current workforce based on future projected work demand. d. Number and type of fatigue related incidents and hazards reported.		M	M
2.5.8	Consider seeking independent peer review and advice on the bio-mathematical model underpinning the rules inbuilt into rostering and fatigue detection processes. This should be governed and reported back to the FRM Committee.		M	M
2.5.9	There is a potential opportunity to compare and learn and improve fatigue management from other high risk, 24 x 7 rostered operations such as the Department of Corrections who have been specifically focused and prioritizing this area in recent years.		M	M
2.5.10	Review and update the 2014 Stevedoring Hours of Work Policy to include recent changes.	Yes	S	M

Key Findings and Recommendations

2.6 INCIDENT REPORTING AND INVESTIGATION

Ref	**Key Findings** (with reference to recommendations)
2.6.1	Overall incident reporting including near miss reporting may not adequately capture the volume of incidents that are potentially occurring at POAL. This view is based on worker feedback to the Reviewer and from review of the past year's incidents. This may in part be due to factors such as the difficulty workers have in using the Portsafe system and partly due to a perception that line management do not follow up on H&S issues and see those raising them as troublemakers. (2.6.7)
2.6.2	The Reviewers note POAL are working to improve the reporting culture including cultural and leadership issues that may hinder this. (No recommendation)
2.6.3	There have been reports to Reviewers that frontline workers have reported incidents to supervisors that are not entered into Portsafe. (2.6.7)
2.6.4	The Reviewers noted that there are near miss incidents where no harm has occurred, but there was potential for serious harm or fatality. These events have not adequately assessed in relation to their risk and are not investigated in relation to that risk. (2.6.8, 2.6.9) Further detail has been passed to POAL by the Reviewer.
2.6.5	More investigation resources are required to ensure high potential incidents can be adequately investigated. (2.6.10)

Key Findings and Recommendations

Ref	Recommendation	Immediate action required	Implementation Period	Estimated Impact
2.6.7	In addition to the steps POAL are already taking, POAL should seek to improve the frequency of risk, hazard, near miss and incident reporting. Key to this is ensuring that incidents are accepted by line management and responded to in a timely and open manner with those raising the issues.		S-M	H
2.6.8	Review the H&S framework to establish more effective criteria to determine when investigations should be carried out into near miss incidents where serious harm or fatality could have occurred.		S	H
2.6.9	Where applicable, link incident reporting to critical H&S risks in order to determine where key controls have failed and require improvement.	Y	M	H
2.6.10	Train more workers to support investigations in appropriate methodologies to increase the capability of the organisation to create learning from incidents and strengthen controls as a result. Consider applying a 'learning teams' approach to help with learning from the front line to improve work. Learning teams bring together a group of people who were involved in a safety incident, or who might have useful information about it, to learn and improve (Link to WorkSafe NZ information on Learning Teams: https://www.worksafe.govt.nz/the- toolshed/case-studies/wepr-case-studies/involving-everyone-in-learning-reaps-benefits)		M	M

Key Findings and Recommendations

2.7 ORGANISATIONAL CULTURE & ENGAGEMENT

Ref	**Key Findings** (with reference to recommendations)
2.7.1	**Climate survey key findings** Survey perceptions indicated that senior management presence in the workplace is low. (2.7.10)
2.7.2	Rules and procedures were perceived to be the greatest focus rather than pro-active engagement and discussion when senior management does visit the workplace. (2.7.10)
2.7.3	It is perceived that there is a high level of blame attribution to workers after an investigation has been completed. (2.7.10)
2.7.4	Perceptions are positive in relation to investment into safety and understanding and communication of safety rules and responsibilities. (2.7.10)
2.7.5	There are mixed perceptions regarding worker relationships with frontline supervisors and leaders and their safety leadership capabilities. (2.7.12)
2.7.6	Safety representation and worker engagement also indicated mixed responses to ensuring the voice of the worker is heard. (2.7.13)
2.7.7	**Focus Group Key Findings** Some workers in the Container Operations teams perceived that there was a culture of retribution that occurs when H&S issues are raised which results in reduced hours and opportunities for promotion by front line management. (2.7.12) It is noted that senior leadership have emphasised the importance of H&S reporting and that safety leadership training is intended to be increased.
2.7.8	Night shift workers felt there was a potentially different culture at night where control adherence differed from training and procedures, in particular for high risk work such as lashing. This was exacerbated with lower levels of supervision and oversight by the health and safety function. (2.7.10)
2.7.9	Night shift workers perceive that there are times where inconsistency in resourcing levels compromises the ability to work safely. (2.7.10)

Key Findings and Recommendations

Ref	Recommendations	Immediate action required	Implementation Period	Estimated Impact
2.7.10	Share, discuss, and hold action planning sessions using the results of this safety climate survey. The Reviewers understand that POAL have held similar sessions on engagement. Action planning sessions should enable workers to share their ideas and thoughts on how to improve H&S.		M	M
2.7.11	Continue carrying out safety climate questionnaires at biannual intervals (6 monthly) as a mechanism for tracking climate movement based on this baseline survey (including multilingual options).		M	M
2.7.12	Increase frontline leadership training as a key focus area including pastoral care for workers.		M	H
2.7.13	Work with supervisors and line management who supervise high risk activities such as lashing to define clear protocols around minimum staffing levels to provide a clear and consistent organisational response.	Y	S	H

Key Findings and Recommendations

2.8 HEALTH & SAFETY FUNCTION

Ref	**Key Findings** (with reference to recommendations)
2.8.1	Personnel changes at a H&S management level has impacted the ability of the team to develop, implement, and monitor the effectiveness of the H&S framework. (2.8.6, 2.8.7)
2.8.2	During the Review, the incumbent Senior Manager H&S left POAL and a new appointment was made. Recruitment for a new H&S structure is underway. This new appointment continues to report to the Deputy CEO/CFO with an indirect reporting line to the CEO, not directly to the CEO as per the Reviewer's recommendation.
2.8.3	It is noted that the future direction would enable full and unfettered access of the Senior Manager H&S to the CEO and Board.
2.8.4	At the time of the Review there was a lack of understanding of the intent and content of the "Strong Foundations, Safe People Programme." Concern was raised that there is no involvement of the current H&S function. (2.8.8)
2.8.5	It is noted that the 'Strong Foundations, Safe People' programme is to be superseded by a new strategic H&S plan.

Key Findings and Recommendations

Ref	Recommendations	Immediate action required	Implementation Period	Estimated Impact
2.8.6	Establish a GM H&S position that reports directly to the CEO.	Y	S	H
2.8.7	The Reviewers recommend re-establishing a H&S structure and function that includes the following capabilities: H&S Transformation leader, Critical H&S Risk Programme Wellness/Injury Management/Health resourcing, Safety Systems *Please note this a suggested indicative recommendation for guidance that POAL should evaluate based on its future operational requirements.*		M	M
2.8.8	Ensure that the head of H&S prioritises the setting of a new comprehensive H&S strategy.		S	H

Key Findings and Recommendations

2.9 TRAINING

Ref	**Key Findings** (with reference to recommendations)
2.9.1	Overall, the standard of training and assessment activities is carried out to a high level. (2.9.4., 2.9.7)
2.9.2	The connection between the training curriculum and controls established for managing critical risks requires improvement to ensure that workers in critical areas have a common understanding of the risks and controls. (2.9.5)
2.9.3	Although there are many areas where engineering controls have been applied, there is a strong focus on training as an administrative control in a high-risk operation where greater use of elimination and engineering controls could be adopted. (2.9.8, 2.9.6)

Ref	Recommendations	Immediate action required	Implementation Period	Estimated Impact
2.9.4	Consider existing training in relation to work as done versus work as imagined and how this could be used to create a dynamic training environment where variability is explored.		M	H
2.9.5	As part of the recommended critical risk programme ensure that training captures key controls and golden safety rules required to prevent fatalities or serious harm from identified critical H&S risks. This should include collaboration with those responsible for creating and delivering training with the H&S Risk teams		M	H
2.9.6	Consideration should be given to the creation of a set of "Golden Rules" or "Lifesavers" (these are key controls which are easily digestible for all that work at the POAL)	Y	M	H
2.9.7	Improve on-the-job re-assessment so it is carried out at an appropriate frequency (i.e. every two years).		M	H

Key Findings and Recommendations

2.9.8	Look for opportunities to create higher levels of controls (elimination, substitution, engineering) in areas where are a purely behaviour/training relation safety control is in place to manage significant critical H&S risk.	Yes	S	H

2.10 CONTINUOUS IMPROVEMENT

Ref	**Key Findings** (with reference to recommendations)
2.10.1	The Reviewers have concerns about the practice of video recording shift toolbox meetings as this may be contributing to an environment of low trust between workers and management. 2.10.3)
2.10.2	The content of shift toolbox meetings is too dense for effective adoption by workers, and the size of the groups included in the meetings does not allow for free discussion or questioning by workers. (2.10.3)

Ref	**Recommendation**	Immediate action required	Implementation Period	Estimated Impact
2.10.3	Consider the adoption of elements of a lean management system, - specifically Leader Standard Work and Daily Management Systems (DMSs). These offer opportunities for collaborative engagement between front line leaders and workers to better define daily priorities and collectively resolve problems as they occur.		M	M

Appendix

Climate Survey Results

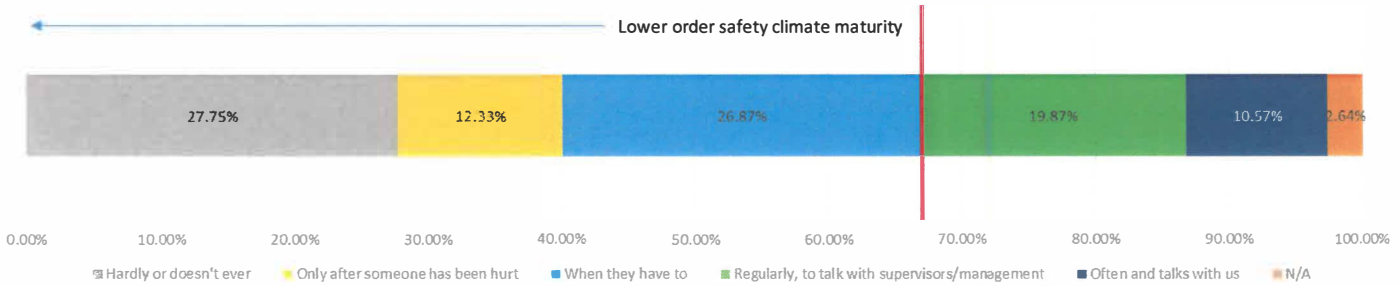
3

Safety Climate Survey

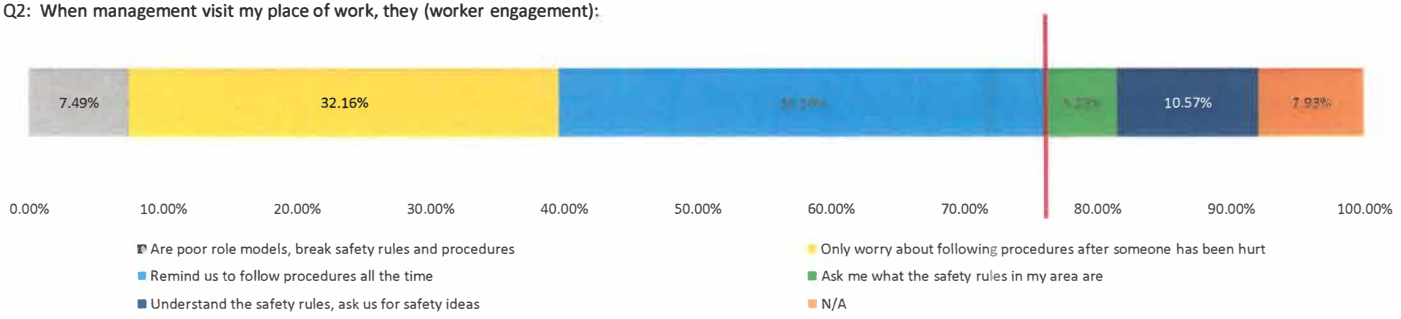
There were 227 climate surveys were completed from the total workforce of 667 employees and conducted in 7 different languages. 86% of the responses were from workers in higher risk positions such as stevedoring. Office based workers had a lower uptake on completing the survey, however this is not considered material to the findings of the survey due to the relatively lower level of H&S risk that these workers are exposed to. The sample size represents a margin of error of 5.29% and a confidence level of 95%.

Management Questions:

Q1: Senior Management visits my work area (frequency):

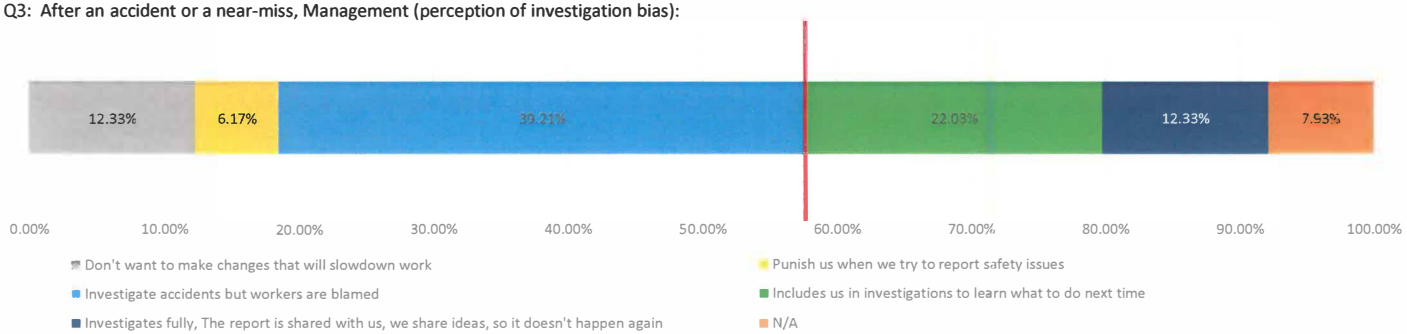


Q2: When management visit my place of work, they (worker engagement):

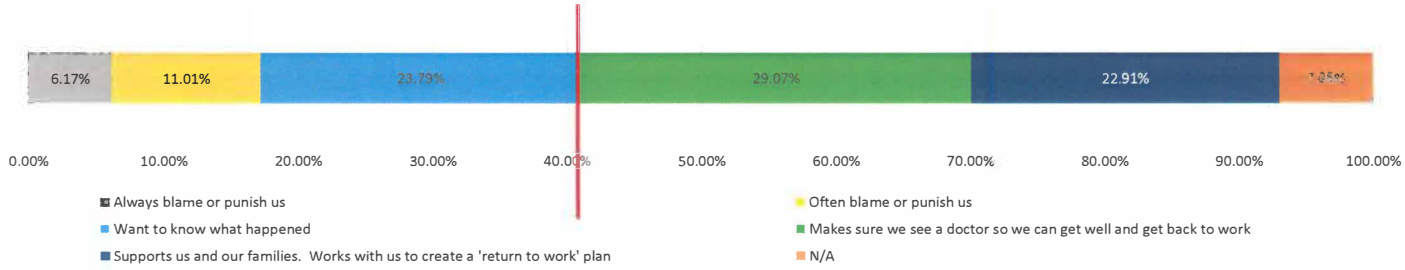


Safety Climate Survey

Q3: After an accident or a near-miss, Management (perception of investigation bias):

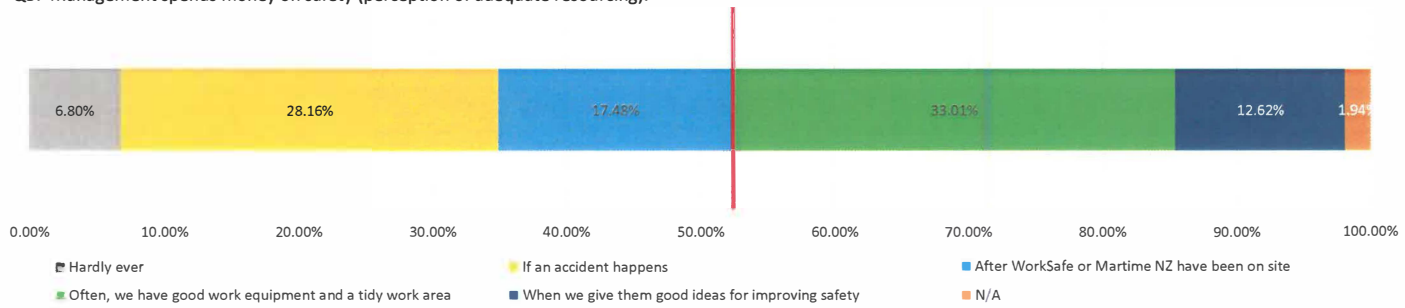


Q4: When workers are injured, Management (just culture and care for workers):



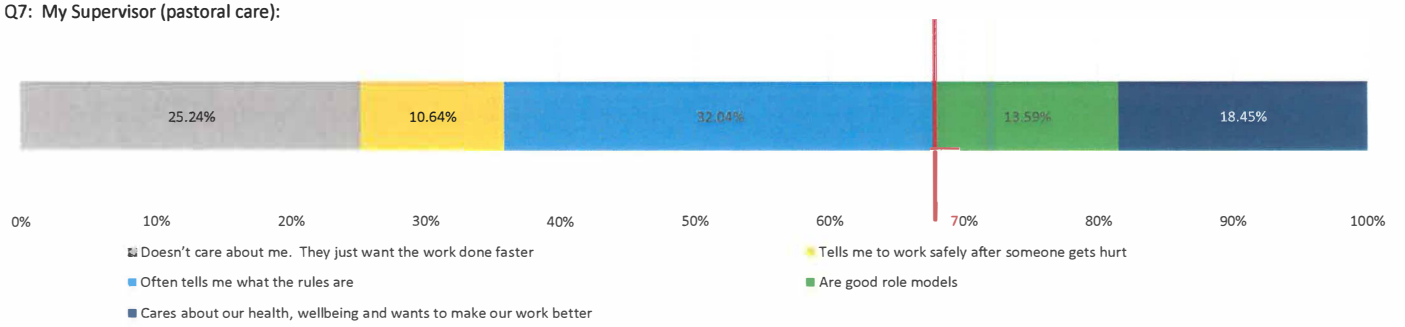
Safety Climate Survey

Q5: Management spends money on safety (perception of adequate resourcing):



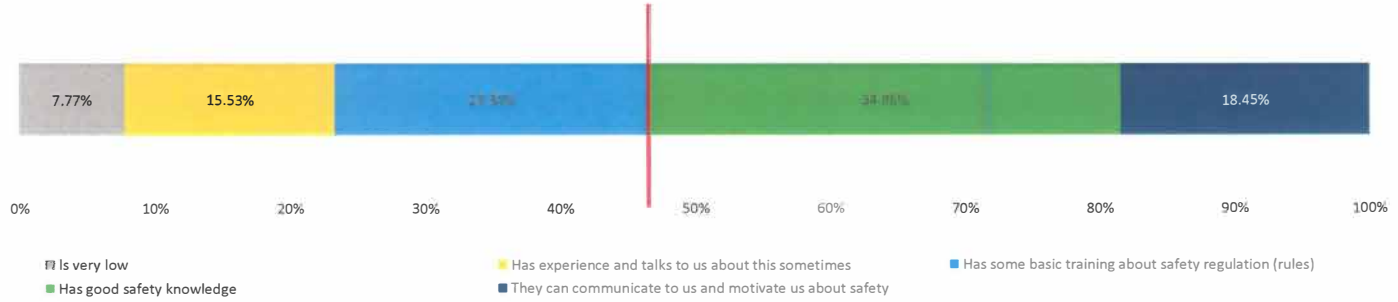
Frontline Leadership/Supervisor Questions

Q7: My Supervisor (pastoral care):

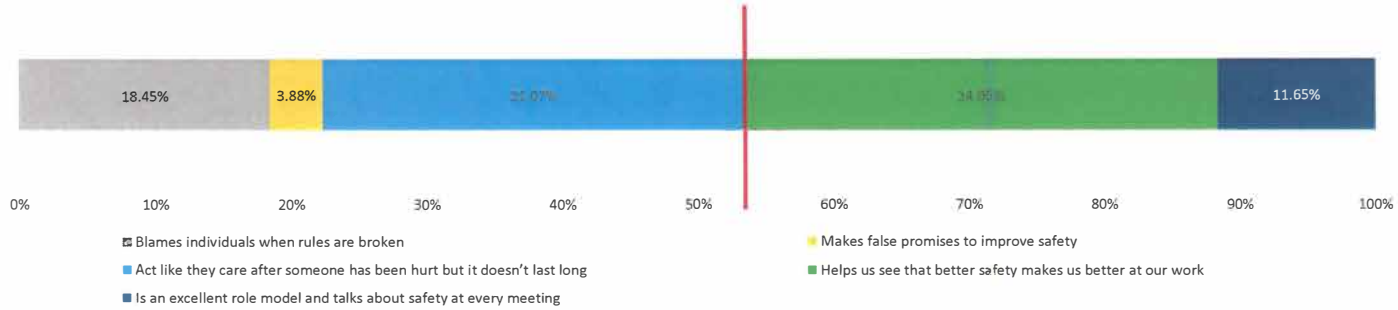


Safety Climate Survey

Q8: My supervisor's knowledge of health and safety:



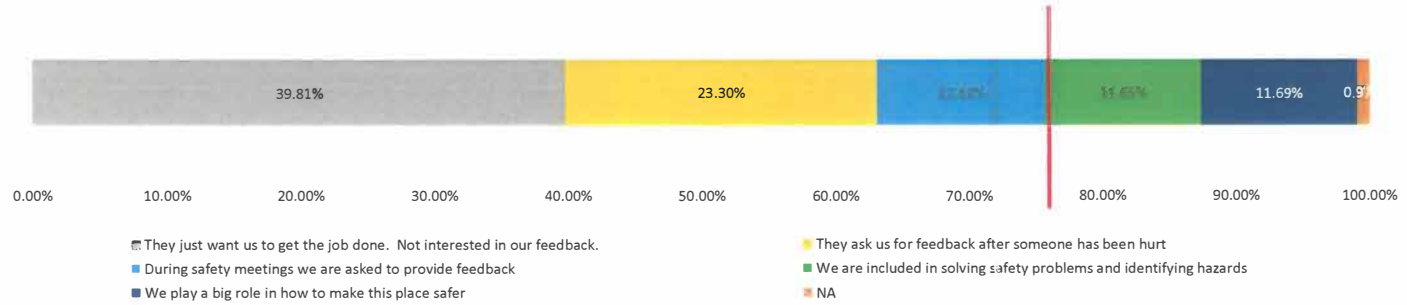
Q9: My supervisor (role modelling)



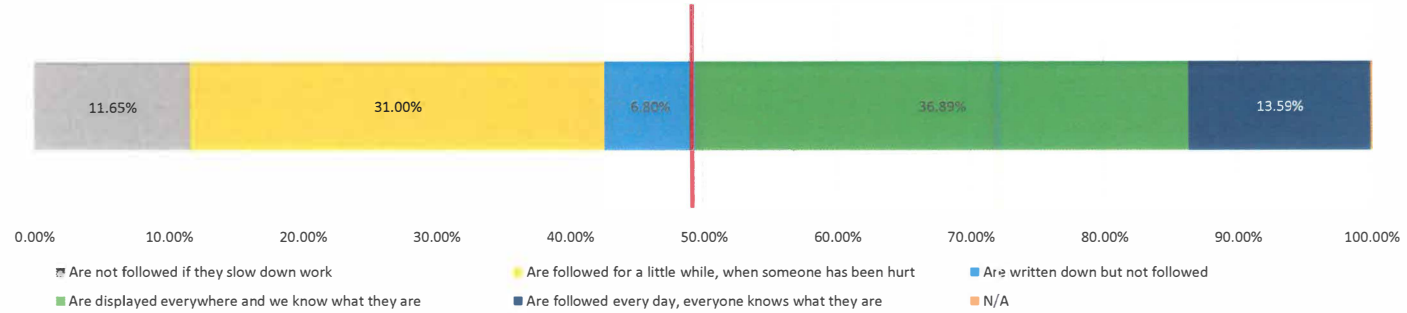
Safety Climate Survey

POAL/Safety Rules Questions

Q10: At POAL (worker engagement):



Q6: Safety rules and responsibilities:

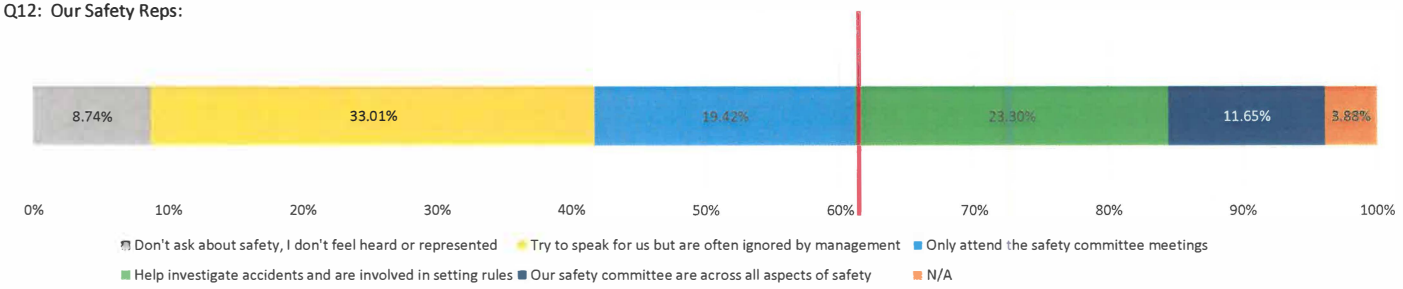


Safety Climate Survey

Q11: At POAL (critical H&S risk)

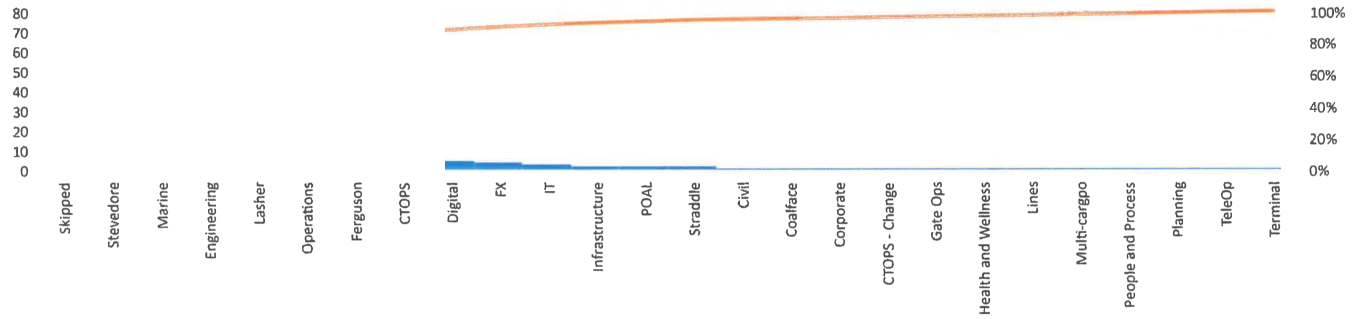
Safety Representative Questions:

Q12: Our Safety Reps:



Safety C mate Survey

Q13: What department do you work in (open re ponse):



Safety Climate Survey

Q14: Do you have any other comments? (open response)


Roger McRae, Independent Chair CHASNZ
Chris Alderson, CEO CHASNZ
Jon Harper-Slade CFIOSH, GM Safety Innovation CHASNZ
Emma Brookes, Health and Safety Specialist CHASNZ