IN THE DISTRICT COURT
AT TAURANGA

CRI-2015-070-000617
CRN15070500268
[2015] NZDC 22242

WORKSAFE NEW ZEALAND
Informant

v

AFFCO NEW ZEALAND LIMITED
Defendant

Hearing:	29 and 30 September and 1 October 2015
Appearances:	G Hollister-Jones for Informant M Hammond and K McLuskie for Defendant
Judgment:	20 November 2015

RESERVED JUDGMENT OF JUDGE P S ROLLO

Background

[1] On 19 August 2014, Jason Matahiki suffered a serious workplace accident during the course of his employment as a night cleaner at Affco New Zealand Limited (Affco), at its Rangiuru plant, near Te Puke.

[2] The left side of his head was penetrated by one of the prongs of a suspended spreader hook, part of the mutton chain, which entered his head above and behind his left ear, before the point of the hook exited immediately to the left of his left eye. Mr Matahiki was carried, suspended on the hook, for a very short distance before his screams alerted a workmate to hit the emergency stop button for the chain.

[3] Mr Matahiki was immediately assisted by his workmates, who supported his weight so that he was no longer suspended above the killing floor, and eventually the hook attached to his head was dissembled and removed from the mutton chain. Mr Matahiki could then be taken off-site for needed medical treatment.

[4] Most fortunately, the physical injuries to Mr Matahiki have not been otherwise significant or permanent, although he still suffers significant emotional harm from the experience.

Charge

[5] As a result of these events, Worksafe New Zealand Limited (Worksafe) has charged Affco with a breach of s 6 and s 50(1)(a) of the Health and Safety in Employment Act 1992 (the Act), that being an employer, Affco failed to take all practical steps to ensure that its employee, Mr Matahiki, was not exposed to the hazard of the moving 'foreleg chain', while at work.

[6] Affco defends the charge on the basis that the real cause of the injury to Mr Matahiki was his own actions, such that Affco is not culpable.

Legal provisions

[7] Section 6 requires 'every employer to take all practicable steps to ensure the safety of employees while at work, and in particular to take all practicable steps' - to 'provide and maintain for employees a safe working environment' (s 6(a)) and to ensure that while at work 'employees are not exposed to hazards arising out of the arrangement,...organisation,...working, or use of things in their workplace' (s 6(d)).

[8] Section 50(1)(a) makes it an offence for an employer to fail to comply with the requirements of Part 2 of the Act, in this case, of s 6.

[9] Section 19 deals with the duties of employees (which is relevant to the defence case before me). It requires every employee to take 'all practicable steps to ensure (a) the employees's safety while at work....; and (b) that no action or inaction of the employee while at work causes harm to any other employee'.

The relevant facts

[10] Mr Matahiki was in his fifth season with Affco at Rangiuru on the night cleaning gang. He was therefore an experienced cleaner, familiar with the premises and equipment and the work practices at the Affco plant.

[11] I was told there are usually 13 to 15 members on the night cleaning gang, although when double-shifts on the mutton floor are worked, and it is necessary for a much quicker cleaning of the mutton floor between those shifts, that cleaning gang might swell to 24 or 25 members.

[12] The mutton chain, in its totality, I was told, is in excess of 100 metres long, from the slaughter board ('up' the chain), to the end product carcass ('down' the chain). Mr Matahiki's cleaning responsibilities, on 19 August 2014, were that part of the mutton chain, the surrounding equipment, walls and floor, situated by a device known as the 'head off machine'. This machine was not in operation on the mutton chain at this particular time. Its usual function was to assist mechanically with the removal of the sheep or lamb's head, which then fell on to a large drip tray (the drip tray).

[13] This drip tray is one of several key factors in this case. It is rather like an elongated household shower base, perhaps one and a half metres long, with raised sides and a base sloping from a high point 'down-chain' to a low point 'up-chain' where there was a large chute hole through which the severed heads fell into the by-product area below the mutton floor.

[14] The injury to Mr Matahiki occurred immediately down-chain past the highest point of this drip tray.

[15] The charge refers to the 'foreleg chain'. In fact, up until that part of the mutton chain, there are parallel chains, perhaps 65 to 75 centimetres apart, looking up-chain, the 'foreleg chain' to the left, and the 'hind leg chain' to the right. This configuration of the parallel chains enables the slaughtered animal carcass to be

suspended from either the hind legs, from the hind leg chain, or between both hind and forelegs from both chains, or only by the forelegs from the foreleg chain.

[16] Immediately past the drip tray both chains rise to a slightly greater height, for perhaps four to five metres length, enabling persons or equipment to pass under the elevated chains there more easily from one side to the other of the mutton floor. The hind leg chain ends perhaps some 10-15 metres past the head off machine.

[17] The movement of the foreleg chain, in close parallel position to the hind leg chain, is another key factor in this case.

[18] Another key factor in this case is the then positioning of a stainless steel rectangular, box-section frame. This had previously held a scanner device. This 'scanner frame' was attached to the left side of the foreleg chain guard (looking up-chain), with the lower edge of the scanner frame at approximately the same height as the dual prongs of the foreleg hooks. The dimensions of the frame were not given to me, but during a site view, with counsel, it was held in its former place for counsel and me to view. This was immediately past the drip tray just as the elevation of the foreleg and hind leg chains began. The frame was perhaps 30 cms long by 20 cms high at its outside edges.

[19] This scanner frame, since removed, was redundant at the time of the injury and had been for quite some time since the scanner device had been removed. The frame was affixed, by chance, approximately the width of a man's head (Mr Matahiki's head, in fact, I find) from the position of the right side prong of the foreleg chain hooks (viewed down-chain). Equally, one might say it was situated the width of a man's arm or shoulder from such a prong, and obviously less if there were a carcass suspended from such a hook.

[20] The redundant scanner frame was never identified by anyone, including Affco management, the mutton floor workers, their safety committee, the night cleaners and their safety representative, or independent health and safety auditors engaged by Affco, as a safety hazard. In the circumstances of this injury to Mr Matahiki, it clearly was a crush hazard.

[21] The spreader hooks on the foreleg chain alternate, a double hook (one hook facing down-chain and a second hook facing up-chain, attached to the same shank) followed by a single hook (facing down-chain). Those respective spreader hooks are two pronged, the prongs inclined on an angle slightly upwards from horizontal, to the point of each prong, those prong points being rounded and hence significantly blunt. This is another key factor in this case.

[22] The height of the slightly elevated end of a standard prong of a spreader hook on the foreleg chain from the concrete floor was measured, during the site visit, at 165cms. This was confirmed in the evidence and confirmed by counsel. This is exactly Mr Matahiki's height (165cms in his shoes). He was measured, at my request, during one of the breaks in the course of his evidence. These measurements are also key factors in this case. They mean, ineluctably, that if Mr Matahiki were standing on the concrete floor immediately under the foreleg chain, any passing hook might 'part his hair' but could not enter the side of his head just behind and above his left ear. He is simply too short for that to have occurred. He must have been in an elevated position at the time.

[23] This is a further key factor in this case. If Mr Matahiki were standing on the higher, down-chain end of the drip tray, immediately by the start of the scanner frame (as the chain moved down-chain), the end of a prong would be at the same approximate height as the entrance wound to Mr Matahiki's head just above and behind his left ear.

[24] The relevant hygiene requirements for the operation of the Affco plant require the cleaning of all relevant surfaces daily after use. This involved the night cleaning gang, including Mr Matahiki, hosing, scrubbing, disinfecting, wiping down and subsequently checking the cleanliness of the mutton floor, its walls and all equipment in its work areas, as well as the hind leg and foreleg chains (including the hooks and their shanks).

[25] The night cleaning gang also cleaned other areas of the plant's operation during their shifts but the focus in this case is limited only to the circumstances on the mutton floor.

[26] I was told that after the essential cleaning had taken place, a process known as 'detailing' was then undertaken. This involved a further, essentially final inspection by the night cleaners of the mutton floor work areas and all equipment located there, to ensure that nothing had been missed during the main cleaning process. Where some missed blood or animal matter was seen during the detailing, it would be removed and the relevant area appropriately cleaned.

[27] At the time of the injury, 19 August 2014, detailing occurred with the foreleg and hind leg chains moving, presumably so various night cleaning staff, at different stages of the chain, could review the state of cleanliness of the individual hooks and shanks as they passed by. Any further cleaning arising from that detailing inspection would then happen as the chains continued moving. Additionally, when the chains were moving in unison, certain other machinery, such as the head-off machine, automatically operated as well.

[28] This is another key factor in this case, which interrelates with the other key factors I have identified as giving rise to this unfortunate, serious injury to Mr Matahiki.

[29] I understood the great majority of the staff at Affco to be seasonal workers. Those workers undergo an annual induction, on their commencement or return to work. That involves tuition on the company policies and procedures, including an emphasis on health and safety in employment issues, requirements, practices and goals. Each of the employees receive a copy of the company manual, which again details the company's policies and practices, including health and safety in employment obligations, expectations and requirements.

[30] In addition, as the Act requires, there are established health and safety processes, monthly health and safety meetings, attended by the plant manager, Kevin Casey, and other senior staff, as well as weekly tool-box health and safety meetings, conducted by the staff health and safety representatives. In the case of the night cleaning gang, these were convened, as I understood it, by the night cleaners' own health and safety representative.

[31] In addition, specific training on areas of health and safety practice were given periodically to specific Affco staff, focused on the requirements of their specific work duties. With the night cleaning gang, these focused on the use and storage of cleaning chemicals and substances, but also, relevant to these proceedings, lock-out procedures to disable machinery in a fail-safe way during repairs and maintenance, and during the cleaning processes.

[32] I interpolate that the machinery lock-out procedures were explained in evidence and also shown to me, in principle, during the site visit. This procedure involved an individual staff member disabling specific machinery (for example, the foreleg and hind leg chains and automated machinery operated with those chains) by switching it off at a control box (as opposed to a temporary, emergency 'red button' stop, such as immediately after Mr Matahiki was injured). That staff member would then lock the off-switch with a padlock device which carried a name tag advising the identity of that staff member controlling the sole key to the padlock. This process then made it impossible for any other person to inadvertently restart the specific machinery until the lock securing the lock-out had been removed by that sole key-holder staff member.

[33] In addition to the above-mentioned health and safety procedures and staff reviews, Affco also has external health and safety audits and reviews conducted by appropriate experts. These are usually on an annual basis, enabling an independent eye to be run over the company's plant, processes and practices, in order to identify actual or potential health and safety hazards within the work place, and remedial steps that might be undertaken to prevent or mitigate such hazards.

[34] From the evidence I heard and the documentation put before me, not only by Worksafe witnesses, but also by Mr Casey, the plant manager, I am satisfied that the company took its health and safety in employment obligations and responsibilities very seriously, and strived to avoid harm in the workplace to any persons present there, including its employees.

[35] However, the issue in this case is whether the specific steps undertaken by Affco, in the circumstances, were adequate?

The actual injury incident

[36] I find that on the evening of 19 August 2014, near the end of the night cleaning shift, during detailing, Mr Matahiki was standing between the moving chains on the higher, down-chain end of the drip tray, which would have given him just sufficient height to be able to see the top of the two-pronged spreader hooks of the foreleg chain. Standing on the concrete floor, close to the moving chain, Mr Matahiki simply would not be able to see the top of the spreader hook prongs, because of his height. He would therefore be unable to check fully the cleanliness of each passing hook during detailing.

[37] There is no evidence that Mr Matahiki stood on any other object or objects to gain greater height during this process, and indeed, as I have alluded to, the facts indicate that he must have been standing on the drip tray down-chain end. Because of the entry point of the right-sided prong into the left side of his head, Mr Matahiki was obviously facing down-chain. The left side of his head had to be to the right of the right-sided prong.

[38] Because of the blunt, rounded end of each prong, penetration of the head would not happen, I find, without some form of restraint on Mr Matahiki's head to stop it simply being pushed or knocked forward, albeit bluntly, by the passing prong.

[39] I find that what happened is that Mr Matahiki's head has come into contact with the right-side prong, perhaps because he was distracted or partially lost his footing or because he had been bending and stood upright into the path but to the right of that right-side prong. The prong has pushed his head forward, it seems to me, and the right side of his head must have immediately come into 'crush' contact with the scanner frame. This must have been substantially a glancing blow (as he had no real injuries to the right side of his head) but it was sufficient to cause such a degree of resistance to Mr Matahiki's head that the prong then penetrated into the side of his

head, just behind and above his left ear, and continued to pierce right through the left side of his head and out again just beside and to the left of his left eye. I find that this must have required a degree of continued resistance to the forward passage of Mr Matahiki's head which must have occurred because his head had to pass between the scanner frame and the forward moving right-side spreader hook prong.

[40] As I have said, particularly from the site view and also from the photographs, although it was not precisely measured, I find the gap, between the right-side prong passing by the previous position of the scanner frame, to be essentially consistent with the width of Mr Matahiki's head. I am also satisfied that, although Mr Matahiki's head was restrained to some degree by the presence of the scanner frame, it was, as I have commented, a glancing blow, with his head squeezing through the gap substantially unscathed on the right side (consistent with the accepted medical evidence of no real injuries to the right side of his head).

[41] I find no evidential basis for any other explanation for what happened that night that could cause this injury to Mr Matahiki. The fact that the prong penetrated right through and out the front of his head indicates a continuing restraint, I find, that is not consistent otherwise with the prong simply nudging into the side of his unrestrained head.

[42] I am therefore satisfied that this work place injury was caused by the coming together of these identified key factors, Mr Matahiki's being on the drip tray during detailing in the confined space between the two moving foreleg and hind leg chains, the right side prong of the foreleg spreader hook coming into contact with the left side of his head, and the then presence of the scanner frame causing some 'crush' resistance to his head. Without any one of these factors being present, this serious incident almost certainly would not have happened.

The respective cases

[43] The prosecution case is that this is not negligent employee responsibility but a failure by Affco to properly fulfil its health and safety obligations under the Act, by allowing the foreleg chain to be moving during the relevant cleaning process.

Affco's own policies and practices provided for the lock-out of the chain and other machinery, when activities such as repairs and maintenance and cleaning of machinery were being undertaken, and as this did not happen. Accordingly, the prosecution submits that the charge is proved.

[44] The defence case is that Mr Matahiki admitted, in cross-examination, that he should not have been on the drip tray. The moving chains during cleaning and detailing were reasonable industry practice at that time. The scanner frame had never been identified, at any time, by any person, as a health and safety hazard. It was therefore not known to be such a hazard. The company had taken all reasonable and practicable steps to identify hazards and to train its staff in health and safety practices in accordance with Affco's legal obligations under the Act.

[45] But for Mr Matahiki's being on the drip tray, where he acknowledged he should not have been, the injury would not have happened. Affco is not culpable in those circumstances, the defence submits.

Discussion

[46] Mr Matahiki did admit, in cross-examination, that he should not have been on the drip tray, but my clear view of his evidence, in this regard, is that this concession by him was with the benefit of hindsight and only after that proposition was firmly put to him by Mr Hammond. I find that it was not because there was any actual proscription against being on the drip tray.

[47] Ms Kirikiri, the night cleaning supervisor, knew of no such prohibition, although she said it was not necessary to go on the drip tray, as she suggested one could clean the head-off machine from the surrounding floor. Similarly, Ms Marshall, the night cleaners' health and safety representative, knew of no such prohibition from being on the drip tray. She said that it was often necessary to get on the drip tray when cleaning the head-off machine.

[48] Significantly, no company documents were produced before me nor referred to otherwise in the evidence that confirmed that there was a company prohibition on

any cleaner being on the drip tray during the cleaning process. Nor was there any evidence from any employee of Affco in any degree of a supervisory or managerial role that this was so. Additionally, I am satisfied that there would, logically, be occasions, possibly at least daily, when a cleaner would need, or would choose, to get onto the drip tray to clean in and under the head-off machine, then situated beside and over the drip tray. As accepted, and as shown in the contemporaneous photographs of the scene, this was a machine protruding across the path of the foreleg chain very likely to gather up blood, fat and animal matter on, in, and under its various parts as carcasses moved by throughout a killing shift.

[49] So I put little evidential weight on Mr Matahiki's admission that he knew he should not have been on the drip tray. He told me he had no real recollection of the incident, which I accept is not unusual when a person is involved in a traumatic event such as this. He conveyed the impression, in his evidence-in-chief, that he was standing on the concrete floor, not the drip tray, but because of the height measurements I have referred to, this clearly cannot have been so.

[50] In so finding, I do not suggest Mr Matahiki has been untruthful, merely that he has been mistaken on this point. If he now appreciates or suspects that he was on the drip tray immediately prior to his injury, he no doubt regrets that circumstance and he may well recognise that it was unwise for him to be there at the time, hence his answer to Mr Hammond's question. I am satisfied that Mr Matahiki had a sense of regret, at the time, about the effects of his injury, apologising to Mr Casey (as Mr Casey told me) for what happened. I took from this evidence not that Mr Matahiki accepted he was at fault, but that he regretted the inconvenience and perhaps difficulty that his injury might present to Mr Casey. His answer to Mr Hammond is not inconsistent with this finding.

[51] Michael Nidd, an expert in the design, construction and operation of meat plants nationally and internationally, called by the defence, told me that there is no meat industry standard or standard operating procedure for the cleaning operation in meat plants. He also told me that the industry practice for most of the country's meat plants is not to have the chains moving during cleaning, with only some plants doing so. However, I accept that this circumstance within the wider meat industry does not,

of itself, prove that a moving chain was necessarily an unsafe practice. Neither does the fact that Affco has now adopted the practice, I was told, of not running the chain during cleaning and detailing also prove that its former practice of doing so is, of itself, necessarily evidence that the previous process was not safe. Affco now simply advances the chains, with all cleaners standing back, then stops them so the next section of the stationary chains can then be cleaned, before they are advanced again, with the cleaners standing back, for the next section to be cleaned while stationary etcetera.

[52] This is a marginally slower cleaning process, I was told, but clearly much safer as it avoids possible serious injury arising from the constantly moving chains, particularly when the cleaning process involves close inspection and cleaning of those very chains.

[53] However, I find that this should have been obvious to Affco at a much earlier stage, particularly when its own safety protocols unequivocally provided for the lock-out of machinery during cleaning. In saying that, I acknowledge the inherent danger that slaughter board workers and knife hands face when working in close, often wet and potentially slippery conditions on the mutton chain. Their work involves movement along and sometimes around the two chains and carcasses hanging from their hooks. That is clearly a potentially more hazardous work situation than that of night cleaners, although the latter, of course, are required to hose, foam, scrub and cleanse in and around all machinery including the chains, as I have referred to, activities bringing their own potential hazards.

[54] But the focus of the Act is on the identification, elimination, isolation or minimising of significant hazards (ss 6-10) and the employer taking 'all practicable steps', being 'all steps to achieve the result that it is reasonably practical to take in the circumstances', to achieve that required result in any circumstance (s 2A(1)). In saying that, I am alive to the provisions of subs (2) and the fact that 'a person required to take all practical steps is required to take those steps only in respect of circumstances that the person knows or ought reasonably to know about'.

[55] This is an important limb of the defence case. Affco, its agents, experts and employees were unaware, Mr Hammond asks me to infer from the evidence, of the significant hazard presented by the moving foreleg chain during cleaning and detailing, having regard to the current industry practices and the then current state of knowledge of a significant proportion of the meat industry.

[56] And as I have commented on, none of Affco, its agents, experts and employees was aware that the redundant scanner frame could be a potential crush hazard. I find that they should have been. The scanner frame served no purpose. It should have been removed (and one might opine, it should never have been sited there, so close to where it could always have been a potential crush hazard, especially to a taller man). Mr Casey conceded the frame 'had been overlooked' as a potential trapping point, in his evidential interview with James Napier, health and safety inspector, of Worksafe, on 8 January 2015.

[57] But the charge against Affco alleges the company 'failed to ensure that its employee, Mr Matahiki, was *not exposed to the hazard of the moving foreleg chain* while at work' (my emphasis). Thus, the focus must be on the moving foreleg chain as a reasonably identifiable hazard, having regard to the current state of knowledge about the likelihood that harm of that nature and severity would be suffered by an employee (s 2A(1)).

[58] The difficulty with the defence submission is that whilst Mr Nidd has confirmed that there was some industry practice for moving chains during cleaning, Affco's own then health and safety protocols clearly referred to the requirement for machinery to be locked-out during such cleaning. Mr Casey acknowledged this in his evidential interview with Mr Napier, on 8 January 2015. His acknowledgement is entirely consistent with the company's relevant documentation. He also conceded in that interview that running the chain during cleaning 'was not acceptable'.

[59] These were honest and responsible answers, and entirely apposite. They saw Mr Casey also concede, in effect, that even though there were health and safety protocols, processes and training, there were no scheduled or random checks on health and safety compliance, but that there would be in the future.

[60] I find the following facts –

(a) Affco's health and safety processes, protocols and some of its practices were satisfactorily compliant with the Act's requirements, and I accept, as I have noted, the company intended to provide a safe and healthy workplace to its employees and persons at the plant;

(b) The night cleaning gang members did receive specific training, from time to time, focussed on promoting a safe and healthy workplace through prescribed appropriate workplace practices;

(c) The reality was, however, that notwithstanding that purported training and the on-going tool-box site staff safety meetings, and the company's monthly and other reviews, the night cleaning gang did not fully follow the company's training, as apparently taught and as specified in its workplace instructions. Additionally, the night cleaning supervisor did not appear to know or recall many of the essential safety requirements or be familiar with the company's safety documentation, and the health and safety representative displayed no greater apparent knowledge of those practices. Mr Matahiki certainly did not know them, I find. In saying that, the responsibility for what happened on 19 August 2014 rests with Affco, not with its low level staff;

(d) These circumstances illustrate the on-going need for any employer to ensure not just a training process, including documentation proscribing unsafe practices and mandating practical, safe procedures for staff in their workplace, but scheduled and also random monitoring to ensure full and on-going understanding, and necessary compliance by relevant employees with all health and safety expectations, obligations and requirements when in the workplace;

(e) That did not happen adequately, if at all, in this case. Section 5 of the Act refers to the object of the Act of 'promoting excellence in health and safety management, in particular through promoting *the systematic management of health and safety*' (my emphasis). The night cleaning gang was not 'systematically managed' in an adequate way that ensured the standards of the Act were being met.

[61] Mr Matahiki should not have been standing on the drip tray in the relatively small gap between the two moving chains during the detailing. However, as I have commented, with his height and the necessity to see the tops of the spreader hooks as they passed by, to do his job he perhaps felt he had no immediate other course open to him.

[62] The practice of detailing with the chains moving was unsafe, and contrary to the company's clear instructions to the contrary. This is for two reasons, I find. When the chain is moving, so are the machines within the mutton chain. These machines, including the head-off machine, just by Mr Matahiki's standing position, are potentially very dangerous and clearly can represent a serious health and safety hazard to cleaners or others in the workplace. Second, the moving foreleg chain is, by its very nature, exceptionally unforgiving and unrelenting, as Mr Matahiki regrettably found out, when carried off, suspended by the skin of his head.

[63] The foreleg chain, and its associated machines, should have been appropriately locked-out, as Affco's then health and safety protocols dictated. The company should have ensured, by on-going training and, most importantly, on-going monitoring, that its health and safety protocols were being adequately adhered to by its relevant staff.

[64] These were critical company failures. Proper procedures properly followed, the company's responsibility under the Act, would have prevented this serious injury to Mr Matahiki. These were obvious, practicable steps that Affco failed adequately to appreciate and act upon at that time. I note that policies and procedures seem to have changed positively and promptly since 19 August 2014, to the company's credit.

Result

[65] This is not a case of employee causation, as the defence submits: it is a case of company failure to comply with its statutory obligations under s 6 of the Health and Safety in Employment Act 1992.

[66] For the reasons I have referred to, I am satisfied that the prosecution has proved the offence under ss 6 and 50(1)(a) of the Act beyond reasonable doubt.

P S Rollo
District Court Judge

RESERVED DECISION DELIVERED BY ME PURSUANT TO SECTION 68 OF THE SUMMARY PROCEEDINGS ACT 1957

PM NEWMAN
DEPUTY REGISTRAR
20 NOVEMBER 2015