THIS FINDING IS SUBJECT TO PROHIBITIONS ON PUBLICATION UNDER S 74 OF THE CORONERS ACT 2006

IN THE CORONERS COURT
AT ROTORUA

I TE KŌTI KAITIROTIRO MATEWHAWHATI
KI ROTORUA

CSU-2016-HAS-000198

UNDER THE	Coroners Act 2006
AND	
IN THE MATTER OF	An inquiry into the death of **Niko O'Neill BROOKING-HODGSON**

Dates of Hearing: 22 and 23 July 2021

Appearances:
Mr O Christeller for Brooking-Hodgson Whānau
Ms A Longdill & Ms A Simpson for WorkSafe New Zealand
Mr B Nathan & Ms E Kittelty for DG Glenn Logging Limited
Mr S Crosbie for Pan Pac Forest Products Limited
Mr P Anderson - Counsel to Assist
Constable A Revell - NZ Police Inquest Officer

Date of Finding: 8 December 2021

FINDINGS OF CORONER D M LLEWELL

Contents

Introduction

[1] Niko O'Neill Brooking-Hodgson was 24 years old, of Māori descent (Ngāti Porou) and in a de facto relationship with an infant daughter. Niko was described as an amazing human being. He was a great father, well known and liked in the community. He played for his local premier rugby club and was selected as a lock for the Poverty Bay representative side.

[2] Niko was employed by DG Glenn Logging Limited as Head Breaker Out. He was part of a crew working in the Esk Forest, at the Pohokura Block, Te Haroto, situated north-west of Napier and near the Mohaka River.

[3] Approximately 10:50am on 22 August 2016, Niko was undertaking a line retrieval operation in order to move the hauler to another landing site. As the line was being hauled, a D-shackle attached to the line became snagged on an obstruction. Niko moved position to inspect the situation. As he did so, the line spontaneously became free which released tension. The weight and gravity then sent the line and gear with speed towards Niko and a co-worker.

[4] Niko was hit by the line, D-shackle or block (or a combination of all three) and received fatal injuries to his head and chest. First aid was provided by his co-workers until emergency services arrived. His injuries were non-survivable. He died at the scene.

[5] I acknowledge the Brooking-Hodgson whānau and Te Araroa community were deeply affected by the loss of Niko, which was compounded by the passing of another member of their whānau (also in a forestry accident) 364 days after Niko's death

Condolences

[6] From the outset, I extend to Niko's whānau, his partner and forestry colleagues my sincerest condolences for their loss.

Procedural Background

[7] Niko's death was the subject of a Police investigation. Attending officers were satisfied there were no suspicious circumstances surrounding his death and no other person was the subject of a criminal investigation.

[8] Because the incident occurred in a workplace, Police notified WorkSafe NZ / Mahi Haumaru Aotearoa which then became the lead investigation agency.

[9] By way of Minute dated 23 July 2020, Chief Coroner Judge Marshall transferred Niko's file from now retired Coroner Scott to me for completion. I opened an inquiry on 11 August 2020.

[10] Between 23 November 2020 and 15 July 2021, I convened a number of case management and pre-inquest conferences to determine the issues for inquest, interlocutory matters, the contents of the coronial inquiry and inquest document bundles, and other procedural issues.

[11] The inquest hearing was held on 22 and 23 July 2021 in the Gisborne District Court.

Jurisdiction

[12] Section 57 of the Coroners Act 2006 (the Act) provides that a Coroner opens and conducts an inquiry to establish, so far as is possible, that a person has died, the person's identity, when and where the person died, the causes of the death, and the circumstances of the death.[1]

[13] An inquiry is not to determine civil, criminal, or disciplinary liability.[2] A Coroner may make recommendations or comments in relation to a death for the purpose of reducing the chances of further deaths occurring in circumstances similar to those in which the death occurred.[3]

[14] The standard of proof, or threshold that needs to be met before a Coroner can be satisfied that something has been proved, is the balance of probabilities, which means that it is more probable than not. However, there is a principle that where there is a serious matter at issue there must be *"... stronger evidence before being satisfied to the balance of probabilities standard ... Moreover, the principle requiring more cogent evidence generally in serious civil cases is sound and well established in New Zealand."*[4]

[15] Minute No. 3 dated 29 March 2021 acknowledged Niko's whānau were dissatisfied with WorkSafe's investigation for a number of reasons. The coronial jurisdiction cannot be used as an appellant court to dispute, challenge or relitigate WorkSafe's investigation and the outcomes of that investigation. Whether the actions or inactions of a person conducting a business or undertaking (PCBU) constitutes a breach of the Health and Safety at Work Act 2015 (HSWA), and whether WorkSafe made the right decision when they declined to prosecute any person or company involved, were not issues for inquest or my wider inquiry.

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[1] Coroners Act 2006, ss 57(1) and (2).

[2] Coroners Act 2006, s 57(1).

[3] Coroners Act 2006, ss 57(3) and 57A.

[4] *Z v Dental Complaints Assessment Committee* [2009] 1 NZLR 1, per Blanchard, Tipping and McGrath JJ at [102], [105] and [112]. See generally, *Anderson v Blashki* [1993] 2 VR 89 (SC) at 96.

[16] Under section 57(4) of the Act, a further purpose for an inquiry is to determine whether the public interest is served by a death being investigated by authorities in the performance or exercise of their functions, powers, or duties; and to refer the death to them if satisfied the public interest would be served by doing so. As discussed later in these findings, some additional evidence was received around the circumstances of Niko's death. However, in the absence of any new compelling facts and because the regulatory context at the time of the incident was not modified by evidence at the inquest, then in my opinion further investigation or referral would not be in the public interest. This determination is without prejudice to any rights Niko's family may have and is not intended to fetter the statutory obligations of any authority.

Issues for Inquest

[17] Minute No.6 dated 15 June 2021 set out the issues for inquest as follows:

a) What is best practice in dealing with an obstruction during a line retrieval?
b) Is line (and block) retrieval a different operation from line shifting?
c) What is a "straw line" – its purpose, how does it operate, and would it have avoided Niko's death?
d) Are there deficiencies in policy and guidance for line retrieval in the Approved Code of Practice for Safety and Health in Forestry Operations 2012 (ACOP)?

[18] Minute No.4 dated 13 May 2021 set out areas for potential Coronial recommendations, including:

a) Whether the ACOP should be amended to include standard operating procedures for line retrieval;
b) Whether the ACOP should be amended to include standard operating procedures for safely managing an obstruction during line (and block) retrieval;
c) Whether such procedures must include the following:
    - responsibility and ultimate control for line (and block) retrieval;
    - line quality standards;
    - mandatory use of a straw line;
    - safe distances from rigging, moving lines and blocks;
    - safe distance from the bight of a moving rope and D-shackles; and
    - modes of communications for a line retrieval operation.

Cause of Death

[19] Forensic Pathologist Dr Katherine White conducted a post-mortem examination on 23 August 2016. Dr White concluded that the direct cause of Niko's death was head and chest injuries sustained in a forestry incident.

[20] [redacted]

[21] Forensic Toxicologist Dr Helen Poulsen analysed toxicological samples. Her first report dated 14 October 2016 confirmed minor traces of alcohol (less than 5 milligrams per 100 millilitres) detected in the blood and urine, likely from means other than deliberate ingestion (i.e. internal metabolic events post-mortem). Caffeine was also confirmed in the blood. Dr Poulsen provided a supplementary report dated 1 June 2021 which confirmed there were no synthetic cannabinoids or metabolites detected in Niko's blood or urine, and there was no evidence of the use of alcohol or cannabis.

[22] [redacted]

[23] I accept the evidence of Drs White and Poulsen. I am satisfied that the cause of Niko's death was non-survivable head and chest injuries sustained in a forestry incident.

[24] Niko was verified deceased by a St John Ambulance paramedic at the scene at 11:20 on 22 August 2016.

Parties and Witnesses at Inquest

Brooking-Hodgson Whānau

[25] Mr Richard Brooking, Niko's father, was the first to provide evidence (with Niko's daughter supporting him in the witness stand). Mr Brooking talked about the tragedy of losing their son and his belief that no forestry family should have to endure

such pain. His view was that those killed in the forestry sector were predominately young Māori men and that health and safety were not taken seriously. He advocated for more regulation that was clear and direct. He wants to see real change to forestry practice and strengthening of the ACOP.

[26] In response to questions asked of him, Mr Brooking agreed that a more collaborative approach for developing rules and regulation was desirable, including engaging with forestry workers on the ground (i.e. a bottom-up verses top-down approach). He was supportive of a regional rather than centralised health and safety regulator. Mr Brooking advised that consulting with Unions would not necessarily result in a representation of all forestry personnel. In terms of the ACOP, Mr Brooking wanted quality not quantity. He thought that the ACOP should contain all necessary guidance for high risk activity, be fit for purpose and be able to be stored in the glovebox so it is readily available for workers on site.

[27] Mr Leonard Reedy's evidence was based on 25 years of working in the forestry sector. Mr Reedy is currently a hauler driver (and has been for 10 years) but has worked in all areas of forestry operations, including as breaker out and head breaker out. In these roles he has used a variety of different machinery.

[28] With reference to a diagram[5], Mr Reedy outlined the constituent parts and activity of a scab skyline system cable logging operation. He addressed training generally in the forestry sector, including his own mentoring and assessment of other workers for skill competencies, explained the nature of hauler work and limitations to sight, outlined the differences between line shift and line retrieval operations, explained the use and benefits of a straw line, the importance of and types of on-site communications between crew, his opinions about the ropes used on the day of Niko's accident and actions of the hauler driver.

[29] Mr Reedy referred to the ACOP being commonly called the "Bush Bible". His evidence was that it is the first point of reference for forestry workers if they are unsure of a correct practice. He confirmed the lack of any guidance about line retrieval in the ACOP. Mr Reedy considered that best practice guides are generally used for training and accreditation purposes rather than on the job reference.

[5] Competenz Best Practice Guide for Cable Logging (January 2005) at page 52 (Inquest Bundle Document 12) and Diagram of Cable Logging (FITEC, 2000) (Inquest Bundle Document 5).

[30] Ms Hazel Armstrong provided expert evidence having been involved in the forestry sector in review, investigation and advisory capacities over several years. Ms Armstrong had been commissioned by the whānau to provide an assessment and report following Niko's death.[6] Her evidence at inquest explained the context for the Independent Forestry Safety Review (IFSR) in 2014 and subsequent 2018 review. She noted that the ACOP has not been updated and comprehensive regulations for forestry are not yet in place. Ms Armstrong considered this inquest was an opportunity to reinforce 2016 findings of my predecessor, Coroner Bain, on those points.

[31] Ms Armstrong explained why line retrieval is a discrete risk. For the purposes of assessing and managing risk, Ms Armstrong's opinion was underpinned by the "Swiss Cheese model"[7] of how defences, barriers and safeguards may be penetrated. This systems-based approach (rather than a person-based approach for assessing and managing risk) is premised upon the view that humans are fallible and that counter measures assume that though we cannot change a human condition, we can change the conditions under which humans work. This, to an extent, looks past the acts or omissions that may occur due to carelessness or negligence, and puts systems in place to protect against those risks despite certain behaviour. Ms Armstrong promoted this model as underpinning New Zealand's health and safety regulatory regime.

[32] Ms Armstrong also opined about the use of a straw line, competency requirements for line retrieval, control during a line retrieval operation, communications, ropes and lines under tension, and the need for an exclusion zone. She confirmed the lack of any formal unit standards and accreditation specifically for line retrieval. She proffered a number of recommendations in relation to issues raised.

[33] Ms Armstrong had not seen a relevant 2017 best practice guide[8] until it had come to her attention through the circulation of evidence for inquest. Having had the chance to review that guide, Ms Armstrong conceded under questioning that it was a satisfactory document and could not offer any substantive improvements. She observed that the guide's section about line retrieval would be a good starting point for amending the ACOP.

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[6] Report by Ms Hazel Armstrong dated 1 August 2018 commissioned by the NZ Council of Trade Unions on behalf of Niko's whanau (Inquest Bundle Document 4).

[7] *"Human Error: Models and Management"* by James Reasons (BMJ Volume 320, 18 March 2000) (Inquest Bundle Document 14).

[8] Competenz Best Practice Guide for Breaking Out in a Cable Harvesting Operation (September 2017) (Inquest Bundle Document 17).

WorkSafe New Zealand / Mahi Haumaru Aotearoa

[34] Mr Grant Duffy, Engagement Lead, Sector Lead and Programme Manager for Forestry was scheduled to provide evidence on behalf of WorkSafe but tragically and suddenly died only weeks out from the inquest hearing.

[35] Ms Kelly Hanson-White, WorkSafe's Regulatory Frameworks Policy Team Manager provided evidence instead. Although she was not an expert in forestry practices and was not involved with WorkSafe's investigation of Niko's incident, her evidence valuably explained the Health and Safety at Work regulatory framework, supporting regulations, the ACOP, other guidance and particularly how the different components are intended to work together.

[36] Ms Hanson-White provided statistical information (with an explanation of the associated challenges in calculating these due to the categorisation of reported forestry incidents and fatalities) that confirmed Niko's incident was the only formally recorded death in a line retrieval operation. There have been no serious harm or notifiable incidents associated with that operation since. Her evidence also detailed the creation of the 2017 best practice guide[9] with a focus on the section about shifting the line / retrieving ropes.

[37] Ms Hanson-White clarified the various agency responsibilities in the health and safety regulatory framework. WorkSafe (being a Crown entity) does not hold responsibility for the development of legislation or associated regulations. This is undertaken by the Ministry of Business, Innovation & Enterprise (MBIE) Health and Safety Policy Team on behalf of the Minister for Workplace Relations & Safety. While Ms Hanson-White's policy team works closely with MBIE to provide an operational perspective (informed by its regulatory role and expertise), the statutory responsibility for the development of the ACOP sits with WorkSafe.

[38] Another helpful aspect of her evidence was her summation of the status, and consequently the legal enforceability, of various instruments of the regulatory framework. Mandatory obligations are only expressed in legislation, associated regulations and/or Safe Work instruments. In contrast, compliance with the ACOP is not mandatory in the strictly legal sense therefore compliance with the ACOP cannot of itself be enforced. That said, an ACOP is considered in the industry and by the regulator as providing benchmarks of acceptable and safe practices. Deviations from ACOP standards would generally need to achieve equal or higher safety outcomes. Best practice guidelines do not have

[9] Ibid at page 26.

mandatory status either but Ms Hanson-White did appreciate their use in a training context.

DG Glenn Logging Limited

[39] Mr Robert Scurr provided evidence in his capacity as Director and Operations Manager of DG Glenn Logging Limited (DGL). Acknowledging the tragedy for and grief of Niko's whānau, it was clear the incident had deeply affected the company and Niko's colleagues.

[40] Mr Scurr confirmed Niko's employment with DGL, his experience, qualifications and training, outlined the personal protective equipment required for the role and key steps undertaken by a breaker out, his appreciation of the incident on 22 August 2018, DGL's policy and procedure for maintenance and replacement of ropes, use of radio transmitters and the "tooter" system. Following Niko's incident, DGL initiated its own safe operating procedure (SOP) for line retrieval before the 2017 best practice guide was published.

[41] Mr Scurr provided a useful video that illustrated the setting up and use of a straw line in ideal circumstances. The video was never intended to be or received by me as representing or reconstructing the environmental situation at the time of Niko's incident. It did however provide the inquest with important context and understanding about the operation of a straw line.

[42] Whilst Mr Scurr acknowledged there was some utility in the use of a straw line, he did not agree that a straw line would have avoided Niko's death. From his perspective, the critical issue was that Niko was not standing in a safe area, contrary to several policies about moving ropes, and in contradiction of Niko's training and experience.

Pan Pac Forest Products Limited

[43] Pan Pac Forest Products Limited was an interested party in the inquest. It did not provide evidence or question witnesses, and its Counsel maintained a watching brief.

Other Evidential Matters

[44] WorkSafe's Investigation Report[10] provided an evidential platform on the circumstances of and operational context in which Niko's incident occurred. I have also drawn upon other primary coronial inquiry documents obtained throughout the course of the initial Police investigation and WorkSafe's regulatory investigation.

[45] The evidence of the co-worker who was with Niko at the time of the incident has not been afforded much weight because he had only been on the job for 4 days, was only

[10] Report dated 27 July 2017 at page 14 (Inquest Bundle Document 1).

beginning his training under Niko's supervision, and his respective statements contained minor inconsistencies. The co-worker was not called to give evidence in person at inquest.

[46] Though the hauler driver, [redacted], was not called to give evidence in person at inquest, I have considered and weighed the statements made by him in the course of the investigations described above. That evidence was also subsequently interpolated at inquest by Mr Scurr.

[47] The inquest heard evidence concerning a number of secondary matters, such as the effectiveness of DGL's radio equipment, existence of flags near the backline, qualifications of crew members involved, and concerns about the quality of the tail rope. I am not required to make findings on these secondary matters except to the extent that they assist in addressing the issues for inquest.

[48] Minute No. 4 dated 13 May 2021 raised a key factual issue, namely whether the tail rope used in the operation on the day of the incident was in sub-optimal condition[11]. This matter was appropriately addressed by WorkSafe through the issuance of an Improvement Notice under the HSWA (which was complied with). For the avoidance of doubt, I am satisfied that although the condition of the tail rope may have contributed to the incident, it was not a direct or causative factor.

[49] During the course of the inquest some additional evidence around the circumstances of the incident came to light, which are addressed in the following section.

Circumstances of Death

Incident of 22 August 2016

[50] The introductory paragraphs [3] and [4] set out a high-level summary of the circumstances that led to Niko's death. Following consideration of prior statements, written evidence at inquest, questioning of the witnesses and additional photographic material through the circulation of evidence for inquest, there is now greater clarity as to the circumstances of the incident.

[51] The rigging and set up for the line retrieval operation was unusual in that the backline was at a higher elevation well above the hauler, with approximately 300 metres between the hauler and the backline.

[52] The tail rope was not stopped as it was approaching the backline, but I accept it had been slowed in preparation for the D-shackle coming closer to the tail block.

[11] Mr Scurr's evidence objected to some evidence of behalf of Niko's whānau that the tail rope was "sub-standard".

[53] The wire strops were not removed from either the top corner or tail blocks and were still both hooked up to their respective anchor stumps.

[54] As evidenced by photographs of the top corner block, it is likely that block had been released given the D-shackle was still in place (but had remained stropped to the anchor stump).

[55] The hauler driver advised Niko by radio transmitter that the tail rope was snagged with an obstruction (but that it would clear soon). Fundamentally, Niko never acknowledged or communicated in response before tension was applied to the snagged rope.

[56] At that critical point, the distance between the hauler and the backline was such that it could not be visually appreciated that Niko may have moved to inspect the situation.

[57] Niko had moved into an unsafe area while the rope was still moving, and potentially within the bight of the rope, when the sudden release of tension on the tail rope caused the D-shackle to fly up the hill and inflict the fatal injuries to Niko's head and chest.

Other Circumstances

[58] Niko was very capable, qualified and experienced to carry out the role of Head Breaker Out. He held the appropriate Unit Standards to undertake the role (standards covering the tasks generally) and had achieved exemplary results, scoring 95% for audits of his competency. It can never be known why Niko moved into an unsafe location.

Determination of Issues for Inquest

What is best practice in dealing with an obstruction during a line retrieval?

[59] The only way to have completely avoided Niko's death would have been for the tail rope to be stopped when the snag occurred. In the absence of clear concise communication and confirmation between Niko and the hauler driver, tension should not have been kept on or further applied to the rope.

[60] Continuation of the operation should only occur when the safe locality of crew at the backline has been confirmed. Due to factors such as distance, lack of sight from the hauler and essentially the crew at the backline with the first-hand knowledge, that responsibility and confirmation can only logically be given by the head breaker out.

[61] Furthermore, if one form of communication is not received (i.e. by radio transmitter) then an alternative form of communication should be deployed (i.e. talkie tooter system) with no rope being re-engaged until information is exchanged (and acknowledged as received).

Is line (and block) retrieval a different operation from line shifting?

[62] Line shifting and line retrieval are not dissimilar however they are not the same operation and have different risk profiles. Generic standards and controls for line shifting or another activity incumbent in a line retrieval are inappropriate for the management of the specific hazards associated with retrieval.

[63] There are some key differences between the two operations. Line retrieval involves returning all the gear situated at the backline back to the landing in order to break down the hauler and move the set up to another location for log haulage.

[64] D-shackles are utilised for that purpose and that creates a specific hazard associated with sending the D-shackle down the line, connecting equipment to the rope and retrieval of it. Unlike other operations with moving ropes, the line retrieval operation will require crew to move into the exclusion zone to release the blocks from the rope. This is a critical and unique hazard which may warrant different controls to be implemented to address risk.

What is a "straw line" – its purpose, how does it operate, and would it have avoided Niko's death?

[65] A straw line is a light-weight line used to lay out or shift working ropes. The line can be spooled on the straw line drum or come in separate coils and be carried manually.[12] It has joining hooks spliced into each end which allow the rope to be run across a gully downhill from ridgelines and joined up as needed to complete a loop which is connected to the heavier rope to be pulled around the setting. The straw line usually comes in sections which are between 70 and 80 metres long.

[66] The primary use for a straw line is to bring heavier rope around the backline and to improve control when ropes are being shifted or retrieved. A straw line is only used when a line shift or retrieval is taking place (whereas a working rope is always active, whether it be pulling logs in or pulling rigging out). A straw line is a standard piece of equipment that comes with a hauler and so it is not an extra item to be purchased.

[67] Mr Reedy gave evidence that he always uses a straw line when operating a hauler. He stated that whether a straw line is used or not is ultimately the decision of the crew foreman with that decision generally being made when the pre-harvest plan is determined before a line retrieval takes place. He estimated that the use of a straw line adds an extra five to ten minutes to the operation, so it was not onerous in terms of the time saved by not using one.

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[12] Competenz Best Practice Guide for Cable Logging (January 2005) at page 68 (Inquest Bundle Document 12).

[68] A straw line can keep the ropes off the ground so that the D-shackle may be less likely to become obstructed. Mr Reedy's view was that even if the ropes are on the ground and the D-shackle becomes snagged, using a straw line means that it is easier and safer to unsnag the obstruction. The straw line is able to be pulled backwards and forwards by the hauler operator to unsnag the D-shackle. This allows the shackle to be unsnagged without applying more force, which can otherwise cause the D-shackle to "fly up the hill".

[69] In the event of there being a quick tension release of a snagged rope, the rope would be propelled downwards, not upwards (i.e. towards the hauler driver with protection in the hauler cab and away from the breaker outer) thereby improving safety for the ground crew.

[70] The straw line is a synthetic rope that is smaller in size and has less loading capacity than a working rope and so it can be more susceptible to being overloaded. Mr Scurr's evidence suggested that due to its small size and often being run around objects, a straw line can be easily overloaded and become worn from rubbing on logs and terrain. It cannot handle the weight that the machine is able to put on it, so a straw line can break or come undone because it has joins.

[71] The benefit of the reversibility of rope movement by use of a straw line and proviso of not overloading it has been specifically recognised by the following control:

> *Whenever a shackle is to be placed in the eye of the tail rope, a straw line is to be attached to the shackle (Straw to Tail) so the Hauler Operator has the ability to reverse the rope movement should the shackle become snagged. Care should be taken not to overload the straw line.* [13]

[72] Whether a straw line is suitable for use in all terrain was the subject of extensive evidence. Mr Reedy was of the clear opinion that a straw line is able to be used in all terrain and should be used whether the terrain is steep, flat or downhill. He further opined that in situations where the rope is on the ground, the straw line can still be used as a safety device. It will drag on the ground. If it meets an obstruction, the tow rope can be used backwards and forwards to clear the obstruction. He considered that reversing the rope, while still being held by the straw line would be safe.

[73] Mr Scurr agreed that reversing the rope is one way that you could possibly clear an obstruction but his view was that while you can wind the straw line in to attempt to bring it forward, at the same time you are increasing tension on the line and this does not

[13] Competenz Best Practice Guide for Breaking Out in a Cable Harvesting Operation (September 2017) at page 26 (Inquest Bundle Document 17).

necessarily mean the obstruction will clear as it could be hooked in both directions. It could also break the line or go the other way. Mr Scurr's view was that the use of a straw line should be subject to the proviso that excessive tension should not be placed on the line. The risk of excessive tension results from two key factors - elevation and distance.

[74] The straw line is more likely to break when used over long distances where the backline is higher than the hauler, and the rope is being pulled uphill. This places more weight on the line. The hauler has enough power to break the straw line at any point, so the hauler operator must be careful how much strain or tension is put on the rope. If the line does break and the rope is suspended, the ropes will retract and that renders standing at either end dangerous.

[75] Mr Scurr was concerned that by using a straw line in inappropriate conditions or attempting to put enough tension on the rope to raise it up and over obstacles, then there would be a chance that the straw line would break and that effectively replaces one risk with a worse or at least different risk.

[76] There must be a nexus between the cause and circumstances of Niko's death and any recommendation for the mandatory use of a straw line when line retrieval is being undertaken. In other words, there must be a direct link between those matters for me to be satisfied that the use of a straw line would reduce death in similar circumstances. This requires an analysis of whether the use of a straw line in this situation would have led to a different outcome.

[77] Mr Reedy's view was that if a straw line was being used and the D-shackle had become snagged, Niko's crew could have continued ahead using the straw line, cleared the obstruction, added further pressure and lifted the D-shackle over the obstruction, released the straw line pressure and carried on. Mr Scurr did not agree. His evidence was that in Niko's situation, because the hauler was higher than the backline, the straw line would have been excessively loaded and unable to keep the rope off the ground. In other words, one hazard would have been replaced with another.

[78] Adopting the practice of using a straw line (with an explanation that it stops the eye of rope dragging on the ground) was a specific industry learning and recommendation for the task of line retrieval set out in WorkSafe's Investigation Report.[14] Of itself that indicates that having regard to the circumstances of Niko's death, the use of a straw line was recognised and promoted for the task of line retrieval and for inclusion in the ACOP.

[14] Report dated 27 July 2017 at page 14 (Inquest Bundle Document 1).

Are there deficiencies in policy and guidance for line retrieval in the Approved Code of Practice for Safety and Health in Forestry Operations 2012 (ACOP)?

[79] Evidence was unanimous from all parties at inquest that there is no policy or guidance about line retrieval in the ACOP.

[80] Prior to Niko's death, the forestry industry did not perceive line retrieval as a specific risk, nor was training provided specifically for that operation. The statistical evidence provided by Ms Hanson-White indicates that line shifting has been a more common source of harm or potential harm to forestry workers over the past decade than line retrieval, with only one notifiable incident where the task may have been line retrieval (compared to 21 notifiable incidents in that time frame, including one fatality, relating to line shifting).

[81] Following Niko's death, the Best Practice Guide for Breaking Out in a Cable Harvesting Operation[15] was published in September 2017 by the key forestry sector training organisation. This occurred a few months after WorkSafe's investigation was completed. This best practice guide was created by a review group, with a WorkSafe representative, who was aware of the circumstances of Niko's incident and ensured that the specific risks associated with line retrieval was discussed within that group and guidance was issued to industry for that operation.

Other Matters Arising

Contributory Negligence and its Effect on Culpability

[82] In opening submissions, Mr Christeller on behalf of Niko's whānau drew my attention to a recent Health and Safety at Work Act 2015 (HWSA) sentencing decision of District Court Judge Cathcart.[16] This case concerned the death of a forestry worker who was struck while logs were being hauled out of a steep valley via a skyline cable system. The incident did not occur in the process of line retrieval, but Counsel submitted there were similarities between that case and Niko's.

[83] The jurisdiction section of this finding acknowledged that it is not the role of the Coroner to make any findings in relation to civil, criminal or disciplinary liability. Moreover, my inquiry (and an inquest generally) operate in an inquisitorial not prosecutorial setting. However, I have considered the Court's comments in *Pakiri* and whether they have relevance to the issues for inquest.

[84] In *Pakiri*, the deceased was standing in the wrong place at the wrong time when he was struck and killed. His crew had incorrectly designated a safe retreat distance of 20

[15] Competenz Best Practice Guide for Breaking Out in a Cable Harvesting Operation (September 2017) at page 26 (Inquest Bundle Document 17).
[16] *WorkSafe New Zealand v Pakiri Logging Limited & Ernslaw One Limited* [2021] NZDC 14158 (16 July 2021).

metres (which was where he was standing at the time of the incident). The safe retreat distance should have been identified as being no less than 45.4 metres before the drag. This was the principle operational error that led to the fatality.

[85] The forestry companies argued that this was a situation where the victim contributed to his own death. They submitted that the deceased had reported to work with prohibited drugs in his system, failed to follow instructions to retreat further away from the fatal haul and was not facing the drag at the time that the haul started. Because of the victim's conduct, they contended the victim's contributory negligence was his failure to observe relevant standards in the logging industry and as a result he contributed significantly to the accident causing his death. They argued that this was one of those rare cases where a worker's conduct is relevant to an assessment of corporate culpability under the HSWA.

[86] In finding that the deceased's contributory conduct carried no weight on quantum of reparation or culpability, the Court highlighted several authorities that suggest a victim's contributory conduct being considered in health and safety prosecutions is disfavoured. The Judge went on to say that *"... observance of these principles ensures the foundational duty under the statutory regime is not easily undercut. Employers must guard against workplace accidents that result even from foolishness or carelessness of the employees."*[17]

[87] Counsel for Niko's whānau used the Court's comments on the contributory conduct of a worker in *Pakiri* to illustrate his view of the entire premise for our modern health and safety regime. The sorts of mistakes that a worker may make, even carelessness or negligence, do not negate the employer's duty and obligations, even if a worker's mistake was a contributing factor to a health and safety incident.

Independent Forestry Safety Review and Contemporaneous Findings

[88] In response to a spate of forestry-related deaths (between March 2012 and November 2013), now retired Coroner Wallace Bain convened eight inquests over a period of time and issued contemporaneous findings in 2016. A key reason for conducting the inquiries in this manner was to identify common themes and causes of deaths in the forestry sector with evidence relating to forestry safety arising in each inquest.

[89] Coroner Bain considered the Independent Forestry Safety Review (IFSR) which was commissioned in January 2014 and completed in October 2014 by the forestry

[17] *Pakiri* at [124]

industry. The aim of the IFSR was to *"... identify the likely causes and contributing factors to the high rate of both injuries and fatalities in New Zealand and make recommendations to improve safety in the forestry sector"*.[18] Coroner Bain acknowledged the Government's responses to recommendations from the IFSR as being positive steps toward reducing fatal work-related incidents in the forestry sector.

[90] While endorsing the activity and outcomes of the IFSR, Coroner Bain formed the view that due to active steps and policy initiatives that were underway at the time of issuing the contemporaneous findings, specific recommendations from those inquest findings were not required.

[91] There was some confusion at an early stage of this inquiry into Niko's death as to whether Coroner Bain had made formal recommendations. However, during the pre-inquest phase preparing for inquest, it was accepted by Counsel for Niko's whānau those were not formal Coronial "recommendations" as envisaged under section 57A of the Act.

[92] Evidence and submissions for Niko's whānau on the interrelationship between the IFSR and those contemporaneous findings was essentially that the promises of a comprehensive review of the ACOP, along with strengthening the associated regulatory framework for the forestry sector, have not been implemented as contemplated in 2014 and 2016.

Regulatory Framework Ongoing

[93] Ms Hanson-White gave evidence that following the ISFR and Coroner Bain's 2016 forestry contemporaneous findings, it was clear to the regulator that a comprehensive review of the ACOP would be required to incorporate outcomes from both of those inquiries. However, widespread reform of the entire health and safety regulatory framework was underway at the same time. In August 2013, the Government accepted a recommendation of an Independent Taskforce on Workplace Health and Safety to create new legislation. The new Health and Safety at Work Act and the first suite of supporting regulations were passed in 2015 and came into force in 2016.

[94] Ms Hanson-White confirmed that work on the remaining regulations to complete the intended health and safety regulatory framework is ongoing. New regulations for governing the safe use of plant (i.e. machinery, equipment and vehicles) and structures are expected to be in place from 2022.

[18] Findings of Coroner Bain in relation to the death of David Wayne McMurtrie (26 November 2016) at page 9.

[95] Work on developing regulations governing hazardous work activity has yet to commence. These regulations are intended to set mandatory competencies or qualifications for particular types of work (including within the forestry sector) as well as prescribe safe practices. In response to questioning, Ms Hanson-White acknowledged that line retrieval and/or parameters for the use of a straw line could be well placed for inclusion in these hazardous work regulations.

Amending the ACOP – Quality not Quantity and Accessibility

[96] The current ACOP was published in December 2012. In January 2014, WorkSafe undertook a short-term review of the ACOP. That review was limited to clarifying responsibilities of principals, contractors and supervisors. The review was completed, approved by the Minister and an amendment to the ACOP was published in November 2014. This took the form of a supplementary document, which addressed the roles and responsibilities of principals and contractors.

[97] Ms Armstrong accepted that it was not feasible for everything to go into the ACOP. There will need to be a balance struck between the detail in the ACOP and what is communicated in other forms of control and information (such as regulations, instruments (supporting technical regulatory rules), codes, good practice guidelines or best practice guides, standards, industry safety alerts, fact sheets and training materials).

[98] Ultimately those decisions will need to be made following the requisite statutory consultation process. It may be pragmatic and logical, in light of the ongoing regulatory work outlined above and expected to be in place or instigated in 2022, for a collaborative dove-tailed consultation process (i.e. amending the ACOP and hazardous work regulations).

[99] ACOP's require Ministerial approval to be published, revoked or amended. The Minister may approve, amend, or revoke a code of practice only if satisfied that the development process involved consultation between unions, employer organisations, and other persons or representatives of other persons affected, or reasonably likely to be affected, by the code, amendment, or revocation.[19]

[100] An ACOP may take 1 - 2+ years to produce. The time varies due to the complexity of the topic, the extent of proposed amendments, the required consultation, and the level of agreement amongst parties about best practice.

[101] Niko's whānau strongly advocated for a "bottom-up" approach. Ms Armstrong's referred to a Council of Trade Union's Rūnanga who might also be a suitable conduit to

[19] Section 222(2) of the HSWA.

represent workers. Perhaps that Rūnanga might also provide an avenue to bring a Māori perspective into the discussion. During his evidence Mr Brooking identified a disconnect, in that a significant number of forestry workers are Māori and come from rural communities, which is far removed from Wellington where decisions ultimately seem to be made in his view. He advocated for some regional oversight and collaboration between Wellington and the crews on the ground as one way to improve the regulatory framework.

[102] Of relevance to the topic of engagement, I note that MBIE's Health and Safety at Work Strategy 2018 – 2028 specifically recognises worker engagement, participation and representation as a priority area in the strategy. That priority is also restated in the Forestry Sector fact sheet that also acknowledges forestry workers often engage and participate in health and safety in less formal ways.[20]

[103] Mr Brooking gave evidence that he believed health and safety regulations need to be clearer and more direct. His view was that there are many different rules and those rules are not clear. He advocated for the use of one central document, the ACOP (colloquially known as the "Bush Bible"). That way, every worker would be on the same page daily and retrieving their information from the same place. He spoke of the use of illustrations and diagrams to make the ACOP more accessible to a forestry worker with low literacy. Mr Reedy was also of the view that there was a need for plain and simple language as well as more diagrams and illustration to be used in the ACOP.

[104] Other matters need to be considered for accessibility of the ACOP for workers in isolated forest locations. It is not uncommon to have no or limited internet connection so accessing electronic versions of material is more often than not impracticable. It was said that even access to technology for downloading and printing vast documents is challenging for some. During the inquest, it became clear that owning a paper bound copy of the ACOP was a privilege as print runs or available copies have become harder to source.

Recommendations or Comments

[105] Under section 57A of the Act, I must consider whether it is appropriate to make any recommendations or comments to reduce the chances of further deaths occurring in similar circumstances to Niko. The threshold is the "potential reduction" of similar deaths, not complete avoidance.

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[20] Available at https://www.mbie.govt.nz/business-and-employment/employment-and-skills/health-and-safety/health-and-safety-strategy/.

[106] Having regard to the submissions of the parties, evidence heard at inquest, the determination of the issues set out above and other matters raised during the course of the inquest, I consider there are sound reasons to provide formal recommendations.

[107] With competing evidence, we cannot say for sure whether the use of a straw line might have led to a different outcome. However, it is more probable than not that a straw line would have given the hauler driver more flexibility and manoeuvrability for the ropes which could have avoided the obstruction or provided an avenue to clear it.

[108] I am satisfied that the benefits of a straw line are real and tangible and outweighed by the time and expense involved. The hazard and risks of its use can be mitigated by astute use and the proviso not to overload the straw line.

[109] Accordingly, I draw the attention of WorkSafe New Zealand / Mahi Haumaru Aotearoa and the Ministry of Business, Innovation & Enterprise (MBIE) to the following recommendations made under section 57A of the Act:

a) Amend the ACOP to include the operation of line retrieval as a distinct operational risk separate from line shifting;

b) Introduce standards for line retrieval within the ACOP that may include the controls set out in the Best Practice Guide for Breaking Out in a Cable Harvesting Operation[21] and should also include:

   i. Competency requirements for line retrieval and associated Unit Standards that are required to be achieved to undertake that operation;

   ii. Identification of a safe retreat distance and exclusion zone (with methodology for calculating and marking said distance and zone);

   iii. Address management and control of the line retrieval operation; and

   iv. A procedure for clearing an obstruction, including consideration of the release of tension on the ropes to avoid recoil, collaborative and informed decision-making between a head breaker out and hauler driver on the best manner to clear an obstruction, and confirmation that crew are in a safe position before applying tension to the ropes.

c) Incorporate the mandatory use of a straw line for line retrieval (in the ACOP and/or regulations) but subject to identifying the optimal conditions for deployment of a straw line that mitigates other health and safety risks (e.g. elevation, distance or other environmental factors);

d) Promote and support the development of new Unit Standards with competency requirements, training and accreditation for line retrieval;

[21] Competenz Best Practice Guide for Breaking Out in a Cable Harvesting Operation (September 2017) at page 26 (Inquest Bundle Document 17).

e) Give urgent priority to the development of the next phase of the Health and Safety at Work regulatory framework with specific reference to the forestry sector (i.e. hazardous work regulations);

f) The Best Practice Guide for Breaking Out in a Cable Harvesting Operation[22] is to be publicised and linked prominently on both the Safe Tree and Competenz websites; and

g) In giving effect to these recommendations, have particular regard to importance of greater engagement and participation of affected forestry personnel, with an aim to produce an ACOP which is accessible, meaningful and fit for purpose.

[110] In accordance with section 57B(1) of the Act, WorkSafe New Zealand / Mahi Haumaru Aotearoa and the Ministry of Business, Innovation & Enterprise (MBIE) were provided with my provisional findings (dated 1 November 2021) for the opportunity to comment on my proposed recommendations.

[111] My provisional findings were provided to Niko's whānau. Having regard to one concern raised by Mr Christeller on their behalf, amendments have been made to paragraph [16] of these final findings. A courtesy copy of my provisional findings was also provided to the two forestry companies that participated during the inquest and to the hauler driver.

Feedback from WorkSafe New Zealand / Mahi Haumaru Aotearoa

[112] I received feedback by way of written response dated 25 November 2021 which was positive and appreciated. WorkSafe noted that recommendations (a), (b), (c) and (g) related to amending the ACOP and affirmed (as previously outlined at the inquest[23]) that WorkSafe has decided that a review of the ACOP can occur alongside the work to be done by MBIE on the hazardous work regulations (with potential for the review process to feed into those regulations).

[113] It was indicated that the WorkSafe team has taken on board the evidence from the inquest concerning the need for greater engagement and participation of forestry workers on the ground and will endeavour to ensure that their voices are heard as part of the guidance review and ACOP amendment process. They are also desirable for an ACOP

[22] Ibid.

[23] Evidence of Ms Hanson-White (pages 130 – 131) and noting that compliance with regulations is mandatory, in contrast with an ACOP.

(and other guidance) which is accessible, meaningful, and fit for purpose. Accordingly, they had no difficulty with recommendation (g).

[114] WorkSafe is committed to comprehensive engagement with interested parties as part of the review, including forestry workers, unions, forestry contractors, forestry companies, forest owners, union organisations, Competenz, the Forestry Industry Safety Council and the Forestry Industry Contractors Association.

[115] WorkSafe had no difficulty with recommendation (a) requiring the identification of the operation of line retrieval as a distinct operational risk separate from line shifting.

[116] WorkSafe noted that recommendations (b)(i) – (iv) and (c) set out prescriptive requirements for inclusion in an amended ACOP. They undertook to ensure that those recommendations are fully discussed, however, it was considered premature to unequivocally commit at this point to those matters being included in an amended ACOP. This concern was based on their statutory responsibility under s222(2) of the HSWA to implement a consultation[24] process with relevant parties.

[117] For the avoidance of doubt, a coronial recommendation is just that. It is premised on the issues and evidence at inquest as an avenue to reduce further deaths in similar circumstances. I appreciate that a recommendation cannot undermine or determine the outcome of a subsequent consultative process, but it should be respected as an indication of a discrete subject matter that warrants free, frank and open consultation with affected parties.

[118] With reference to recommendation (d) about new Unit Standards, WorkSafe noted that the primary responsibility for developing these for the forestry industry now rests with a newly established entity Muka Tangata Workforce Development Council (formed as part of the Reform of Vocational Education). They suggested that my final findings also be provided to that entity. WorkSafe indicated a commitment to raise the lack of any Unit Standard covering the line retrieval operation with the Council, to engage and support the Council to address this matter.

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[24] In *Wellington Airport Ltd v Air New Zealand* [1993] 1 NZLR 671, the Court of Appeal endorsed dicta from *Port Louis Corporation v Attorney-General of Mauritius* [1965] AC 1111, 1124 where Lord Morris of Borth-y-Guest, delivering the judgment of the Privy Council stated: "The requirement of consultation is never to be treated perfunctorily or as a mere formality. The local authority must know what is proposed, they must be given a reasonably ample and sufficient opportunity to express their views or to point to problems or difficulties: they must be free to say what they think".

[119] With reference to recommendation (f) about improving the publications of the 2017 Best Practice Guide, WorkSafe advised that work is already underway for implementation of this recommendation.

[120] WorkSafe advised that given the statutory obligation for the development of regulations[25] sits with MBIE's Health and Safety Policy team on behalf of the Minister for Workplace Relations & Safety, accordingly they would revert to MBIE to provide feedback on my recommendations (e) and (c) on advancing the regulatory framework and mandatory use of a straw line being included in regulations.

[121] In relation to the scope of the ACOP review, WorkSafe advised that they were conscious that the suite of guidance material for the forestry and arboriculture industry will need to be examined as a whole rather than piecemeal, so that informed and consistent decisions can be taken about matters that require updating, replacement or revocation, new guidance material and appropriate forms for updated or new guidance. I have already acknowledged in paragraph [97] of these findings that it may not be feasible for everything to go into the ACOP and there will need to be a balance struck between the detail of the ACOP and other forms of control and information.

[122] In addition to the ACOP, WorkSafe's feedback recorded ten other regulatory instruments for the forestry industry (i.e. other ACOP's, Guidelines, Best Practice Guidelines and Fact Sheets ranging in date from 1995 – 2016). I note that only one of those instruments was admitted as evidence for this inquest.[26]

[123] This listing was provided to support the proposition that "a comprehensive approach for review" is required to ensure there is a consistent approach; streamline the consultation process (so that interested parties can be consulted on all proposed areas for change or development within one process, rather than sequential processes for different topics within the industry (or indeed the same topics but included across different guidance materials)); to allow an assessment as to current divisions of topics between different guidance materials is sensible and effective; and to permit a fresh assessment of the best form for updated or new guidance to take (whether that be incorporation within regulations, within ACOP's, Guidelines etc.).

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[25] Outlined in paragraph [37] of these findings.

[26] Best Practice Guidelines for Safe Retreat Positions in Breaking Out (July 2014) (Inquest Bundle Document 16).

Feedback from the Ministry of Business, Innovation & Enterprise (MBIE)

[124] I received feedback by way of letter from the Manager, Health and Safety Policy dated 26 November 2021 which was appreciated. MBIE confirmed their role to advise the Government on the operation of legislation and support the development of legislation, including regulations made under the HSWA. MBIE's feedback was limited to those aspects of my recommendations.

[125] With reference to recommendation (c) about the mandatory use of a straw line when carrying out line retrieval in cable logging operations (to be achieved by inclusion in the ACOP and/or regulations), MBIE stated that they do not consider regulations would be the best means of requiring such detailed requirements of work methods or equipment. Their view was that level of detail is better provided in an ACOP or guidance developed by WorkSafe in consultation with the forestry sector.

[126] MBIE's position is that incorporating the proposed additional requirement (for use of a straw line) in the ACOP would be consistent with current industry practice and expectations. In their view, because the requirement would only apply in certain circumstances (which need to be determined by the duty holder), a regulatory requirement is likely to be challenging to enforce and less effective than an ACOP might be. In other words, regulations are most effective only where they impose clear mandatory controls that apply in all situations.

[127] With reference to recommendation (e) to give urgent priority to the development of the next phase of the Health and Safety at Work regulatory framework (i.e. hazardous work regulations), MBIE advised that they are currently giving effect to Cabinet policy decisions to develop new regulations for plant and structures.

[128] Those regulations feature significantly in cable logging and other aspects of forestry operations, and will provide for mandatory design registration, item of plant registration, inspection of cable logging equipment and traction control equipment used in steep slope harvesting. MBIE expects these regulations to be passed in 2022 and that they will improve the standards of inspection and maintenance of equipment, and support improvements in work methods in all aspects of cable logging.

[129] MBIE's work programme provides that after those regulations are completed, they will then begin consideration of new regulations for hazardous work. They anticipate that may include licensing of classes of workers or imposing mandatory controls on critical aspects of certain high-risk work (such as working at heights or excavations).

[130] The scope and content of new regulations for hazardous work will be a matter for the Government to decide and subject to Cabinet approval.

[131] MBIE confirmed their intention that the process will begin with consultation of the types of work that will be subject to regulation, rather than ACOP's or guidance. In preparing a consultation document, MBIE will have regard to (among other matters) coronial recommendations and the 2014 report of the Independent Forestry Safety Review.

[132] Regretfully, no indication of a potential timeframe for proposed hazardous work regulations was provided to me. My recommendation for urgent priority to this phase of regulatory work stands as it related to evidence at the inquest (i.e. that promises of a comprehensive review of the ACOP, along with strengthening the associated regulatory framework for the forestry sector, have not been implemented as contemplated in 2014 and 2016).

Findings

[133] I find that Niko O'Neill Brooking-Hodgson died on 22 August 2016 in the Esk Forest, at the Pohokura Block, Te Haroto, near Napier. He died from non-survivable head and chest injuries sustained in a forestry incident while undertaking a line retrieval operation.

Restrictions on Publication

[134] Under section 74 of the Act, I am satisfied it is in the interests of decency and personal privacy to prohibit the making public of photographs of Niko obtained during the investigation of his death.

[135] I am also satisfied it is in the interests of justice and decency to prohibit the making public of the specific information contained in paragraphs [20] and [22] of these findings.

[136] On 26 July 2021, I made interim non-publication orders under section 74 of the Act which prohibited the making public of:

a) The name of the hauler driver involved in the incident that led to Niko's death;
b) Evidence of Ms Armstrong in response to questions put to her at the inquest on 22 July 2021 which may be perceived as critiquing the WorkSafe NZ investigation; and
c) A photograph of Mr Scurr taken from the public gallery at the inquest on 23 July 2021.

[137] I am satisfied those interim non-publication orders remain valid and necessary for upholding either the interests of justice, decency, public order and/or personal privacy. Thereby, I am making permanent non-publication orders in that regard.

[138] I am satisfied that such interests outweigh the public interest (if any) in the publication of the above evidence, and that an infringement on the principles of freedom of expression is justified.[27]

Conclusion

[139] I would like to express my sincere thanks to all Counsel and the parties involved in the inquest into Niko's tragic death. Submissions and evidence were constructive and focussed. Feedback on recommendations was also well received.

[140] Niko's whānau have endured the pain of their loss and waited patiently since his death in 2016 to reach this point. I am hopeful that these findings bring closure for them and that the recommendations promoted may bring about lasting change and improvement in forestry health and safety.

[141] Mr Brooking said at the inquest, even one death is too many in the forestry industry, and families should have confidence that their young men come home out of the bush safely every night.

[142] Minute No. 3 dated 29 March 2021 set out my undertaking to provide a copy of these findings to the Forestry Industry Safety Council (FISC) and the Forestry Industry Contractors Association (FICA) for their information as other key stakeholders in the forestry sector.

[143] Given the nature of these findings and particular references to the 2017 Best Practice Guide[28], I also direct that a copy of these findings be provided to Competenz for their information by virtue of its role as another stakeholder involved with the implementation of potential Unit Standards for the operation of line retrieval.

[144] Having regard to WorkSafe's feedback, I also direct a copy of these findings to be provided to Muka Tangata Workforce Development Council for their information by virtue of its role as another stakeholder involved with developing potential Unit Standards for operation of line retrieval.

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[27] Ibid.

[28] Competenz Best Practice Guide for Breaking Out in a Cable Harvesting Operation (September 2017) (Inquest Bundle Document 17).

[145] My inquiry has now concluded. I again offer my sincere condolences to Niko's whānau, his partner and forestry colleagues for their loss of a vibrant young man in tragic circumstances.

Moe mai rā e tama, haere atu rā ki ō tīpuna ki tua o te ārai.
Moe mai rā i tō moenga roa.

Coroner DM Llewell

Poroporoaki [29]

Whāia te huarahi	*Pursue the path*
o te mātauranga.	*of learning.*
Ka piki ake koe,	*The higher you climb,*
Ka whānui atu ngā pae.	*the wider the horizons.*
Rapuhia ngā pae	*Seek also the horizons*
i roto, i tōu nei ngākau.	*within yourself.*
E tipu, e awhi, e tū.	*Grow, embrace, stand tall.*

[29] Competenz Best Practice Guide for Cable Logging (January 2005) at page 352 (Inquest Bundle Document 12).