IN THE EMPLOYMENT RELATIONS AUTHORITY
AUCKLAND

AA 267/08
5070954

	BETWEEN	NEWTON TE RANGI Applicant
	AND	TACHIKAWA FOREST PRODUCTS (NZ) LIMITED Respondent

Member of Authority:	Alastair Dumbleton
Representatives:	Greg Lloyd, counsel for Applicant Glenys Steele, advocate for Respondent
Investigation Meeting:	28 May 2008
Submissions Received	18 June, 10 and 16 July 2008
Determination:	23 July 2008

DETERMINATION OF THE AUTHORITY

Employment relationship problem

[1] The Authority has investigated the dismissal from employment of Mr Newton Te Rangi by Tachikawa Forest Products (NZ) Limited.

[2] Mr Te Rangi was summarily dismissed on 19 October 2006 for serious misconduct. The dismissal resulted from his conduct on 5 October 2006 and followed the employer's disciplinary inquiry held shortly afterwards.

[3] A fortnight after the dismissal Mr Te Rangi's union raised a grievance, claiming that the disciplinary action was substantively unjustified and procedurally unfair. The remedies sought to resolve the grievance included interim reinstatement, reimbursement of lost wages, and compensation for hurt, humiliation and loss of dignity.

[4] The parties attended mediation and tried, but without success, to resolve the grievance through that process. Afterwards unfortunately there was a long delay before the claim was lodged in the Authority. This did not occur until 3 March 2008, about 17 months after dismissal. Mr Te Rangi's union the NDU has acknowledged its responsibility for that delay which is great enough to have some bearing on the practicability of reinstatement, should remedies fall to be considered in the outcome of this investigation.

[5] The legal test of justification which must be applied by the Authority in reaching its determination at the end of an investigation into any grievance claim, is contained in s 103A of the Employment Relations Act 2000. How the test is to be applied was explained by the Employment Court in *Air New Zealand Ltd v. Hudson* [2006] 3 NZELR 155.

[6] In its decision the Court noted that under s 103A justification for dismissal must be determined on an objective basis, the Authority being required to judge all of the relevant circumstances as they were at the time the dismissal occurred.

[7] Accordingly the Authority must objectively assess whether Tachikawa's actions and how Tachikawa acted, were what a fair and reasonable employer would have done.

[8] The grounds for the dismissal of Mr Te Rangi were found by Tachikawa to have arisen from the following circumstances. On 5 October 2006 at Tachikawa's Rotorua timber mill Mr Te Rangi was operating the No. 1 Horizontal saw, or Hori as it is known. Paths on which timber is conveyed for cutting by the machine became blocked by some of the boards as they travelled along. To free the blockage and allow production to continue unimpeded, Mr Te Rangi shut down the machine and set out to go to the place where the jam had occurred.

[9] He approached the blockage area from an elevated walkway or catwalk. It is suspended in the middle of the mill, several metres above the basement floor on which the Hori is built. The deck of the walkway is about 1 metre above the upper part of the Hori, and handrails running along its side are 2.2 metres above the saw. From the handrails down to the basement floor is 4.9 metres.

[10] Mr Te Rangi climbed down from the walkway at a point where there was no means provided for diverting from its path. Because the handrails ran along the side

of the walkway at that point, Mr Te Rangi had to climb over them to get down to the Hori itself and then approach the area of the blockage.

[11] After he had freed the jam-up of board he reversed his journey to go back to the operator's station. Just as he was climbing up from below the walkway and was about to pull himself onto it, two of the employer's managers approaching along the walkway saw Mr Te Rangi. He completed his climb in front of them and said a few words before hurrying away to restart the saw.

[12] Mr Te Rangi's actions of climbing up and down from the walkway while going to and from the blockage area of the saw have been known about since those actions occurred on 5 October 2006, and they have not been disputed by him and his employer.

[13] The two witnesses who saw Mr Te Rangi climb back onto the walkway and over the handrail were the Site Manager, Mr Russell Black, and the Health and Safety Manager, Ms Joyce Bryan. They immediately completed a formal report in which they gave the following description of the incident:

> *Newton Te Rangi climbed up from the outfeed roll case end of the No.1 Hori and climbed over the handrail on to the cat walk just as Joyce/Russell arrived at the same time.*

[14] The report, which gave the time of the incident as 11.35 am, included a description of the hazards associated with Mr Te Rangi's actions, as follows:

> *Taking a short cut. Not using designated walk way. Danger of slip, fall from height to machinery outfeed. Risk of serious harm injury. Breach of procedures.*

[15] The report recommended preventative action to be taken as follows:

> *Observance of procedures. Possible disciplinary actions after investigation depending on outcome.*

[16] Later on the day of the incident Mr Te Rangi was questioned about it. He signed a written report, part of which sets out answers given by him to questions from the employer, as follows:

> *(Q) Are you fully trained and aware of the hazards of this machine?*

(A) *Yes, am trained (have SOPs) for most machines.*

(Q) *How did you access the outfeed of the machine?*

(A) *I climbed over the handrail off the main walkway onto the outfeed roll case.*

(Q) *Why didn't you access through the gate on the out feed?*

(A) *It takes too long for the Supervisor to get there with the key; by the time he normally gets there you are really stacked.*

(Q) *Why didn't you access the area via the 2 Saw landing?*

(A) *Should have I guess but the step up on to the roll case is missing, has been for ages. To be honest most operators access the out feed over the Saw cover because it's much quicker. We only just stopped doing this because of what has happened to Maanuera.*

(Q) *There is access to the out feed via the basement did you consider using this?*

(A) *Yes, but I didn't have a helmet with me.*

[17] The person named Maanuera referred to by Mr Te Rangi in his answers was a worker who had been seriously injured only a few days earlier on 30 September 2006. While Maanuera was walking across the cover of the machine his body came into contact with the moving saw and his foot was badly cut by it.

[18] The employer proceeded to a disciplinary inquiry, which was held on 12 October 2006. It was centred around the following allegation made against Mr Te Rangi in a letter he was given:

> *That … you entered the outfeed sorting gate area in an unauthorised and unsafe manner. You exited and entered the area by climbing over the walkway guard rails. The entry/exit point was over an open area with an approximate 4.9 metre drop to the concrete floor.*
>
> *This area has been specifically caged and locked due to the serious Health and Safety hazards that exist in that area.*
>
> *The correct procedure was to obtain the key and enter through the gate by the correct means.*

[19] The letter requiring Mr Te Rangi to attend the disciplinary meeting had attached to it a copy of the incident report and the statement of questions and answers, both made on 5 October, and also a copy of the *"Standard Operating Procedure* [SOP] *for clearing blockage under the out feed sorting gates, # 1 Horizontal."*

[20] At the disciplinary meeting Mr Te Rangi was represented by his union. Notes of the meeting record the discussion as including the following:

> *Newton* [-] *know correct procedure would have been to wait to get key. Unlock gate.*
>
> - *did feel safe*
> - *I know it was an unapproved access way*
>
> *Sam* [Union representative] - *no one thinks that rails are no go areas*
> *RB* [Russell Black] – *would you have accessed if had key?*
>
> *Newton explained what happened*
> *Switched*
>
> - *haven't got helmet - operator away*
> - *went to Meke - called Boof* [Supervisor]- *at smoko*
>
> *Sam – can u get at boards from basement access*
> *RB explains*
>
> *N* [Newton] *correct procedure was to wait*
> *Old way to walk over saw.*

[21] The meeting notes record Mr Te Rangi as saying in general that he did not believe he had broken any rule and that he was acting under urgency to get production on the machine going again. He said he felt he had done everything safely.

[22] A letter of 19 October 2006 confirming the decision of Tachikawa to dismiss Mr Te Rangi begins with reference to the disciplinary meeting held seven days earlier, as follows:

> *At the disciplinary meeting you:*
>
> - *Confirmed that you knew and understood the correct procedures for accessing the area in question (this was evidenced also by the signed Standard Operating Procedures).*
> - *Confirmed that you made no effort to get the key as required once you became aware the supervisor was at lunch.*
> - *Confirmed that you accessed the area in an unauthorised manner by climbing over the walkway guard rails. You were seen by the witnesses over a 4.9m drop to the concrete floor basement.*

[23] The letter included the following response by the employer to issues that had been raised by Mr Te Rangi's union representative:

> *We found insufficient merit in their arguments put forward relating to:*
>
> - *There being confusion regarding walkways and catwalks;*
> - *The "everyone does it" argument;*
> - *That the delay in replacing the step on the other side of the deck mitigates the seriousness of the actions taken;*
> - *That there is confusion between operator "shortcuts" and maintenance requirements to access machinery in a safe manner (which occasionally may require access over handrails);*
> - *Disparity of treatment with other employees;*
> - *Production pressures.*

[24] The conclusion reached by the employer from its inquiry was expressed as follows in the dismissal letter:

> *After considering your responses, and the representations put forward by the Union, I have deemed that your actions constitute serious misconduct. This is consistent with the signed Standard Operating Procedures, and your employment agreement, including the Code of Conduct.*

[25] Justification for Mr Te Rangi's dismissal now falls to be determined by the Authority.

[26] As already noted, under s 103A of the Act the relevant point in time for determining whether the employer's actions and how the employer acted were what a fair and reasonable employer would have done in all the circumstances is, "*at the time the dismissal occurred.*"

[27] At the investigation meeting, which took place nearly 18 months after the dismissal, there was a tendency in significant aspects of the evidence for greater prominence to be given to circumstances which were known about by Mr Te Rangi and Tachikawa at the time of the disciplinary inquiry, but which were not made an issue of between them at that time.

[28] This is so in relation to the exact position Mr Te Rangi was in when he was seen climbing up onto the walkway after clearing the blockage.

[29] At the investigation meeting there was no dispute that at about 11.35 am on 5 October 2006, just as Mr Te Rangi was about to climb up on to the walkway and over the handrail, Mr Black and Ms Bryan saw him from a very short distance away. There was no dispute that he saw them and spoke briefly to them, before going back to the operator's station.

[30] In the Incident Report completed by Mr Black and Ms Bryan on 5 October they described Mr Te Rangi as climbing up *"from the outfeed roll case end of the No. 1 Hori."*

[31] In their report Mr Black and Ms Bryan noted that in their opinion of Mr Te Rangi's actions the hazards he had exposed himself to were *"taking a short cut – not using designated walkways. Danger of slip, fall from height to machinery outfeed. Risk of serious harm injury."*

[32] Later on 5 October Mr Te Rangi was interviewed and his account of what had happened was recorded. When asked how he had gained access to the outfeed of the machine he replied;

> *I climbed over the handrail off the main walkway on to the outfeed roll case.*

[33] No question as to how he had made his exit from the machine is recorded in the investigation notes as having been asked. Mr Black and Ms Bryan did not see Mr Te Rangi when he climbed down from the walkway on to the machinery to clear the blockage, but in the 10 October 2006 letter requesting Mr Te Rangi to attend a disciplinary meeting it was stated that, *the entry/exit point* [to the outfeed sorting gate area] *was over an open area with an approximate 4.9 metre drop to the concrete floor.*

[34] A fall from the top handrail of the walkway to the basement floor would have been a distance of 4.9 metres, whereas a fall from the handrail to the out feed roll case would have been about 2.2 metres.

[35] I find that the distance of any fall risked by Mr Te Rangi, whether 4.9 metres, 2.2 metres or any other distance, was not made an issue of by him at the disciplinary meeting, the notes of which were provided to the Authority.

[36] It is clear from the notice of disciplinary meeting that the heart of the allegation of misconduct was that Mr Te Rangi had *"entered the outfeed sorting gate area in an unauthorised and unsafe manner."* The allegation related to his failure to follow the correct procedure which was *"to obtain the key and enter through the gate by the correct means."* The issue was about climbing over the handrail of the walkway as a *"short-cut"* to reaching the blockage area, instead of following correct procedures which allowed the operator several options for safe access.

[37] There was no indication given in the statement of problem when it was lodged (some 15 months after the dismissal of Mr Te Rangi) that there was any issue about the exact point of entry and exit over the guard rail in relation to the roll case or any other part of the No.1 Horizontal Saw.

[38] It is clear to the Authority that Mr Te Rangi did not seek to excuse or explain his actions as observed by Mr Black and Ms Bryan, by saying that his route of access and exit to the out feed area had not exposed him to a fall of more than about 2.2 metres from the handrail down to the roll case. His explanation or excuse was given around reasons why other options for accessing and exiting the blockage were, in the circumstances, too slow or not as safe as the route he had taken.

[39] Prior to his dismissal Mr Te Rangi had offered the explanation that access through the gate on the outfeed would have caused delay because of the time it would take for the supervisor, who was at smoko or lunch, to bring the key to unlock the gate. He explained that access via the No.2 saw landing was affected by a missing step, and that he had not gained access via the basement because he did not have a hard hat with him. From the investigation notes dated (incorrectly) 4 October 2006 it seems clear that the subject of discussion was the actions of Mr Te Rangi in climbing over the side of the walkway to get down to and back up from the out feed area of the saw. The subject was not the distance of any fall he had risked by diverting from the path of the walkway, the particular route he had chosen to take.

[40] In applying s 103A of the Act the Authority may not revisit the disciplinary inquiry so as to focus on circumstances that were known about then but which only later on, after the dismissal, have been considered to have greater significance than they had at the time. I find that the circumstances as they were at the time Mr Te Rangi was dismissed did not include an issue as to where exactly he was in relation to

the Hori, or to the particular point where the drop was 4.9 metres, when he climbed over the handrail to get to and from the area of the blockage.

[41] I find that the employer did act fairly and reasonably in rejecting as a reasonable explanation for his actions, what Mr Te Rangi said about the missing step in the alternative access route via the No. 2 saw landing. While as part of that route there was in place a steel framework designed for steps, the wooden tread of one step was missing and had been so for some time apparently. The employer had known about this for at least six weeks before 5 October. Left in that condition by the employer the step was clearly unsuitable for its purpose and could have caused injury if someone had slipped off or caught their foot in the frame while climbing on it. The alternative to using the step, if taking that particular route, was to climb up about 1 metre up onto the saw deck or cover, which did not present a risk of falling any greater distance.

[42] In my view it was reasonable for the employer to expect of Mr Te Rangi that if, because of the missing step, he regarded the route via the No. 2 saw landing as unsafe he would use another route which was safe. It was reasonable to expect that he would not simply dispense with safety altogether, just because one of several optional routes had become unsafe.

[43] I find the employer also reasonably rejected as justification for Mr Te Rangi's actions the delay that might have occurred if the key had been sought from the supervisor. Keys were held by others as well, as Mr Te Rangi should have known from the SOP.

[44] At the disciplinary meeting Mr Te Rangi acknowledged that he had known of another safe option, when he said, *"correct procedure would have been to wait and get key. Unlock gate."* That option is referred to in the SOP for clearing blockages under the out feed sorting gates as Step 5: *"Contact supervisor, leading hand or floater, they will unlock gate."*

[45] I also consider that the question of whether there were any SOP's applicable to clearing blockages from the top of the out feed sorting gates, rather than from under them, is another issue that has only been introduced at the stage of the Authority's investigation into the dismissal of Mr Te Rangi.

[46] At the time of the dismissal and leading up to it, which is the relevant time for the purposes of applying s 103A of the Act, the issue of access from under the outfeed was explained by Mr Te Rangi in terms of his not having had a hard hat, and therefore not being allowed to go under that part of the machine. I accept that his explanation at that time had nothing to do with whether the blockage was able to be cleared from under the Hori, but was simply that without a safety helmet the safety rules had not permitted him to go under the machine for any reason.

[47] To prepare for the disciplinary meeting of 12 October, Mr Te Rangi had been provided with an SOP which from its title expressly related to clearing blockages from *"under"* the out feed sorting gates. No issue was raised then about whether that was the applicable SOP if the location of the blockage meant that access had to be from above the out feed sorting gates.

[48] When questioned on 5 October, Mr Te Rangi had confirmed that he had been trained and was aware of the hazards in relation to the No. 1 Hori. Tachikawa had a record of the training given to him in the operation of the machine. He had signed a Training Record and had been through the Standard Operating Procedure (SOP) for Clearing Blockages/Crossups on the Outfeed Sorting Gates on the No. 1 Horizontal Bandsaw Tail Out. In this regard a Training Record had been signed on 7 February 2006. Tachikawa acted fairly in taking into account the degree of training and instruction given to Mr Te Rangi, and in that regard no excuse or explanation for his conduct could reasonably have been regarded by Tachikawa as being available to him.

[49] The degree of seriousness of the misconduct alleged against Mr Te Rangi was expressed in the 10 October 2006 letter from Tachikawa requiring Mr Te Rangi to attend a disciplinary meeting. The outfeed sorting gate area was described as an area that had been *"specifically caged and locked due to the serious Health and Safety Hazards that exist in that area."* Also in that letter Standard Operating Procedures were referred to as communicating the following message to workers:

> *WARNING!! Failure to comply with the following instructions could result in serious harm. Non-compliance is deemed to be SERIOUS MISCONDUCT and disciplinary action will follow.*

[50] Further on in the letter the following provision of the applicable collective employment agreement was referred to:

> *Employees shall abide by all Health and Safety policies, procedures and practices established by the Employer and required by the Health and Safety in Employment Act and shall contribute to the ongoing development of a safe work environment.*

[51] Mr Te Rangi was warned that a potential outcome of the disciplinary procedure could include his dismissal.

[52] In his 19 October 2006 letter advising Mr Te Rangi that the issues raised by his representatives had been considered, Mr Black expressly deemed that his actions constituted serious misconduct as contemplated by the SOP's and Employment Agreement including the Code of Conduct. Viewed objectively I find that Tachikawa fairly and reasonably assessed the actions of Mr Te Rangi to have amounted to serious misconduct. The punishment of summary dismissal was therefore available in the circumstances.

Determination

[53] The Authority determines that objectively Tachikawa's actions and how Tachikawa acted were what a fair and reasonable employer would have done in all the circumstances at the time the dismissal occurred. Dismissal was justified substantively as well as procedurally. It follows that Mr Te Rangi's claim of personal grievance is not upheld. There is no basis for making any orders against the employer to resolve this employment relationship problem.

Costs

[54] Costs are reserved. The parties through their representatives are to confer with a view to resolving the question. If agreement cannot be reached the respondent may file and serve a memorandum of submissions as to costs. The applicant may then have 14 days from service to reply with any memorandum of submissions.

A Dumbleton
Member of the Employment Relations Authority