Business Leaders' Health & Safety Forum

Maritime NZ v Gibson judgement - actionable insights

Notes from webinar series with:
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1. A brief background

Former Port of Auckland (POAL) CEO Tony Gibson was convicted in the District Court on two charges under the Health and Safety at Work Act 2015 (HSWA) – the first time a CEO of a major New Zealand company has been found guilty under the Act.

The charges were brought by Maritime NZ following the death of Pala'amo Kalati at the Port in 2020.

POAL was also charged as a PCBU under the same legislation and pleaded guilty and were fined and paid reparations.

Mr Gibson was found guilty on two of three charges, following a trial. The link to the full verdict is set out in Appendix One below. For a full summary and background on the case you can read: Port of Auckland CEO conviction sets new health and safety precedent (MinterEllisonRuddWatts).

This decision is subject to appeal – and sentencing has been set down for the end of February.

Below we have set out the key learnings for CEOs from this case, as well as key resources (Appendix one) and the particularly instructive paragraph 80 of the judgement relating to general principles that Judge Bonner set out relating to the exercise of an officer's duty of due diligence (appendix two). All panellists agreed that all senior leaders should read the full judgement.

2. This judgement is significant

This is a significant decision, and the first case to outline in more concrete terms, the scope of the officer obligations under HSWA. While as a CEO you shouldn't panic, it is important to not underestimate some of the expectations this case set out for officers.

All expert concurred that every organisation should use this judgement as an opportunity to reflect, review and purposefully focus their own and the organisation's efforts.

3. Priority focus areas for CEOs in 2025

Asked what they would do in 2025 if they were a CEO in 2025, they said:

1. **Review your approach to critical risks and controls** across the organisation, including asking these questions of yourself, your leadership team and board as well as your H&S advisors:
    a. What are our critical risks?
    b. What are the controls for these critical risks?
    c. How effective are these controls?
    d. What are you basing your judgement of that efficacy on?
    e. If you have soft controls in place, why? And, if these are the most appropriate controls ensure you document the reasons for this. *Please see Appendix One for a link to the hierarchy of risk controls which outlines what is meant by soft and hard controls*.
2. **Complete the Institute of Directors 'Good Practice Governance Self-Assessment'** – along with your Board and Executive Leadership Team – set out in the Institute of Directors' Good Governance Guide (link below) – and agree the gaps and actions to address those.
3. **Map where the key accountabilities, roles and responsibilities** for health and safety sit across your organisation and apply rigor to your assessment about how well these are understood and are being met.
4. **Review all current internal and external recommendations from audits, reviews and investigations** – what is their status? Have you accepted them all? If so, how are they tracking? If not, are you clear why not and is that documented? Do you understand the limitations of these audits and reviews?
5. Review how you, the Executive Leadership Team and the Board demonstrate safety leadership and gain an **understanding of 'work as done'**. Consider:
    a. When and where are your visits taking place? Do they account for work that is potentially 24/7? Across different locations?
    b. How are you showing up to these visits? Are you authentic and working on building relationships with workers, or just asking H&S questions focused on compliance?
    c. How are you recording these visits, sharing learnings, and ensuring all feedback is reported on and responded to?
    d. What insights are you gathering from other sources, including workers, H&S representatives, your health and safety committee, monitoring by leaders and H&S teams and internal and external audits?

e. In larger more complex or multi-site businesses, are you doing cross-site and cross team learning?

f. Is the information in your routine reports and from other sources providing you with genuine insights about the effectiveness of your risk management?

6. Purposefully reflect on **your leadership work as CEO**, ask yourself: How am I going to hold myself to account for setting the tone from the top? How do I "turn up" on health safety in different situations across the business? How do I respond to bad news? How do I purposefully maintain that focus and attention through the year? Am I benchmarking stats, or different approaches by other leaders?

4. Key insights and reflections from this judgement

Why was the Board of Directors not charged?

A number of you were interested in why the POAL Board of Directors were missing from this prosecution.

The Forum approached Maritime NZ CEO Kirstie Hewlett for comment on why no directors were charged. Her response is:

"There was not the evidential sufficiency to prosecute the Board. However, related to that point this is worth considering- an officer must exercise due diligence to ensure the PCBU complies with the obligations, and while the obligation of due diligence relates to both directors and a Chief Executive, the ***significant influence they exercise over the management of the business or undertaking*** *is different in relation to the different role of CE or Director and the due diligence they can perform."*

Regardless, the advice from our panellists was clear: this judgement has just as many takeaways for non-executive officers as it does for executive officers.

Context at POAL was important

It is important to note the context at POAL surrounding Maritime NZ's decision to charge Mr Gibson as an Officer. There had been a number of serious harm incidents and fatalities within a short period, prior to the death of Pala'amo Kalati. POAL is also a dynamic, high-risk and diverse environment.

The court has identified that the extent of the duty will be calibrated by the nature of the business and the role of the officer, i.e., not one size fits all'.

A ‘good’ CEO may still fall short

Mr Gibson and the POAL team at the time were doing a lot of work focused on health and safety and investing in health and safety. They also had the support of the Board. The judgement lists 20 examples where POAL was enhancing health and safety. Yet, the court was still critical, in particular:

- Mr Gibson as CEO did not have full understanding of the roles and responsibilities involved in health and safety
- There was a delay in the implementation of key projects, i.e., POAL was doing things, but not progressing them fast enough
- There were multiple warning signs of issues and while work was underway to improve many aspects of health and safety, it wasn’t necessarily focused in the right direction or being done fast enough.

The verdict describes Tony Gibson as ‘hands on’. This does not mean CEOs should not be ‘hands on’, in fact it means they should be actively leading, hands on and inherently understand their critical risks and controls.

This case teaches us that a good leader and a conscious officer may have the best intentions, but still breach HSWA. It is also not necessary for prosecutors to prove an officer didn’t mean to breach HSWA. The key learning here for CEOs is that while it’s easy to show you’re focused on health and safety, how can you show you’re focused on the right things and progressing any work needed to improve critical risk controls?

Work as planned (or imagined) vs work as done

This concept will be well known to many Forum CEOs and Directors. The Court has made several references to this throughout this verdict and how it applies to the expectations of CEOs. It also makes clear that CEOs have an important role to play and not just rely unquestioningly on advice from health and safety advisors or consultants. Importantly in paragraph 80 of the judgement (copied below as Appendix Two) it sets out three key areas for CEOs to consider:

- *An officer in a large PCBU does not need to be involved in day-to-day operations in a hands-on way but cannot simply rely upon others within the organisation who may be assigned health and safety obligations or roles, or who may have more specialised skills or experience, to discharge the duties of oversight and due diligence.*
- *The officer must also acquire and maintain sufficient knowledge of the operations of the PCBU and the work actually carried out “on the shop floor” to adequately identify and address actual workplace hazards and risks.*

- *An officer cannot assume that the PCBU is compliant with its duties under the HSWA in the absence of being told otherwise, or simply assume that the information they receive from their subordinates as to the adequacy or effectiveness of the PCBU's health and safety system and hazard controls is accurate and sufficient. An officer must be proactive in relation to health and safety issues and in a position to properly monitor, verify and interrogate the information they receive.*

Appendix one: Key resources

- Maritime v Gibson verdict: https://www.districtcourts.govt.nz/assets/secure/2024-11-28/2024-NZDC-27975_Maritime-New-Zealand-v-Gibson.pdf
- WorkSafe Victoria has a very clear distillation of The hierarchy of control | WorkSafe Victoria
- Health and Safety Governance: A good practice guide (including the self-assessment): https://www.iod.org.nz/resources-and-insights/guides-and-resources/health-and-safety-a-good-practice-guide#
- Forum resources relating to Health and Safety Governance (resources and videos): https://www.forum.org.nz/resources/governance-of-h-and-s/
- Leading critical risks and controls (Forum resources and videos): https://www.forum.org.nz/resources/critical-risk/
- Please see Appendix Three for Mike Cosman's slides from the second webinar on Wednesday 18 December.

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Appendix two: Paragraph 80 of the Judgement

[80] In summary, the legislative framework, purpose and history, together with the authorities to which I have been referred, support the following general principles relating to the exercise of an officer's duty of due diligence:

(a) An assessment of whether an officer has exercised due diligence must, necessarily, be fact and circumstance dependent.

(b) The duty applies to all officers across all PCBUs, large and small, with both flat and hierarchical structures. The fact that an officer may 32 McLaren Maycroft & Co v Fletcher Development Co Ltd [1973] 2 NZLR 100 (CA), at 107-108; Mason v Dodd [2020] NZHC 1508; Bindon v Bishop [2003] 2 NZLR 136 (HC); Attorney-General v Strathboss Kiwifruit Ltd [2020] NZCA 98; Sansom v Metcalfe Hambleton & Co [1998] PNLR 542; Dovuro Pty Ltd v Wilkins [2003] HCA 51. operate at the head of a large, hierarchical organisation does not mean that the officer's obligations are diminished.

(c) In the case of large, hierarchical organisations, the duty to exercise due diligence is not limited to governance or directorial oversight functions.

(d) The officer's duty under s 44 is, however, distinct from the duties imposed upon the PCBU. The officer is not required to do everything that the PCBU is required to do to comply with its duties. A failure by a PCBU to comply with its duties does not, of itself, mean that its officers have not complied with their duties to exercise due diligence.

(e) An officer in a large PCBU does not need to be involved in day-to-day operations in a hands-on way but cannot simply rely upon others within the organisation who may be assigned health and safety obligations or roles, or who may have more specialised skills or experience, to discharge the duties of oversight and due diligence. The officer must personally acquire and maintain sufficient knowledge to reasonably satisfy him or herself that the PCBU is complying with its duties under the Act.

(f) Where there are others within the PCBU with assigned health and safety obligations or roles, or who may have more specialised skills or experience in the work carried out, an officer must ensure that such persons have the necessary skills and experience to properly execute their roles and must adequately and regularly monitor their performance to ensure that they are properly discharging their functions in ensuring the PCBU's compliance with its duties.

(g) The officer must also acquire and maintain sufficient knowledge of the operations of the PCBU and the work actually carried out "on the shop floor" to adequately identify and address actual workplace hazards and risks.

(h) An officer does not satisfy the due diligence duty by merely putting in place policies or procedures as to how work is to be carried out. The officer must ensure that entrenched and adequate systemic processes are put in place to ensure that the PCBU complies with its duties. In any large organisation, the existence and adequacy of such systems are key.

(i) An officer must ensure that there are effective reporting lines and systems in place within a PCBU to ensure that necessary information in relation to health and safety, workplace risks, hazards and controls

flows to the officer and others in the organisation with governance and supervisory functions. Again, the existence of appropriate systems to monitor, record and direct the flow of relevant information is key, especially in larger organisations.

(j) An officer cannot assume that the PCBU is compliant with its duties under the HSWA in the absence of being told otherwise, or simply assume that the information they receive from their subordinates as to the adequacy or effectiveness of the PCBU's health and safety system and hazard controls is accurate and sufficient. An officer must be proactive in relation to health and safety issues and in a position to properly monitor, verify and interrogate the information they receive.

(k) Due diligence also requires the officer to engage upon, or arrange, an effective process of monitoring, review and/or auditing of the PCBU's systems, processes and work practices to ensure that those systems and processes are achieving their purposes and that relevant safety standards and policies are, in fact, being adhered to.

(l) A court will obtain assistance from evidence as to the state of knowledge of health and safety matters in the relevant industry at the time, the availability of industry standards or guidelines, and the practices of comparable officers and businesses. However, the Court must objectively determine the reasonableness of the officer's actions or omissions in the relevant circumstances. It is not a case of simply comparing the officer's conduct with that of other officers in similar positions. It is no sufficient answer to a charge alleging breach of the s 44 duty to suggest that the officer's conduct was of a standard generally acceptable in the relevant industry at the time. If the officer's actions objectively fall below the standard required by the statute it does not assist the officer that comparator officers may also have routinely been falling below that standard.

Appendix three: Slides from webinar two (Mike Cosman)

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Lessons from the MNZ v Gibson decision for senior leaders

With Mike Cosman and Craig Marriott

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Context

- The tragic death of a lasher working at Port of Auckland Limited (POAL) led to an investigation into both local and systemic factors by Maritime NZ (MNZ)
- Both POAL (PCBU) and Mr Gibson (CEO/Officer) were charged with offences under HSWA
- POAL pled guilty, were fined and paid reparations
- Mr Gibson defended in an 8-week trial, but was found guilty of one offence of failing to exercise due diligence to ensure POAL met its duties
- Sentencing due in early 2025, unless an appeal against conviction is lodged before 24 December 2024.

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The facts

- Context specific
- History of previous fatalities and prosecutions at POAL
- COVID-19 restrictions
- Problematic automation project underway
- Challenging relationship with Unions
- Significant investment in health and safety

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The key issues

- The respective roles and expectations of Chairs, non-executive and executive (CEO) officers. Same duty – different benchmarks
- The relationship between a PCBU failure and an officer failure- connected but not the same
- The extent of the implied vicarious liability of a CEO/officer for repeated acts or omissions by their team
- The test of what a *'reasonably careful, diligent and skilful officer'* would do in similar circumstances
- Does being '*hands on*' increase your potential liability?

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The key messages

- **Don't panic!**
- This case, especially if considered by the High Court, will help clarify previously uncertain expectations
- The new IoD/WS Governance Good Practice Guide was not in place at the time but now represents the current state of knowledge about what good looks like
- Context is everything –dynamic, diverse, high-risk environments will demand greater focus
- Scope the risk profile, develop a strategy, plan the work, resource the plan, work the plan, monitor the outcomes–rinse and repeat
- Put workers at the heart of everything you do