BeSafe Taranaki

Health & Safety Update

THE GIBSON DECISION & CHANGES TO HSWA

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Gibson v *Maritime New Zealand*

Implications for officer safety assurance and due diligence

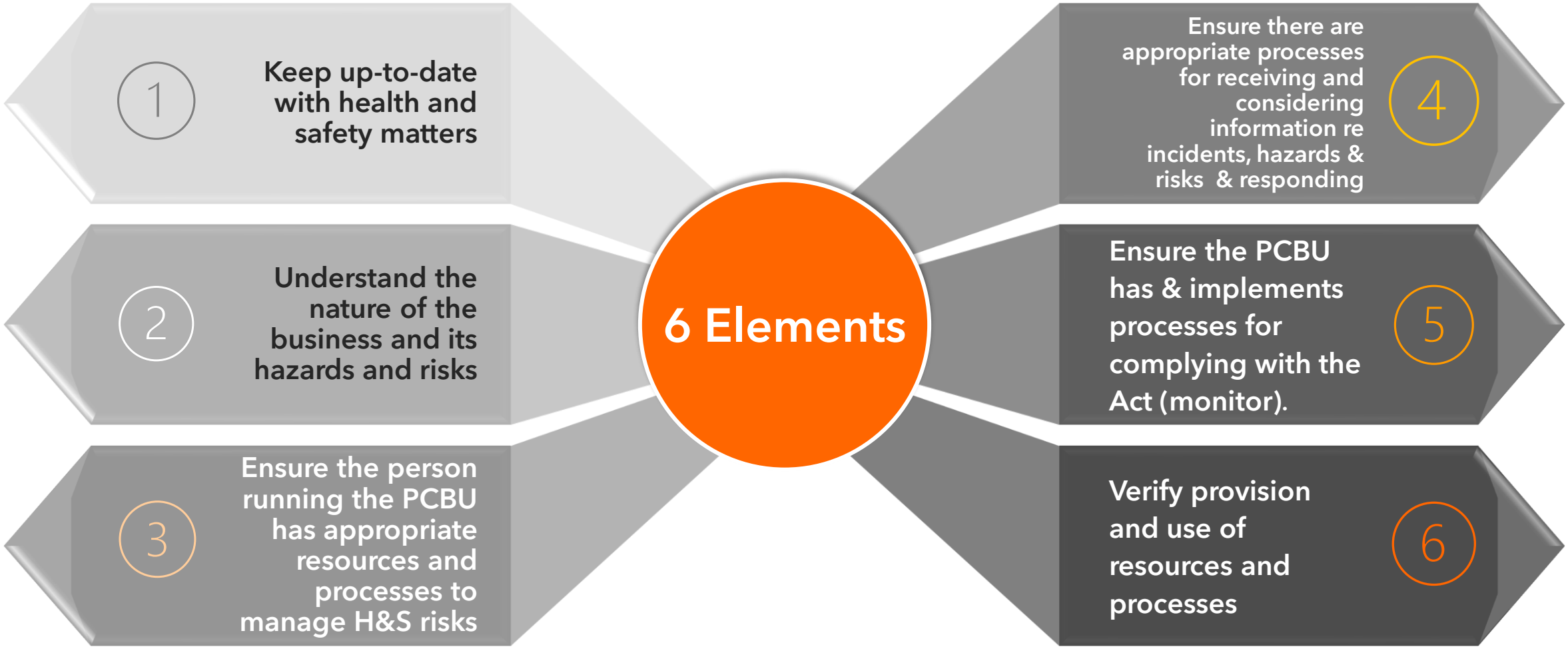
Why this decision matters

- First High Court decision examining officer liability in a large NZ business
- Focus was on verification and actions, *not* an absence of systems
- Confirms expectations for officers in relation to critical risks

Definition

In exercising due diligence, an officer is required to exercise the care, diligence, and skill **that a reasonable officer** would exercise in the same circumstances, taking into account (without limitation) the nature of the business or undertaking and the position of the officer and **the nature of their responsibilities**

Due Diligence Duty ~~Includes~~ …



Tragic fatality – Mr Kalati

- Mr Pala'amo Kalati (31 y/o) worked for POAL
- POAL operates 24/7
- Mr Kalati was employed as a lasher in **April 2020** and he had been trained and completed 60 hours of supervised work
- In **August 2020** Mr Pala'amo Kalati (31 y/o) was killed while working on the night shift at Fergusson Container Terminal, POAL
- He had been working within an exclusion zone around an operating crane, and he was tragically crushed and killed by a shipping container that dislodged during a crane lift

Mr Gibson, former CEO of POAL

- Puts CEOs in the spotlight
- First successful prosecution of a director in a complex operation
- Charges were brought by Maritime NZ
- POAL was charged and pleaded guilty to breaches of s36 (the primary duty of care) and reckless conduct
- Mr Gibson was charged under s44 for a failure to exercise due diligence, s44(4)(c) and s44(4)(f)

Tragic fatality context – Mr Kalati

- POAL was an essential service operating during the COVID-19 pandemic conditions (creation of bubbles etc)
- Mr Kalati was (mis)directed on how to work by his supervisor
- The team was working contrary to a company rule
- The container that dropped was as a result of someone's failure to untie it properly from other containers
- Mr Gibson was **not** charged with accountability for the fatality – he was charged with failing to take reasonably practicable steps to prevent the fatality

Critical Risks at POAL

- POAL's HSMS identified 7 critical risks
- Handling loads was one of the critical risks
- The "three container width rule" was a key control of an operating crane
- Specialist H&S team at POAL

Elements of the offence

1) *POAL was a PCBU (s36 primary duty)*
2) *Mr Gibson was an officer (s44)*
3) **Mr Gibson failed to comply with s44 duty**
4) **That failure exposed workers to risk of death or serious injury (s48)**
   - What were the circumstances in which Mr Gibson was acting?
   - What steps would a reasonable officer take in those circumstances to ensure POAL's compliance?
   - Did Mr Gibson fail to take those steps?
   - Strict liability offence, no need to prove intent or recklessness

District Court decision

As CEO Mr Gibson was required to engage in effective systems leadership. He had a responsibility to ensure the resources and processes in place ensured compliance with POAL's duties under HSWA. That required him to ensure that the information he received reflected work as done or 'what people are doing on the ground'

Mr Gibson, former CEO of POAL

Court found that Mr Gibson was **aware of risks** in relation to the business and was put on notice with the earlier convictions, which reflected that there were failures in POAL's safety systems

Due diligence **requires curiosity** as to how work is actually done rather than reliance on expecting workers to do what they are expected to do or to assume a system is working without interrogating it to test whether it is effective

Cont'd *Tony Gibson, former CEO of POAL*

Mr Gibson failed to exercise the care, diligence and skill a reasonable officer would have exercised in the same circumstances and this failure was due to the following criteria:

- He had the capacity and the ability to influence the conduct of POAL in relation to its failures, and
- He was required to take active steps to obtain adequate information about the nature of the work being undertaken and the risks associated with the work, and
- a reasonable CEO would have recognised shortfalls in POAL's management of exclusion zones and would have ensured POAL utilised appropriate resources and processes to address those shortfalls, and
- His breach of the s44 duty "*made it materially more likely that POAL would breach its duty of care to ensure that stevedores were not exposed to this risk of death or serious harm*"

Work as done vs work imagined

The difference between the reality of work carried out by workers on the ground, versus the methods of work designed, understood or expected by management and other staff who do not actually undertake the work was examined.

During Mr Gibson's tenure as CEO, POAL was convicted of offences under the HSWA or previous legislation on four occasions:

- January 2014 serious injury where a stevedore fell overboard from a vessel because a safety rail which should have been in place on the vessel was not in place.
- October 2014 serious injury involving a stevedore falling through a hatch lid on a vessel.
- Pilot boat speed offences between 20 April 2017 and 31 January 2018 due to a failure to implement processes to ensure speed restrictions were observed.
- An August 2018 incident where a nightshift straddle driver was killed when his straddle carrier tipped over.

Relevance of PCBU charges and convictions

- On each occasion POAL pleaded guilty
- Demonstrated deficiencies in the implementation of POAL's safety systems and processes
- Under cross-examination, Mr Gibson accepted that each previous case was an example of the disconnect between work as done and what should have been done

Action reports

- In 2018 an audit report was prepared by KPMG which assessed the progress that POAL had made following previous audits in 2015 and 2016
- The audit made a number of key recommendations, most notably that *"To ensure health and safety is successfully embedded across all Business Units will require the Executive Leadership Team and senior management to be consistently engaged and empowered"*
- An agreed action item arising from this was the development of a responsibility and accountability matrix, this was never developed
- Court found that Mr Gibson was aware that POAL failed to action the recommendations of the KPMG report in an appropriate and timely manner

notes

- Due diligence **requires curiosity as to how work is actually done** rather than reliance on expecting workers to do what they are expected to do or to assume a system is working without interrogating it to test whether it is effective
- Officers are required to **take active steps** to obtain adequate information about the nature of the work being undertaken and the risks associated with the work - the officer must personally acquire and maintain sufficient knowledge to satisfy himself or herself that the PCBU is complying with its duties under the HSWA
- An assessment of whether an officer has exercised due diligence must be fact and circumstance-dependent
- An officer in a large PCBU does not need to be involved in the day-to-day operations in a hands-on way but they cannot simply rely upon others

High Court –

Was there a miscarriage of justice?

Conviction appeal to High Court

- Mr Gibson 'appealed' the DC decision arguing:
- The Court had conflated the separate duties of the PCBU those of the CE as an "Officer"

  Arguing "ultimate responsibility" and "system leadership" points, effectively made TG a proxy for the PCBU

- It applied hindsight reasoning
- There was a mistaken reliance by the Judge on Australian cases
- The court relied on a paper-based expert review
- The decision set the standard of care required by section 44 too high

Narrow focus on Officer duty

- Single charge under ss44 and 48 of HSWA for period of 31 May 2019 to 31 August 2020
- Only focussed on the one critical risk in the business
- Reading the DC decision as a whole, HC Judge did not consider the DC Judge erred in his assessment of Mr Gibson's responsibility for H&S
- The Court accepted Mr Gibson had put in place many positive health and safety steps during his tenure and that he was regarded as a committed leader BUT this was not enough to prevent him from facing prosecution
- The test is not one of perfection: officers are not required to eliminate all risk or guarantee compliance and liability arises from unreasonable omissions (not the mere fact an incident happened)

An officer and a PCBU – not 'same same'

- No brightline test between governance and management
- A breach of a duty by a PCBU does not automatically lead to or mean there has been a breach of duty by an officer
- Even if an officer has done all they are expected to, a PCBU can still be in breach of HSWA
- In this case, the failures of the PCBU were relevant in terms of a factual assessment of what a reasonable officer should have done
- The officer assessment is based on systems oversight and verification
- A CEO/MD may well have responsibilities that straddle governance and management
- TG responsibilities extended to taking reasonable steps to implement and monitor (and improve where necessary) POAL's HSMS

Comparative law

- Australian cases based on repealed provisions were properly distinguished
- The Australian cases based on the equivalent of the NZ provisions were helpful for understanding the PCBU/Officer distinction
- The cases were interpreted in a NZ context

Hands On vs Hands Off

- It cannot be that being responsible exposes a duty holder to greater risk of breaching their obligations than otherwise

- The “hands on” approach of TG to his management responsibilities does not mean he had responsibility for the actions of every worker

Evidence challenges

- Largely upheld the findings of the DC
- Overall, the submissions on "missing evidence" were not accepted
- Other manager opinions on whether TG took reasonable steps "*would not substantively assist*"
- There was no factual evidence comparing what equivalent officers in similar PCBUs were doing at the time, the Judge too readily discounted the relevance of that
- The standard of care is typically determined on evidence from someone with sufficient knowledge and/or experience to say what a reasonable person in the situation of the defendant would have done
- Criminal trials are not trials by expert – ultimately the factfinder must decide factual issues

Setting the standard too high?

- Agreed that TG undertook positive and enhanced H&S steps and actions for POAL and that was relevant to the charge
- But the key question was whether a reasonable officer in the same circumstances would have taken further steps

reasonable conduct does not excuse unreasonable conduct in another part

- Reasonable does not mean perfect but neither does it mean the average of what others would do

Reliance on Systems and Advisors

- Officers can rely on advisers and experts
- But, must not accept assurances without inquiry
- Reasonable reliance on advice is a component of the test – a factual matter – so too is failing to take advice

The relevant reasonable steps TG should have taken

- Needed to have and use resources (people, money, items) and processes – safe operating procedures including the three-container width rule, training, review etc – to manage the critical risk of handling loads
- Needed to verify (monitor and measure) "work as done" to detect non-compliance, including the three- container width rule

The Board has an important role in strategic oversight of resources and processes and a CEO cannot verify their own work

Verification of other operational matters falls within management's purview (including monitoring and measuring reports of work as done prepared by subordinates)

Notable findings

- Prioritising resources to one issue does not necessarily justify lack of progress with another issue – enquiries should have been made about the lack of progress
- The checks of handling work done in 2016 and 2018 were not effective, reference to the controls in limited documentation does not mean he was advised the controls were always followed
- A reasonable officer would have taken steps to implement an appropriate exclusion zone around cranes working over ships and to monitor and verify compliance by lashers on the night shift

Summary

The HC found that a reasonable officer in the same circumstances (considering the nature and scale of the business and the officer's position and responsibilities) would have taken more steps to address the identified risks and failures in the Ports of Auckland systems

- Mr Gibson was personally aware of the critical risks associated with stevedoring and handling loads
- POAL's training materials and documentation regarding the exclusion zone were confusing and inconsistent
- Performance monitoring and safety observations were inadequate to detect non-compliance with the exclusion zone rule, particularly on night shifts
- While Mr Gibson was entitled to rely on expert advice, he should have sought improved performance measures to monitor the effectiveness of the policy
- Mr Gibson was "on notice" of issues with lasher non-compliance following a previous fatality in 2018 and he did not extrapolate the learnings from that fatality
- TG was aware or should have been aware the bow tie assessments were inadequate and not progressed in a timely manner

Board Message

"

Effective verification is not about more reporting. It is about knowing whether critical controls are **working in practice** – and acting when they are not

Setting –State of a Thriving Nation 2025

- NZ's workplace death rate is where Australia was **16 years ago**, and where the United Kingdom was **40 years ago**
- Positively, the number of workplace injuries is **trending down**, but time off work per injury has **doubled** in a decade
- Of the 25 OECD countries with higher productivity than New Zealand – **80%** have a lower workplace fatality rate

HSWA Changes

“The Minister had a blueprint that she's ignored…" referring to a October 2024 joint letter from employers, workers, experts, unions and high-risk sectors (NZISM)

Overview

The Reforms at a Glance

The Amendments under the bill are stated as seeking "to improve the work health and safety system by reducing unnecessary compliance costs and clearly stating what businesses and organisations need to do.
To achieve these goals, the bill would:

- emphasise critical risks
- clarify wording
- strengthen approved codes of practice
- prioritise the regulators' functions."

Key Reforms The new main purpose will be "to provide a balanced framework for securing the health and safety of workers and workplaces that prioritises the critical risks that arise from work including by prioritising the management of those risks by PCBUs".

The Shift

Facelift only?

PCBUs must now demonstrate how resources are directed toward the most serious harms – not simply evidence that all risks are managed equally.

Small PCBUs

Fewer than 20 workers

Narrowed obligations – primary duty obligations now attach to critical risks which must be managed ahead of other risks.

Training, PPE, and supervision requirements are similarly limited, offering significant compliance relief for smaller operators.

Large PCBUs

20 or more workers

Full duties remain – no reduction in scope.

Critical risk prioritisation becomes a mandatory, demonstrable obligation.

Board level governance accountability is confirmed and unchanged.

Structural Change

Two-Tier PCBU System Introduced

Business size now determines the scope of legal obligations – a fundamental structural change to HSWA compliance.

Compliance Obligations by Size

Which tier applies to your organisation?

Small PCBUs
Fewer than 20 workers

Primary duty applies to critical risks"

- Required to manage critical risks ahead of other risks
- Non-critical risks fall outside the primary duty scope
- Basic worker welfare obligations remain (first aid, drinking water)
- Training, PPE, and supervision obligations tied to critical risks only

It is reported that 97% of all businesses in New Zealand are small businesses, being those with fewer than 20 employees. The proposed changes impact a significant portion of New Zealand's workforce.

Large PCBUs
20 or more workers

Must manage all risks – no reduction in scope

- Must prioritise critical risks over other risks
- Full training, PPE, and supervision obligations retained
- Board-level assurance for critical risk management expected

Many welcomed the intent to simplify the system and focus on critical risk, but argued the 2025–2026 reform package will increase harm, complexity and cost rather than reduce them.

Impact

⚠ Creates fundamentally different compliance burdens by business size – the tier your organisation falls into determines the entirety of your primary duty obligations.

New Legal Definition

"Critical risk" is the central organising principle of the reformed Act – defining it correctly is now your first compliance task.

Defining "Critical Risk" – Two Limbs

Limb 1 – Schedule 1A

Listed Hazards

Hazards and activities expressly listed in Schedule 1A of the Act – covering high-risk industries and designated activities.

OR

Limb 2 – Outcome-Based

Serious Harm Likely

Any hazard likely to result in:

- Death
- Notifiable injury or illness
- Notifiable incident
- Certain occupational diseases (Listed in Sched 2 of the ACC Act)

Expressly Included

Mental health harm – where linked to a serious outcome listed under Limb 2.

Legal Significance

Why isn't this consequence based?

"Many important risks, such as violence and aggression in retail, back injuries and some occupational diseases are unlikely to meet the threshold for a critical risk but cause significant harm to workers"

Samantha Turner, Barrister
Stout Street Chambers | July 2026

Legal Duty

Mandatory Prioritisation of Critical Risks

Prioritising critical risks is now a legal duty – how you allocate resources and monitor risk must demonstrably reflect this hierarchy.

1

Step 1

Address First

Critical risks must be managed **before** lower-level risks – sequence risk management programme accordingly.

Priority Sequencing

2

Step 2

Monitor More

Critical risks require increased monitoring frequency – standard review cycles may be insufficient for critical risk categories.

Heightened Oversight

3

Step 3

Allocate More

Resources must be demonstrably directed to critical risks – documented evidence of allocation is expected under enforcement review.

Resource Allocation

Note: Failure to prioritise is not itself an offence – but it directly shapes enforcement focus and resource allocation expectations under the reformed Act.

Reduced Duties for Small PCBUs

Key Point

Small PCBUs gain some 'relief' – but remain exposed through contracts, shared workplaces and other laws.

What Changes, What Remains

No Longer Required

- Primary duty scope reduced to **critical risks only**
- Non-critical risks removed from primary duty obligations
- Training, PPE, and supervision obligations tied to critical risks only

> *"The reforms have focused on costs to businesses of prevention and not the much greater cost of harm"*

What Remains

- **Basic worker welfare** – first aid, drinking water
- **Contractual obligations** imposed by larger PCBUs in supply chains
- **Shared workplace exposures** where other PCBUs' duties intersect

"Small businesses are less safe than large PCBUs – is this a backwards step? Should workers face more risks if they work for smaller companies?"

⚠ **Practical impact** Reduction in legal obligations under the Act – but contractor and supply chain complexity increases significantly.

Legal Reform 2026

Overlapping Regulatory Duties

New Section 35

Where another law governs the same risk in the same situation, compliance with that law now satisfies HSWA – reducing duplication but introducing new risks.

Samantha Turner, Barrister
Stout Street Chambers

The Rule – Section 35

Compliance with another applicable law = compliance with HSWA for that risk

Benefit

Reduces duplicate statutory confusion and burden across regulatory regimes.

For example, requirements under:

- the Building Act 2004
- Maritime Transport Act 1994
- Land Transport Act 1998

The changes to HSWA clarify that a PCBU that complies with a requirement in another Act where it manages the same risk, will be considered compliant with HSWA.

PCBUs operating under sector-specific legislation no longer face parallel obligations for the same risk scenario.

Risk

PCBUs may inadvertently rely on lower or outdated standards from other regimes.

A regime that technically applies may set a standard below HSWA's intended protection level.

Practical Caution

Audit the standard of the other regime before relying on it as safe harbour.

Confirm it meets or exceeds the protection HSWA would otherwise require.

Updated Duty to Manage Workplaces – Recreational Access

Landowners' liability is narrowed

Previous

Broad Potential Liability

Section 37 imposed wide duties on persons who manage or control workplaces – extending potential liability to all persons present at, or accessing, a workplace.

- Landowners and asset owners exposed to claims arising from recreational use of their land
- Submitted there was aambiguity over whether hikers, visitors and recreational users triggered HSWA obligations

New Position

Narrowed Duty – Exceptions Apply

Landowners are **not responsible** for recreational users (e.g. hikers, visitors) unless one of two conditions is met:

Exception 1 The recreational activity is part of the PCBU's own business

Exception 2 Work is occurring at the same time and place

Impact Narrows liability for landowners and asset owners – but proximity of work activity remains a live trigger requiring site-specific assessment.

Officer Duty Clarified

Section 44

Key Message

Officer duties are separate from what an officer does in their role as a worker for the PCBU

Dual-Role Clarification

Where a person holds both an **officer** and **worker** role, only the officer duty attaches. There is no dual exposure – the officer role is the operative legal duty.

Due Diligence Steps

The due diligence steps are now an **exhaustive list, not** merely illustrative. Every step must be satisfied – there is no residual discretion to substitute alternative measures.

Duties for officers (such as company directors, partners, board members, or chief executives), have been clarified to focus on governance functions.

Gibson Case Confirmation

The Amendment confirms the *Gibson* case does **NOT** reduce expectations for directors or CEOs. Governance accountability remains at the same standard as prior case law.

Key Takeaway

Governance accountability is preserved. Operational overlap no longer creates dual exposure – officer-level due diligence duty remains demanding.

Approved Codes of Practice – Safe Harbour

Following an ACOP now equals deemed compliance – a major shift toward certainty and an opportunity for industry led standard-setting.

Strategic consideration: Engage in ACOP development to shape your industry's standards before they are set for you.

Safe Harbour

Deemed Compliance

ACOP compliance equals deemed compliance with HSWA for that specific risk. Following the code provides a legal defence against enforcement action.

Certainty Gained

Industry Role

Industry-Led Standard-Setting

Industry bodies can now develop and submit ACOPs for approval. This opens a direct pathway to shape sector-specific compliance standards.

New Opportunity

Risk

Minimum-Standard Culture

ACOPs risk entrenching minimum-standard compliance. Organisations may cease to go beyond the code, even where higher standards are warranted.

Monitor Closely

WorkSafe's Role Rebalanced

WorkSafe's statutory focus shifts toward guidance and advice first – but enforcement continues, now targeted at critical risks.

Statutory Priority Hierarchy

1

First Priority

Guidance and Advice

2

Second Priority

Codes of Practice

3

Third Priority

Enforcement

Practical Implication

Expect more proactive engagement from WorkSafe; enforcement remains, but is increasingly focused on critical risk failures.

Notification Duties

Clarification, Not Expansion

More detailed examples of notifiable events

What Changed

What Changed

More detailed examples of notifiable injuries, illnesses, and incidents have been added to the Act.

What Did Not Change

No major expansion of notification scope. No new categories of event requiring notification have been introduced.

Impact

More examples provided on what current references mean

Action Required

Review your notification procedures against the updated examples to ensure alignment with current definitions.

Legal Alert

Cross-Cutting Risks

Four ambiguities cut across all PCBUs regardless of size – each demands active legal and operational attention.

Samantha Turner
Barrister
Stout Street Chambers

Cross-Cutting Risks for All PCBUs

Risk 01

Critical Risk Definition

Ambiguity in Schedule 1A and outcome thresholds leaves room for contested classification in practice.

- **Legal Clarity**

Risk 02

Contractor Complexity

Supply chain duty allocation remains unsettled – who bears responsibility across PCBU boundaries is unresolved.

- **Supply Chain**

Risk 03

Psychosocial Gaps

Mental health harm triggers remain context-dependent – the threshold for "serious outcome" linkage is not yet settled.

- **Mental Health**

Risk 04

Regulatory Reliance

Other regime standards invoked under s 35 may fall below HSWA intent – safe harbour may not hold under scrutiny.

- **Safe Harbour**

What to Do Now

Immediate, practical steps differ by size – but all PCBUs should act before enforcement focus sharpens.

20+ Workers
Large PCBUs

1. **Map all existing risks**
   against the critical risk definition
2. **Establish a documented prioritisation framework**
   for managing critical risks above all others
3. **Update board assurance and reporting structures**
   to reflect critical risk hierarchy
4. **Review officer due diligence processes**
   against the now-exhaustive statutory steps

Fewer than 20 Workers
Small PCBUs

1. **Identify which risks qualify as critical**
   under Schedule 1A and the outcome-based test
2. **Review all contractor and supply chain agreements**
   for expanded duty clauses imposed by larger PCBUs
3. **Confirm basic worker welfare obligations remain in place**
   (first aid, drinking water)

⚠ **Early, documented action is the strongest defence – act before enforcement focus on critical risks intensifies.**

Reflections