New Zealand Journal of Health and Safety Practice
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A person with narrow vision has a restricted horizon; a person with wide vision has plentiful opportunities

Beyond Due Diligence: Safety Leadership Culture and the Moral Imperative for Senior Leaders in Aotearoa New Zealand

Vol 3, edition 2, July 2026

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DOI: https://doi.org/10.26686/nzjhsp.v3i2.10681

Abstract

The 2026 High Court decision upholding the conviction of former Ports of Auckland chief executive Tony Gibson under s44 of the Health and Safety at Work Act 2015 has generated considerable commentary in New Zealand's health and safety community. Much of that commentary has focused on the legal and technical implications of the decision. This article argues that the case has more fundamental roots – and a more important lesson. Drawing on personal experience, including a meeting with New Zealand business leaders in the weeks before the Pike River Mine disaster of November 2010, and a framework for Safety Leadership Culture developed over 25 years of practice in high-risk industry, the article contends that workplace safety failures are fundamentally leadership failures. The law can compel minimum standards. It cannot manufacture genuine leadership.

Key words: safety leadership culture; due diligence; Pike River; Health and Safety at Work Act; officer duty; workplace safety; HSWA s44

1.0 Introduction

1.1 The Gibson decision and what it tells us

When the High Court dismissed Tony Gibson's appeal in Gibson v Maritime New Zealand [2026] NZHC 813, upholding the Auckland District Court's finding that the former Ports of Auckland chief executive had failed in his duty of due diligence under s44 of the Health and Safety at Work Act 2015, the reaction across New Zealand's health and safety community was immediate and substantial. Much of the deliberation has focused, understandably, on the technical implications of s44 and what changes the 2026 HSWA Amendment Bill might bring. Barton (2025) describes how the decision affects officers and Lill (2025) analyses the key legal issues; readers seeking detailed legal analysis are directed to both.

This article is concerned with something more fundamental – the question that sits beneath the legal one. Not whether Tony Gibson met the statutory threshold for due diligence, but why senior leaders so often fail to engage genuinely with safety in the first place, and what it would take for them to do so.

The answer, this article argues, lies not in stronger legislation but in Safety Leadership Culture (SLC) – and in understanding what that actually means in practice.

1.2 Why this matters beyond the law

The Gibson decision confirmed that the former chief executive had the knowledge, influence, and resources to address critical safety gaps at Ports of Auckland – and failed to exercise his due diligence to do so. On 30 August 2020, Pala'amo Kalati, a lasher, lost his life when he was fatally struck by a falling container on board a vessel berthed at the port. That human reality sits behind every legal argument about officer duty and should not be obscured by it.

This article is written from the perspective of a practitioner with 25 years of experience managing health and safety in high-risk New Zealand industry. It does not claim the authority of formal research. It claims something different – the authority of someone who has sat in the rooms where these conversations happen, who has watched safety culture flourish and collapse depending on the

behaviour of the leaders at the top, and who has spent a career trying to understand and articulate why that is so.

2.0 The day I understood what was at stake

2.1 A meeting at the Beehive

In the weeks before 19 November 2010 – the date Pike River Mine exploded, killing 29 workers – the author found themselves at the Beehive, standing in for their chief executive at a New Zealand Business Leaders Health and Safety Forum steering committee meeting. It was a room full of the country's leading business chief executives and a Cabinet Minister, the Hon. Kate Wilkinson, Minister for Workplace Health and Safety. The author felt like a fish out of water.

The Minister posed a question to the group: what is the biggest barrier to safety performance in New Zealand?

When the author's turn came, the response was: many senior leaders fail to grasp how safety leadership directly influences safety outcomes – if they did, New Zealand would have a better safety record.

Peter Whittall, a senior executive from Pike River Coal, leapt from his seat in disagreement – so emphatic in his conviction that the chief executive of Fletcher Building, seated nearby, had to intervene to quieten him down. He was absolutely certain he was standing on solid ground.

Weeks later, Pike River Mine exploded. Twenty-nine workers lost their lives.

2.2 What the Royal Commission found

The Royal Commission on the Pike River Coal Mine Tragedy was unambiguous in its findings. Inadequate systems, a lack of effective leadership, and an insufficient focus on worker health and safety had created the conditions for disaster (Royal Commission on the Pike River Coal Mine Tragedy, 2012). It was not a finding about one catastrophic decision. It was a finding about culture – about what happens when safety leadership is absent, performative, or simply never genuinely embraced.

The author has reflected on that Beehive meeting many times since – not with satisfaction, but with the weight of what it illustrated. The leaders in that room were not bad people. They were not indifferent to the safety of their workers in any conscious sense. But the exchange that morning captured something that has driven the author's work ever since: that the single greatest barrier to safety performance in New Zealand is not regulation, not systems, not resources. It is the failure of senior leaders to understand that they are not merely responsible for safety. They are the culture.

That realisation cemented a determination – to expose weak safety leadership culture where it exists, and to strengthen it wherever possible.

3.0 Safety Leadership Culture: what it is and what it is not

3.1 The gauge metaphor

Safety Leadership Culture can be thought of as a gauge on a fuel tank – a live measure of organisational health. Leaders can keep it full, allow it to run low, or drain it entirely without ever realising – until something goes wrong. The gauge metaphor is deliberate. Gauges do not lie, and they do not respond to intention. They measure only what is actually there.

So, what fills the tank? In the author's experience, the most useful place to start is not with a definition of SLC but with a clear account of what it is not – because the things it is not are precisely the things many well-meaning leaders rely upon, believing they are making a difference. The following draws on practitioner discussions within the New Zealand health and safety community, including the Safeguard Forum, and on 25 years of direct experience managing health and safety in high-risk industry – interacting with literally thousands of New Zealand businesses across that time, not just the ones I worked for.

3.2 What SLC is not

SLC is not a product. It cannot be purchased, installed like an app, or outsourced. Like trust, it cannot be demanded – it is built layer by layer through consistent actions over time. Organisations

that treat safety culture as a programme to be implemented will find, invariably, that the culture reverts the moment the programme ends.

SLC is not paperwork. Forms, procedures and documented systems are necessary but not sufficient. They do not keep people safe – visible, consistent leadership actions do. On any worksite, experienced workers can tell within minutes whether safety is genuinely valued or whether compliance is simply performed for the benefit of auditors and regulators.

SLC is not something that can be forced. Real safety behaviour is inspired, not enforced. This distinction maps onto what the author describes, in teaching and practice, as a Culture Curve – adapted from the DuPont Bradley Curve (DuPont, 1995) but rendered in terms that resonate with practitioners in high-risk industries. In the author's rendition, organisations move through four stages – Cowboys, Compliance, Competence – but the destination is Care. Because care creates trust, and trust fosters genuine commitment that no enforcement mechanism can manufacture.

SLC is not a lecture. Slogans, toolbox talks delivered without conviction, and annual safety addresses from the boardroom will not move the needle. What moves the needle is doing the right thing consistently, and without an audience.

SLC is not window dressing. Real culture is lived daily – when leaders act on the concerns workers raise, and when the gap between what an organisation says about safety and what it actually does is negligible. Sometimes unsafe shortcuts are not about individuals cutting corners – they are decisions made in isolation, by people who never see the workers or the risks those workers carry. A leader with genuine Safety Leadership Culture sees those workers clearly and provides the highest level of protection available to them.

SLC is not a destination — it is an outcome. It cannot be declared or decided upon. It results from sustained leadership, deliberate planning, and the kind of discipline that persists even when other pressures are demanding attention. Organisations that understand this stop asking, "have we got there?" and start asking "what are we doing today to keep the gauge full?"

3.3 What SLC requires

SLC requires visible, genuine engagement from senior leaders. When leaders listen, act, ask questions, show up, and consistently model the behaviours they expect of others, the tank stays full. Without that visible engagement, the entire system loses traction – regardless of the quality of the management systems, the sophistication of the audit programme, or the sincerity of the safety policy on the wall.

The gauge does not measure what we say. It only measures what we do.

4.0 Implications for senior leaders and boards

4.1 The gap between compliance and leadership

The Gibson decision should prompt every board member and chief executive in New Zealand to ask not, ‘are we legally compliant?’ but ‘do we actually know what is happening on our sites?’ Those are different questions. The first can be answered by a lawyer. The second requires a leader.

Peter Whittall disagreed with me that day at the Beehive. Tony Gibson, I suspect, believed his organisation was performing adequately. Neither is unusual – it is genuinely hard to see the gauge from the boardroom.

Tony Gibson did not physically harm anyone. Neither did Peter Whittall. But leadership shapes culture, and culture shapes outcomes. When due diligence becomes a governance checkbox rather than a living practice – when the gauge is never checked because no one in the boardroom knows where to find it – the tank runs dry before anyone notices.

4.2 What genuine engagement looks like

The author’s experience across 25 years in high-risk New Zealand industry suggests that the leaders who make the greatest difference to safety outcomes share a small number of characteristics. They show up – physically, on sites, among the people doing the work. They listen without an agenda. They act on what they hear. They treat safety not as a compliance function delegated to a specialist but as a living expression of their values as leaders. And they do these things consistently, without an audience, over years rather than months.

None of this is complicated. But in practice it is rarer than it should be, and its absence is felt – in culture, in trust, and ultimately in outcomes.

The law establishes the floor. What happens above that floor is a matter of leadership character – and that is not something any amendment to the HSWA will change.

5.0 Conclusion

The Gibson decision is an important legal landmark. But its most important lesson is not legal. It is this: senior leaders and boards cannot delegate their way out of safety responsibility, and they cannot compliance-manage their way to a safe culture. Safety Leadership Culture is not built in boardrooms. It is built on sites, in conversations, through visible and consistent behaviour over time.

In Aotearoa New Zealand, where Māori workers are significantly represented in our highest-risk industries, the stakes of poor safety leadership are felt collectively as well as individually – by whānau, by communities, by industries. The Pike River disaster demonstrated that with devastating clarity. The Gibson decision is a reminder that the lesson has not yet been fully learned.

Ehara taku toa i te toa takitahi, engari he toa takitini — success is not the work of one, but of many. Safety is no different.

The gauge does not measure what we say. It only measures what we do.

Submission declaration: This manuscript has not been published elsewhere in its current form. The article draws on and substantially develops two LinkedIn posts which attracted the editor's attention. This has been flagged transparently in the cover letter.

Funding: Self-funded by the author.

Declarations of interest: None.

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