



Officer Due Diligence After Gibson and Whakaari and HSWA Amendment 2026 – A Five-Stage Verification Framework

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Abstract

New Zealand's officer due diligence duty under section 44 (hereinafter, referred to as s 44) of the Health and Safety at Work Act 2015 requires reasonable steps to verify that a person conducting a business or undertaking provides and uses the resources and processes needed for compliance. However, neither the Act nor the case law clearly defines where governance assurance ends and operational management begins. This article examines that boundary drawing on the recent Court cases; the Gibson case which demonstrates that formal systems may be insufficient where warning signs undermine confidence in implementation, and the Whakaari case which emphasises duty-holder identification and individual proof. It argues that officers must obtain and critically test credible assurance and respond when the boundary between governance and operational weakens. The article proposes a five-stage verification cycle: Ask, Receive, Test, Follow Up and Escalate. The framework is a conceptual synthesis of statute, case law and safety-science scholarship and evidence-informed compliance model proposed to establish and verify due diligence. However, it is not a standalone tool, rather a proactive risk management system.

Keywords

due diligence; health and safety governance; verification framework; work-as-done; HSW Amendment Act 2026, section 44

1. Introduction

The officer due diligence duty under the Health and Safety at Work Act 2015 (HSWA) emerged from post-Pike River concerns that governance could not remain passive in relation to health and safety. The Royal Commission and Independent Taskforce called for stronger governance accountability, contributing to the enactment of s 44 Independent Taskforce on Workplace Health and Safety (2013). S 44 imposes a personal duty on an officer to exercise due diligence to ensure that the person conducting a business or undertaking (PCBU) complies with their duties and obligations. Due diligence includes taking reasonable steps to ensure that appropriate resources and processes are provided and used, and to verify their provision and use (HSWA, 2015). However, the Act does not prescribe a single verification method or clearly define where governance assurance ends and operational management begins.

That boundary is central to Gibson v Maritime New Zealand (2026), the most significant New Zealand judicial consideration to date of officer due diligence under s 44. The High Court upheld the conviction of the former chief executive of Ports of Auckland Limited in relation to the implementation and verification of crane exclusion-zone processes. The decision is significant because the officer-level assurance available concerned a known critical risk, previous incidents and acknowledged weaknesses in monitoring. The Court accepted that verification could involve monitoring and measuring “work as done” rather than relying only on documented systems or general assurances Gibson v Maritime New Zealand (2026) as explained in paras. 159-167, 180-186.

Safety science provides a useful way to understand this problem. Work-as-imagined describes how work is expected, prescribed or reported to occur, while work-as-done concerns how people actually perform work in operating conditions (Hollnagel & Clay-Williams, 2022). Similarly, distinction between “safety work” and the “safety of work” cautions that policies, audits and reporting activity do not themselves establish that operational risks are being effectively managed (Rae & Provan, 2019). These concepts are not additional statutory tests. They help explain why verification requires information about actual practice.

The *Whakaari* proceedings identify another boundary. *Whakaari Management Ltd v WorkSafe New Zealand* (2025) concerned whether the company practically managed or controlled the workplace, while the separate s 44 charges against its directors were dismissed because the prosecution had insufficient evidence concerning each director's conduct. Together, those cases reinforce the need to identify the correct duty holder, the relevant capacity and the conduct of the individual officer before liability is attributed.

The Health and Safety at Work Amendment Act 2026 has been enacted but does not come into force until 1 April 2027. It clarifies the governance focus of the officer duty while retaining verification as an express element of due diligence as explained in ss 2 and 22 of (HSWA, 2026).

This article examines how officers can exercise meaningful due diligence without taking over operational management. It argues that officers must obtain and critically assess credible assurance that the PCBU has provided and is using the resources and processes required for compliance. The necessary depth of enquiry should increase significant risk, warning signs, uncertainty or weak information undermine routine assurance. To translate that argument into practice, the article develops a five-stage verification framework: Ask, Receive, Test, Follow Up and Escalate. The practical question is therefore: How do we know the system is being used, and what will we do when the assurance is not good enough? Parts 2-6 establish the legal and evidential foundations; the practical model is set out in part 7.

2. Officer Due Diligence Under S 44: Active Governance and Future Reform

2.1 The Current Statutory Architecture HSWA 2015

The duty of officer is connected to the duties of the PCBU but is separate and personal. Section 18 of the HSWA 2015 includes directors, partners and general partners, people in comparable positions, and people whose position allows significant influence over management. A chief executive is expressly identified as an example, while a person who merely advises an officer is excluded. If the PCBU has a duty or obligation under the Act, an officer must exercise due diligence to ensure compliance. The standard is the care, diligence and skill that a reasonable officer would exercise in the same circumstances, having regard to the nature of the PCBU and the officer's position and responsibilities.

The current s 44(4) describes due diligence through six areas of reasonable steps: acquiring and keeping up to date knowledge of work health and safety matters; understanding the PCBU's operations and associated hazards and risks; ensuring appropriate resources and processes are available and used; ensuring processes exist for receiving, considering and responding to information about incidents, hazards and risks; ensuring processes exist and are implemented for complying with the Act; and verifying the provision and use of the relevant resources and processes. Verification is therefore already explicit, but the Act does not prescribe one assurance method or require officers to personally inspect or technically test every operational control.

The wider statutory structure is important. S 31 provides that duties cannot be transferred. A person may hold more than one duty, and more than one person may hold the same duty, each remaining responsible to the extent of their ability to influence and control the matter. Officer liability is also assessed independently of whether the PCBU is convicted. The current Act contains no express rule separating the conduct of a working director or chief executive into officer and worker capacities.

2.2 The Policy Origins of Active Governance

The policy history reflects a commitment to active governance oversight. The Royal Commission on the Pike River Coal Mine Tragedy concluded that the board had not adequately verified that effective health and safety systems were in place or held management to account. It recommended stronger statutory recognition of directors' governance responsibilities and rigorous review and monitoring of organisational compliance (Commission's Report, 2012).

The Independent Taskforce on Workplace Health and Safety subsequently recommended an Australian-style positive due diligence duty for officers in governance roles (Independent Taskforce on Workplace Health and Safety, 2013). This history helps explain the focus of s 44 on knowledge, understanding, resourcing, information processes and verification. It supports active governance without requiring directors and chief executives to become frontline supervisors.

2.3 The Enacted Changes from 1 April 2027

At the time of writing, the Health and Safety at Work Amendment Act 2026 has received Royal assent but is not yet in force; it commences on 1 April 2027. The Amendment Act leaves the definition of officer in s 18 unchanged. S 22 retains the reasonable-officer standard but changes the structure of due diligence. The current word “includes” is replaced by “means”, making the listed elements exhaustive rather than illustrative. Verification remains expressly required (HSWA, 2026).

The amendment also provides that where a person is both an officer and a worker in a separate or additional role, s 44 applies only to conduct in the officer role. This responds to uncertainty under the present law. In *Sarginson v Civil Aviation Authority* case, the High Court rejected a categorical limit of officer due diligence to governance functions and treated the officer’s operational conduct as relevant to the duty (Hesketh Henry, 2021). MBIE later identified that interpretation as part of the uncertainty the reform was intended to address (MBIE, 2025).

The reform is therefore best understood as **role clarification** and a narrowing of interpretive scope, rather than the removal of active officer accountability. The statutory elements remain focused on understanding, ensuring and verification, while the new capacity rule requires closer attention to the role in which the relevant conduct occurred.

3. Verification Beyond Paper Assurance

Verification distinguishes due diligence from passive receipt of health and safety information. Policies, risk registers, training programmes and audits may show that a system has been designed, but not necessarily that its resources and processes are being used. S 44 therefore requires a checking function beyond evidence of existence.

3.1 What the Statutory Text Requires

Under the current HSWA, officers must take reasonable steps to verify the provision and use of the resources and processes referred to in s 44(4)(c)-(e), including risk-management resources, processes for receiving, considering and responding to incident and hazard information, and processes for complying with the (HSWA, 2015). An approved policy, budget or reporting process may demonstrate provision, but not use.

The language also sets limits. S 44 does not prescribe site visits, independent audit or personal testing of controls, nor does it expressly require officers to prove the effectiveness of every operational control. The depth of verification remains governed by the reasonable-officer standard. The strongest statutory proposition is therefore narrow: officers must take reasonable steps to check that relevant resources and processes have been provided and are being used. Where the available evidence does not support that conclusion, further enquiry may be required. The *Gibson* case gives this practical significance. As explained in paras. 165-167 in *Gibson v Maritime New Zealand* (2026), the High Court judged monitoring and measuring “work-as-done” relevant to verification and accepted that such information could be generated through managers and organisational systems rather than personally collected by the officer.

3.2 Work as Imagined and Work as Done

(Hollnagel & Clay-Williams, 2022) distinguish work-as-imagined, meaning prescribed or expected work, from work-as-done, meaning how work is actually performed in operating conditions. Procedures remain necessary, but their existence does not establish that work is being performed as intended, which matters for governance information. A risk register may record that a control is in place, an audit may confirm a procedure exists, and a dashboard may show completed training. Each may be accurate while providing limited evidence that the control is understood, workable and routinely applied. This highlights the concept of “safety clutter”, defined as safety activities that persist without meaningfully contributing to operational safety (Rae et al., 2018). It also distinguishes between safety work from the safety of work (Rae & Provan, 2019). Both concepts help explain why increased safety activity does not necessarily lead to improved safety assurance.

For officers, a practical implication is to seek evidence that tests formal systems against operational reality. Such evidence sources may include operational data, worker feedback, incident data, targeted audits, control-verification results or specialist reviews. Likewise, New Zealand governance guidance recommends utilising multiple assurance sources (IoD - WorkSafe NZ, 2024). What matters most is whether the evidence collectively provides a credible basis for confidence in safety.

3.3 Assurance Is Not the Same as Reassurance

Reassurance is confidence derived from being told, or assuming, that arrangements are satisfactory. Assurance requires a credible basis for that confidence. A board may receive low injury rates, completed training figures and positive audit results. Their evidential value depends on what they demonstrate. A document-focused audit, for example, may strongly support the conclusion that a system has been designed while providing weaker evidence about how a control operates in practice (IoD - WorkSafe NZ, 2024).

Officers need not distrust management or independently reproduce assurance work. Reasonable reliance is addressed in Section 6.1. However, they need to understand the limitations of the evidence on which they rely. Providing additional reports does not necessarily enhance assurance if it results in increased activity without improving understanding of significant risks (Rae et al., 2018).

For this article, governance assurance means a structured process through which officers obtain and critically assess credible evidence that important health and safety resources and processes are in place and being used. That definition is deliberately narrower than operational risk management.

4. The Gibson Case: Warning Signs, Work as Done and Reasonable Reliance

Gibson v Maritime New Zealand (2026) provides the most substantial New Zealand judicial consideration to date of what due diligence may require where formal systems exist, but the available evidence raises doubt about how those systems operate in practice.

4.1 The Operational and Organisational Context

The proceedings arose from the death of Pala'amo Kalati at the Port of Auckland on 30 August 2020. Kalati was working as a lasher aboard the *MV Constantinos P* container ship when a container fell on him during crane operations. Ports of Auckland Limited (POAL) had an exclusion-zone rule requiring workers to remain three container widths from an operating crane. The fatal event occurred when that rule was not being followed.

POAL was a substantial 24-hour operation with approximately 650 employees, multiple business units and contractors, a specialist health and safety team, formal committees, external advisers and board oversight. Anthony Gibson had been chief executive since 2011, reported to the board and exercised substantial influence over organisational systems and priorities. The High Court nevertheless recognised that he could not be expected to perform his subordinates' work or know every operational detail. The relevant risk was already recognised as critical. Gibson knew of the risk associated with suspended loads. The issue was whether his officer-level steps provided an adequate basis for confidence that the processes intended to manage that risk were being implemented and verified in practice.

4.2 The Charge and Outcome

POAL pleaded guilty to charges concerning its own duties. Gibson was separately prosecuted for an alleged breach of his s 44 officer duty through the category 2 offence provision in s 48(1), with s 49 pleaded in the alternative. The relevant particulars concerned exclusion-zone processes and verification of their provision and use. A separate particular concerned coordination between lashers and crane operators following a COVID-19 operational change.

Following a seven-week judge-alone trial, Gibson was convicted on the exclusion-zone and verification particulars but acquitted on the coordination particular. He was fined \$130,000 and ordered to pay \$60,000 in prosecution costs. The High Court dismissed his conviction, and sentence appeals. The maximum fine for an officer convicted under s 48 is \$300,000, and s 29 prohibits insurance or indemnity for HSWA fines or infringement fees (HSWA, 2015). POAL's breach did not determine Gibson's liability; his own conduct had to be assessed against s 44.

4.3 Verification and Work as Done

The High Court accepted that Gibson had taken many positive health and safety steps. The question was not whether he had generally supported safety, but whether further reasonable steps were required in relation to the specific critical risk and verification failures alleged. The Court considered that verification could include monitoring and measuring “work-as-done”, with information produced through **management systems** rather than personally collected by the officer. The assurance was weak. There was evidence of inconsistent understanding and non-compliance with the exclusion-zone policy, particularly on the night shift. Existing observations did not adequately monitor that non-compliance, and a 2019 board report acknowledged that recorded incidents, near misses and non-compliance were unlikely to reflect the true level of events because of reporting weaknesses.

An earlier 2018 straddle-carrier fatality also mattered because it put Gibson on notice of wider difficulties in monitoring work as done. The Court’s conclusion was not that he had done nothing, but that the available warning signs made stronger monitoring and measurement reasonably necessary in relation to a known critical risk.

4.4 The Limits and Reach of Gibson

Gibson does not require officers to personally supervise frontline work. The High Court recognised that Gibson was not responsible for training or supervising lashers and could rely on expert advice concerning the exclusion-zone policy. His liability concerned the adequacy of officer-level monitoring, not a failure to perform operational tasks. The case should therefore travel cautiously. It concerned a chief executive with substantial influence in a large, complex, high-risk organisation, a risk already recognised as critical, and evidence of previous serious events, acknowledged reporting weaknesses and non-compliance. It supports deeper enquiry where similar information undermines the basis for confidence. It does not establish that every non-executive director must personally visit worksites, receive detailed operational data or test critical controls.

From 1 April 2027, the new capacity rule will also require *Gibson Case* to be read alongside an express distinction between conduct in an officer role and conduct in a separate worker role as explain in s 22 (HSWA, 2026). Its enduring contribution is therefore measured: *formal systems may be insufficient where known serious risks and available evidence undermine confidence in how those systems are being used.*

5. The Whakaari and Buttle Case: Control, Fragmentation and Individual Proof

While the Gibson case concerns the adequacy of assurance within an established system, the Whakaari and Buttle case help identify where legal responsibility sits before assurance is assessed (Whakaari Management Ltd v WorkSafe New Zealand, 2025).

5.1 Practical Management, Control and Fragmented Responsibility

Whakaari Trustee Limited owned the island and leased it to Whakaari Management Limited (WML), which licensed commercial tour operators to conduct walking tours. WML did not itself operate the tours or employ the guides. After the 2019 eruption which resulted in 22 deaths, WML was convicted in the District Court on the basis that it managed or controlled the walking-tour workplace under s 37. The High Court dismissed that conviction, holding that practical management or control required more than the ability to control access to land. Ownership-related rights, licensing arrangements and financial benefit did not establish management or control of the tour work itself as explained in paras. 202-240, 321 of the court judgement.

The case is indirectly relevant to officer due diligence because it cautions against attributing responsibility simply to the person or entity that appears highest in an ownership or contractual structure. The analysis must begin with the statutory duty, the party that holds it and the practical influence or control relevant to that duty.

Whakaari also illustrates fragmented responsibility. Tour operators, the landholding entities, GNS Science and government agencies each held different information or functions. S 33-34 of the HSWA (2015) posits overlapping duties: more than one person may hold the same duty and PCBUs with shared duties must, so far as is reasonably practicable, consult, co-operate and co-ordinate their activities. For an officer, the relevant assurance question is how the officer’s own PCBU depends on other parties, where responsibilities overlap and whether material gaps remain.

5.2 Officer-Specific Evidence

The separate prosecution of Andrew, James and Peter Buttle provides the direct connection to s 44. Each was a director of WML and was charged with failing to exercise due diligence in relation to the company's approach to volcanic risk (Whakaari Management Ltd v WorkSafe New Zealand, 2025).

Judge Thomas dismissed the charges under s 147 of the Criminal Procedure Act 2011 because the prosecution had not produced sufficient evidence to *establish a case to answer*. The case largely addressed what WML or the directors collectively had done, rather than what each individual director personally knew, considered, asked, challenged or failed to as explained in paras. 21–27.

The decision reinforces the personal structure of s 44. A PCBU breach does not establish that every officer breached due diligence, and collective governance evidence cannot substitute for proof of an individual officer's unreasonable act or omission. The limits of this case are equally important: it was a no-case-to-answer ruling based on evidential sufficiency and did not define the substantive content of verification.

Read together, this case imposes a disciplined sequence for **VERIFICATION: Identify the duty, the person or entity that holds it, the practical influence or control relevant to it, and then the conduct of the individual officer**. Only then can the adequacy of reliance, enquiry and verification be assessed.

6. Reliance, Delegation and Mixed Capacities

Officer due diligence necessarily involves reliance on others. The question is not whether reliance occurs, but whether its basis is reasonable.

6.1 Reasonable Reliance

The High Court addressed this directly in the Gibson case. The District Court had stated that an officer could not discharge due diligence by relying on people, lower in the management chain. The High Court qualified that proposition, identifying the problem as “simply” relying on others and assuming compliance without proper enquiry. Appropriate reliance on subordinates with relevant responsibilities remained compatible with s 44 Gibson v Maritime New Zealand (2026) as explained in paras. 100.

This reflects organisational reality. A chief executive cannot personally undertake every technical assessment or independently verify every control, and a non-executive director will ordinarily be further removed from operations. The critical issue is the basis for confidence. Relevant considerations include the competence of the person providing information, the purpose and scope of the assurance process, consistency with other evidence and whether unresolved concerns undermine routine reporting. Reasonable reliance is therefore neither blind trust nor personal duplication of another person's work. It is reliance supported by information of sufficient quality to evident and justify continued confidence.

6.2 Delegation Is Not Transfer of the Duty

S 31 provides that a duty cannot be transferred (HSWA, 2015). This does not prevent operational or technical activities from being delegated. Management may develop a critical-risk framework; a competent health and safety practitioner may operate the system; and engineers, occupational hygienists or auditors may provide specialist work.

The distinction is between allocating activity and transferring the legal duty. Delegation can support due diligence where responsibilities are clear, competent people have adequate authority and resources, and significant information can reach governance. A specialist health and safety function may strengthen the basis for officer reliance, but it does not itself discharge s 44.

6.3 Australian Comparison

Although New Zealand's officer duty was substantially modelled on s 27 of the Australian Model Work Health and Safety Act, which similarly addresses knowledge, understanding, resources, information processes, compliance processes and verification, Safe Work Australia (2025) is more persuasive. *SafeWork NSW v Miller Logistics Pty Ltd* (2024) provides a useful comparison. After a worker was seriously injured when struck by a forklift, Miller Logistics was convicted, while the prosecution did not prove that its sole director, Mitchell Doble, had failed to exercise due diligence. Doble had appointed a manager with specific responsibility for work health and safety, participated in regular safety meetings, reviewed health and safety matters and attended operational sites. The Court recognised the practical necessity of delegation in a multi-site business and assessed whether that delegation, combined with oversight, was consistent with reasonable due diligence.

The case is not a checklist for New Zealand officers. Its value is the broader proposition that competent delegation can coexist with a personal due diligence duty where the officer remains appropriately informed and exercises oversight.

6.4 Mixed-Capacity Officers

The boundary is more difficult where one person performs several roles, as is common in small owner-operated PCBU's. Under the current Act, a person may hold more than one duty (HSWA, 2015, s 32). Operational involvement may affect what an officer knows without converting every operational act into an officer act.

From 1 April 2027, the capacity rule discussed in part 2.3 of this article will require more explicit identification of whether relevant conduct occurred in the officer role or a separate worker role (HSWA, 2016, s 22). These are not additional legal tests. As a practical diagnostic, four questions can help structure that analysis: What role was the person performing when the relevant act or omission occurred? What influence and responsibilities did they hold as an officer? What information was available to them in that capacity? What officer-level response was reasonably available? Asking these questions prevents attributing every operational failure of a working director to s 44 while also preventing genuine governance omissions from being recharacterised as merely operational.

7. A Five-Stage Verification Framework

We draw on the preceding analysis that identified due diligence between a passive recipient of management information and personal supervision of operational work, statutory duties grounded in the Acts (HSWA, 2015); HSWA (2026), specifically s 4, the cases discussed throughout the article, especially the *Gibson's* treatment of work as done and the warning signs (*Gibson v Maritime New Zealand*, 2026). In addition to the governance guidance on multiple assurance sources, critical-control verification and response (ICMM, 2015; IoD - WorkSafe NZ, 2024), and the reviewed literature and the work-as-imagined vs work-as-done distinction in safety science (Ashraf et al., 2026; Boyle & Charlton, 2025; Hollnagel, 2015; Hollnagel & Clay-Williams, 2022; Massey et al., 2007; Michaels, 2024; Rae & Provan, 2019). We developed a proactive framework to assist officers in generating factual evidence. We propose this five-stage framework: **Ask, Receive, Test, Follow Up** and **Escalate**. Its purpose is to assist officers with improved judgement on whether assurance is proportionate to their role, the significance of each risk and the quality of the information they receive. More importantly, it is practical. In practice, significant risk corresponds to the critical risk outlined in the new amendment act. In this article, we define significant risk as an adverse event whose potential or actual consequences surpass the threshold of safety impact established by the PCBU. We rather use significant to differentiate between critical risk and critical control in the next part.

7.1 Ask

Verification begins by asking questions directed at material duties and risks. This stage requires officers to acquire and keep up to date knowledge of work health and safety matters and to understand the PCBU's operations and associated hazards and risks. For significant risk, officers should be able to ask: What can cause serious harm? What controls or processes are most important? Who is responsible for them? What information indicates whether they are being used? What would show that they are weakening or failing?

Critical control management provides a practical model, which can be developed as protocols or set of guidance. Critical controls, i.e., a control that is essential in eliminating or mitigating a significant risk is recommended to prevent unwanted events, defining performance requirements, assigning ownership and determining how performance will be verified (ICMM, 2015). This is good-practice guidance and a preventive measure rather than solely a statutory requirement. It also shows how governance attention can be directed towards what matters most.

7.2 Receive

The second stage concerns the information reaching the officer. Assurance may come from management reporting, incident and near-miss data, worker feedback, specialist advice, audit results and control-performance information. Larger organisations may use several layers of assurance, including operational checks, specialist review, internal audit and external review (IoD - WorkSafe NZ, 2024).

The issue is not volume but relevance, quality and accuracy. Activity measures such as completed inspections or training may be useful, but officers should understand what each measure demonstrates and what it does not. Worker and contractor information can be particularly valuable where it tests formal reporting against operational experience.

Worker information also sits within the HSWA's participation architecture. S 61 of HSWA (2015) requires PCBUs to maintain practices that provide workers with reasonable opportunities to participate effectively in improving work health and safety on an ongoing basis. Information generated through those practices can provide officers with an important source of evidence about work-as-done.

A simple example illustrates the distinction. A board report stating that "100% of critical-control checks were completed" establishes activity but says little about the quality and accuracy of performance. Stronger assurance would also show what the checks found, the number and nature of failures, recurring patterns, the response taken and whether remediation was subsequently verified. The officer need not inspect the controls personally; the value lies in whether the reporting reveals what the checks actually showed.

7.3 Test

Receiving information is not the end of verification. Testing requires critical assessment of whether the evidence supports the conclusion being presented. This may involve comparing sources, questioning unexpected trends, examining recurring findings or seeking explanation where management information conflicts with incident data or worker feedback.

The work-as-imagined/work-as-done distinction noted in part 3.2 is useful here. The question is whether the evidence concerns only the existence of a system or also provides a credible basis for understanding its use. The *Gibson* case confirms that information about work-as-done can form part of verification and can be generated through organisational systems rather than personal inspection *Gibson v Maritime New Zealand* (2026) as explained in paras. 165-167.

Testing should remain proportionate. Where credible sources consistently support the same result, further enquiry may add little. However, managers must critically verify that the information received accurately and reliably reflects the underlying risks and operational conditions. Where evidence is contradictory, incomplete, or unsupported, further enquiry is required to establish a sound basis for decision-making.

7.4 Follow Up

Assurance loses value if identified weaknesses disappear from governance attention once an action is allocated. The level of follow-up should reflect significance. Routine matters may remain within ordinary management systems; a failure affecting a control relied on to prevent death or serious harm may justify greater visibility of interim controls, ownership, timeframes and evidence of remediation.

Critical control protocols or guidance should appropriately connect verification processes with response actions. When a control fails to meet its established criteria, whether designed to eliminate or mitigate a risk, this should trigger an investigation and prompt corrective action.

Administrative closure and substantive resolution are not necessarily the same. Recording an action as closed confirms completion of an action-management process, not automatically that the underlying weakness has been addressed. For significant matters, the assurance system should be capable of distinguishing between the two.

7.5 Escalate

Routine assurance may cease to be adequate. Escalation is appropriate when the existing process no longer provides a reasonable basis for confidence. Triggers may include repeated incidents, failure of an important control, contradictory information, recurring findings, unreliable reporting or unresolved uncertainty. The Gibson case illustrates how previous serious events and known monitoring weaknesses can change what further steps are reasonable as explained in paras. 180-186.

Escalation does not necessarily mean officer intervention in operations. A proportionate response may include targeted management review, more specific reporting, specialist advice or independent assurance. Independent review may be useful where internal capability is limited, the issue is highly technical, previous responses have failed or the credibility of the existing assurance process is itself in doubt (Institute of Directors New Zealand, 2024).

The purpose is to improve the quality or independence of assurance, not add paperwork. The cycle can therefore be summarised as: ask what matters, receive credible information, test its basis, follow significant weaknesses through, and escalate when routine assurance no longer supports confidence. Figure 1 shows the relationship between the five stages.

Officer due-diligence verification cycle

A graduated cycle: intensity increases with risk and as confidence weakens

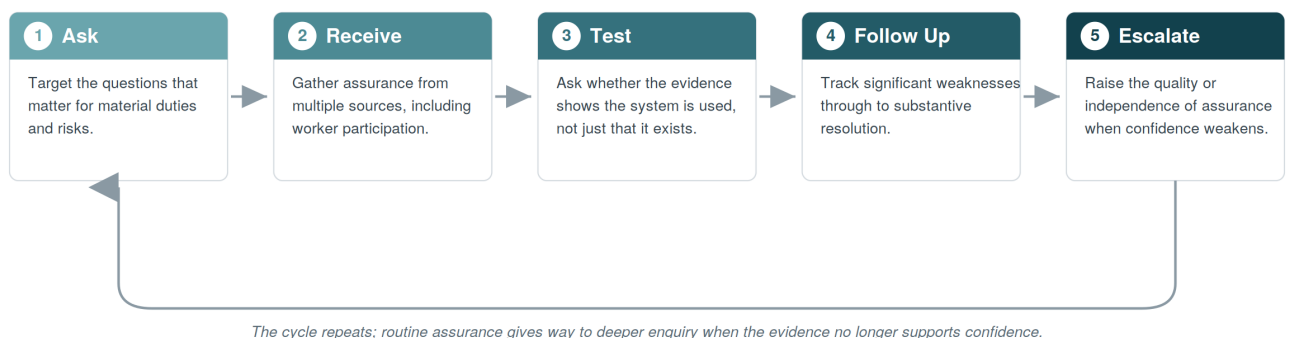


Figure 1. The officer due-diligence verification cycle: Ask, Receive, Test, Follow Up and Escalate. Source: the authors.

8. Discussion

This article is based on a comprehensive review of relevant literature and recent high-profile court cases related to officer due diligence and the responsibilities of PCBUs. Our analysis indicates that the due diligence obligations of officers remain consistent under the new HSAW Amendment Act (2026) and may carry even greater implication concerning critical risks (referred to as significant risks throughout this article). We have developed and propose a five-stage framework to assist officers in generating and verifying factual evidence based on the information available to them. Additionally, we recommend that officers actively investigate critical control management within the PCBU. The framework provides a pragmatic approach grounded in reality, context-related and focused on what works in practice while recognising limitations.

8.1 Recommendations: Proportionality and the Governance Boundary, and Future Work & Research

Proportionality is built into the reasonable-officer standard. A non-executive director will ordinarily act through governance processes, whereas a chief executive may have greater influence over resources, reporting systems and management accountability. The assessment should therefore focus not on prescribing different checklists for different roles, but on the officer's actual responsibilities, the information reasonably available to them, and the responses within their authority (HSAW, 2015, s 44(2)).

Proportionality also guards against micromanagement. Verification should improve governance information before increasing direct officer involvement in operational work. The officer need not become the supervisor, inspector or technical specialist. Competent advice may be relied upon where the basis for that reliance remains sound, as discussed in part 6.

This consideration is particularly important for small PCBUs because their assurance processes may be simpler and more direct, given shorter information chains and the likelihood that officers also work operationally. From 1 April 2027, new s 25A will require small PCBUs to comply with ss 36–43, except s 36(3)(e), only in relation to critical risks, while the welfare-facilities duty in s 36(3)(e) continues according to its terms. Section 25A(3) further requires other provisions of the Act, insofar as they relate to a small PCBU's duty under a critical-risk provision, to be read subject to this limitation; the statutory examples expressly identify officer due diligence under s 44 and s 11 (HSWA, 2026). Importantly, this limitation does not remove the officer duty. Future research should therefore examine how small PCBUs interpret and operationalise these modified duties, particularly how officers maintain effective assurance of critical risks within less formal organisational structures.

8.2 Limitations and Recommendations for Future Work & Research

We like to highlight that the five-stage framework proposed in this article is an evidence-based framework sensitized by the authors. It is not empirically validated yet. We highly recommend that solely completing the five stages does not necessarily lead to due diligence, nor is it a statutory test or mandatory checklist. Reasonableness remains context-specific.

The framework is graduated in intensity rather than fixed in procedure. Where risks are well understood and assurance is credible, routine processes may be sufficient. Where the basis for confidence weakens, the depth or independence of assurance should increase. The objective is not more safety activity, but better evidence and adding to safety knowledge (Aven, 2014).

Hindsight requires the same level of discipline. The occurrence of harm cannot by itself establish an officer breach. The question is what was reasonably required in the information available at the time. The *Whakaari* case reinforces the need for individual proof, while the *Gibson* case shows that warning signs available before an event can legitimately alter what further steps are reasonable. The governance boundary is therefore not defined by distance from operations. It is defined by role-appropriate assurance: officers must know, ask and test enough to maintain a credible basis for confidence without taking over the work of those responsible for operational execution.

We certainly recommend the framework to be tested in different PCBUs of various sizes and the authors look forward to hearing the experiences of the users. They are also open to suggestions and dialogue in future. The authors are looking forward to an empirical study of the framework in future.

9. Conclusion

Officer due diligence under s 44 requires active governance without operational takeover. The *Gibson* case demonstrates that formal systems and substantial safety activity may be insufficient where available information undermines confidence in how a known serious risk is being managed. *Whakaari* and *Buttle* provide the counterweight: responsibility must first be attached to the correct duty holder, and officer liability requires individualised proof.

The proposed framework in this article, Ask, Receive, Test, Follow Up and Escalate, provides a pragmatic way to structure officer verification without turning it into a statutory checklist. Its intensity should change with role, risk and the quality of assurance.

The central proposition is straightforward. Officers do not have to replace those who manage and perform the work. They do need a credible, evidence-based basis for knowing that the PCBU's important health and safety resources and processes are being used, and they must respond when that basis for confidence is no longer adequate.

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Use of artificial intelligence

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