



Due Diligence? Due Now!

A legal perspective

Vol 3; edition 3; October 2026

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DOI: <https://doi.org/10.26686/nzjhsp.v3i3.11639>

Abstract

While something of a mouthful, “due diligence” is an integral part of navigating the framework of Health and Safety Law in Aotearoa. But what is due diligence? How did it get here? What are the legal ramifications of getting it wrong, and what can you practically do to make sure you get it right? Whether you are a PCBU, an officer, employer, employee or merely an interested party, due diligence will impact on your working life in ways you may or may not expect. This paper touches on the scope of the term, its application, and emphasises the importance of understanding both the history as well as the current state of the law as persons in the workplace who may be subject to, or affected by, this important duty.

Introduction

The term “due diligence” carries a heavy legal burden in the context of Health and Safety Law. From its beginnings in the whispers of pleadings under the old Health and Safety in Employment Act 1992, through the evolution into its current form under the Health and Safety at Work Act 2015, the term has remained an important concept for those in charge of health and safety in the workplace to wrap their head around. This article is focused on defining due diligence, where it came from and how it can go wrong, the way Courts approach due diligence at trial, and what the state of the law is now, including reference to overseas jurisdictions and what practitioners should practically be aware of. The authors argue that the history of the term is just as important as the way it is currently used and understood, and that no matter the statutory changes that occur in this area, due diligence will remain an integral and important concept for those in charge of workplace health and safety to both understand and exercise diligently to the most “reasonable” of their abilities.

Early History of Health and Safety law in New Zealand

The Fragmented Pre-1992 Framework

Prior to the passing of the Health and Safety in Employment Act 1992 (HSE), New Zealand’s workplace health and safety laws were spread across roughly 10 general statutes, each particular to different industries or hazards. A further 20 statutes were also relevant to workplace health and safety.¹ This created a fragmented system in which employers often struggled to identify which rules applied to their workplace.²

¹ Peter Kiely and Stephen Langton “*The Health and Safety in Employment Act 1992 – An Overview*” (1994) 19(2) New Zealand Journal of Industrial Relations 75.

² Above n 1 at 196

Enforcement relied on government inspectors visiting worksites to check compliance. As a result, health and safety was often treated as a matter of meeting government regulations rather than as an internal responsibility of management.³

Introduction of the ‘all practicable steps’ test:

The 1992 Act sought to replace this “mish-mash” of legislation with a single framework which would move greater responsibility onto employers.⁴ This occurred during a broader period of deregulation and increasing emphasis on self-regulation.⁵ As then-Minister of Labour Bill Birch explained, responsibility for maintaining high health and safety standards was to be placed “directly on the shoulders of the employers”.⁶ The Act therefore marked a shift from a prescriptive, government-enforced model towards a ‘Robens approach’, where employers were expected to actively manage health and safety themselves.

The lynchpin test of the Health and Safety in Employment Act 1992 was the requirement for employers to take ‘all practicable steps’ to ensure the safety of their employees (HSA, s 6)⁷. Judging the boundaries of ‘all practicable steps’ was to be assessed against:

- (a) The potential nature and severity of the harm
- (b) The likelihood of the harm occurring
- (c) Knowledge about the harm
- (d) Available ways of preventing the harm, what measures were available to achieve the desired safety outcome and how effective those measures were likely to be
- (e) Whether those measures were available and what they would cost.

Early judgments suggest that the “all practicable steps” standard was understood as raising the expectations placed on employers. In *Mair v Frasers Bacon Ltd [1994]*, Judge Everitt described the Act as requiring “a new philosophy”, stating⁸:

Employers are now required to be analytical and critical in providing and maintaining a safe working environment. It is not just a matter of meeting minimum standards and codes laid down by statute, it requires employers to go further and to set their own standards after due analysis and criticism. This is a new duty cast upon employers. It now requires the conscious exercise of judgement and discernment on the part of employers. One can go further and say that the discharge of an employer's duties cannot be equated with conformity to a code. The employer must actively adopt and promote the principles enshrined in the Act; new attitudes and judgements are required.

The Court reinforced this approach, arguing that an employer’s duties “cannot be equated with conformity to a code”.⁹ Rather, employers were required to actively adopt and promote the principles of the Act, requiring “new attitudes and judgements”.¹⁰

As Judge Cockril later observed in *Cronin-Lampe v Board of Trustees of Melville High School*, following the enactment of the HSE Act in 1992, “more onerous health and safety obligations applied to employers”.¹¹

Foreseeability and the ‘All Practicable Steps’ Test

The standard was amended in 2003 to note that ‘all practicable steps’ were to be based on what risks were known or ought to have been reasonably known by the employer (HSEA, s 2A(2)). This addition to the Act would prove to be important.¹²

³ Above n 1 at 196

⁴ Above n 1 at 195

⁵ Emma Doust *Enforcement and promotion of work-related ill health in New Zealand: Have we made progress under the Health and Safety at Work Act 2015?* (Master of Health Research Report, Victoria University of Wellington, 2021) at 10.

⁶ (15 September 1992) 523 NZPD 77

⁷ *Health and Safety in Employment Act 1992*, s 6

⁸ *Mair v Frasers Bacon Ltd* DC Dunedin CRN3012009612, 24 February 1994 at 14

⁹ Above n 8 at 28

¹⁰ Above n 8 at 32

¹¹ *Cronin-Lampe v The Board of Trustees of Melville High School* (No 2) (1992) 20 NZELR 236 at 36

¹² *Health and Safety in Employment Act 1992*, s 2A(2).

This issue was illustrated in *Department of Labour v Highway Transport Services Ltd*, following the tragic death of employee David Webster in 2004.¹³ Webster was killed when an overhead gantry boom was struck by a larger-than-usual forklift, and fell on him. The Department of Labour argued that the employer had failed to take all practicable steps, particularly given that a cheap modification could have prevented the boom from becoming detached.¹⁴ However, the Court dismissed the charge, finding that the sequence of events was not reasonably foreseeable. The employer had told workers to use the smaller forklift to move the boom out of the way, and the possibility that it could be powerful enough to move the boom wasn't considered.¹⁵ The "all practicable steps" test could therefore be limited by what an employer could reasonably be expected to know before an accident, rather than what could be identified after it.

Early judicial development of due diligence:

While absent from the language of the early statute, the term due diligence had begun to emerge organically within the courts. In *Buchanan's Foundry Ltd v Department of Labour* [1996], Justice Hansen applied this reasoning in the context of the 1992 Act, expressly describing the requirement to take all reasonably practicable steps as involving considerations of "a total absence of fault", "all reasonable care" and "due diligence".¹⁶

The concept of due diligence was closely connected to the courts' rejection of "hindsight perfection". In *Buchanan's Foundry*, Justice Hansen emphasised that the requirement to take all reasonably practicable steps was "not a counsel of hindsight perfection".¹⁷ Due diligence therefore did not require an employer to demonstrate, after an accident occurs, that every precaution had been taken. Rather, the question was whether the employer had exercised the 'due diligence' that was reasonably practicable in the circumstances as they were at the time.

This understanding is also reflected in *Department of Labour v Linework Ltd* [1999] where the Court affirmed the language of *Buchanan's Foundry* and contextualized the "all reasonably practicable steps" requirement in terms of "due diligence".¹⁸

Australia's Development of Due Diligence

In 2008, Australia launched its own investigation into its then occupational health and safety laws.¹⁹ Much like New Zealand, laws concerning due diligence were not a universal or well-defined concept across Australian states. While appearing in a scattering of statutory defences (NSW OHS Act s 26²⁰; Qld Act s 167(4)²¹, which used "reasonable diligence") no jurisdiction had clearly defined the expected standard of care.²²

The most commonly cited test for due diligence came from the *R v Bata Industries Ltd (No 2)* [1992], requiring a defendant demonstrate²³:

1. *They were familiar with their occupational health and safety obligations*
2. *They had a system in place to manage occupational health and safety risks and adequately supervised compliance with that system.*
3. *The system complied with relevant industry standards and practices.*
4. *Company officers reported to the Board on the operation of the system, and safety concerns were reported in a timely way.*
5. *They responded personally and immediately when they became aware of a failure in the system.*

¹³ *Department of Labour v Highway Transport Services Ltd* DC Hamilton CRN 04019501737, 27 May 2005

¹⁴ Above n 13 at 6

¹⁵ Above n 13 at 24

¹⁶ *Buchanan's Foundry Ltd v Department of Labour* HC Christchurch AP48/96, 7 June 1996 at 4 per Hansen J

¹⁷ Above n 16 at 15

¹⁸ *Department of Labour v Linework Ltd* [1999] DCR 40.

¹⁹ National Review into Model Occupational Health and Safety Laws, Second Report to the Workplace Relations Ministers' Council (Report, January 2009) 73 [23.151]–[23.152].

²⁰ Occupational Health and Safety Act 2000 (NSW) s 26.

²¹ Workplace Health and Safety Act 1995 (Qld) s 167(4).

²² Above n 19 at [23.151]

²³ Above n 19 at [23.161]

Yet the Review found that case law offered only "limited guidance" on the meaning of the duty.²⁴ It noted that decisions such as *Inspector Ken Kumar v David Aylmer Ritchie* and *Workcover Authority of NSW (Insp Dowling) v Barry John Coster* reached opposite outcomes on similar facts, largely because courts applied the concept on a case-by-case basis.²⁵

To address this, the Review recommended that due diligence be defined and codified explicitly in statute. Under Recommendation 88, it called for a positive duty owed by 'responsible officers', requiring them to act proactively: staying current on WHS matters, and identifying the business's hazards to ensure proactive risk-management.²⁶

In line with these recommendations, the Australian government enacted the *Work Health and Safety Act 2011 (WHS Act)*, which codified due diligence as a positive duty on officers.²⁷ This was set out in s27, adopting the Review's proposals almost verbatim.²⁸

The expectations for meeting due diligence were clearly defined in s 27(5), taken almost verbatim for the National review, requiring:²⁹

An up-to-date knowledge of work health and safety matters

An understanding of the nature of the operations and the hazards and risks

Appropriate resources and processes to be available and used to eliminate or minimise risks to health and safety

Appropriate processes to exist for receiving and considering information regarding incidents, hazards and risks and responding in a timely way

Processes to be in place for complying with the PCBU's duties and obligations under the Act

To verify the provision and use of those resources and processes.

Thus, when the Royal Commission on New Zealand's Pike River Coal Mine Tragedy was launched, Australia was already midway through developing its own guidelines.³⁰

The Commission was highly critical of the Act's 'all practicable steps' standard, calling for a clearer and more prescriptive approach to health and safety duties.³¹ In response, the Government looked to Australia's Model WHS Act when developing the Health and Safety at Work Act 2015 (HSWA). The influence of the Australian model is evident in the HSWA's approach to due diligence. Section 44(4) of the HSWA,³² which defines the meaning of due diligence, essentially mirrors s 27(5) of the WHS Act,³³ reflecting the extent to which the Australian approach was incorporated into New Zealand's legislation.

Understanding Gibson: A Case Study on Due Diligence

Having canvassed the history of due diligence, the case of *Gibson v Maritime NZ* decided in 2026 sets new precedent under the HSWA for Courts and directors when interpreting this area of the law. The judgement is therefore integral for officers instructing PCBU's in having an up-to-date understanding of their duties under s 44, ensuring they exercise reasonable due diligence to provide for the health and safety of their workers.

Tragedy and Background

Mr Kalati was tragically killed as a shipping container hoisted from a crane dislodged and crushed him in the early morning whilst he was working as a lasher. The way Mr Kalati and his co-worker undertook their work that morning was on the advice of a senior shipping hand and in breach of the port authorities 3 width rule, a health and safety measure designed to protect lashers from this very danger.³⁴ Investigation after the incident into workplace health and safety practices found that there

²⁴ Above n 19 at [23.155]

²⁵ Above n 19 at [23.156 - 23.157]

²⁶ Above n 19 at 77

²⁷ *Work Health and Safety Act 2011* (Cth).

²⁸ Above n 27, s 27

²⁹ Above n 27, s 27 (5)

³⁰ *Royal Commission on the Pike River Coal Mine Tragedy Volume 1* (Department of Internal Affairs, 2012)

³¹ Above n 30, at 33

³² Health and Safety at Work Act 2015, s 44(4).

³³ Above n 27, s 27(5)

³⁴ *Gibson v Maritime NZ* [2026] NZHC 813 at [32].

was a “culture, particularly on night shift, of stevedores engaging in unsafe practices or cutting corners, including non-compliance with the three-container width rule.”³⁵ Night workers gave evidence that they rarely saw or interacted with management during their shifts,³⁶ and training materials relating to the rule were found to be “confusing and often inconsistent” with the workers’ understanding of it.³⁷

Mr. Gibson as the officer of the relevant PCBU under the HSWA, Port of Auckland Limited (POAL), was charged for failing to uphold his duty under s 44 to exercise due diligence to ensure the PCBU complied with its health and safety obligations.³⁸ The case was notable as it was “the first time an officer of a large and complex PCBU” had been convicted for their failure to exercise due diligence under this provision.³⁹ The Court’s analysis of the arguments therefore would set an important precedent, irrespective of the outcome.

Trial and Appeal

At trial the District Court held that Gibson had failed “to ensure, so far as is reasonably practicable, the health and safety of workers ” which had exposed them to the risk of “severe injury or death” which ultimately occurred.⁴⁰ Gibson appealed on the basis that the sentence handed down by the District Court was “manifestly excessive”⁴¹ and that the judge had made errors such as framing Gibson as a proxy for the port’s actions, misinterpreting s 44 and overall applying too high a standard. The High Court however, agreed with the District Court’s conclusion that Gibson had breached s 44. The key themes of the Court’s discussions on appeal were the reasonableness of Gibson’s actions, the relevance of past positive acts, whether a comparison with the conduct of equivalent officers was appropriate, and the overall scope of the duty under s 44.

Burden and Standard of Proof: What is Strictly Liability?

The Court confirmed that s 44 is a strict liability offence. Strict liability is a legal standard and its application in this case meant there was no need to prove that Gibson had any intention to breach his duty or had behaved so recklessly as to cause a breach.⁴² The prosecution in this case were therefore trying to prove that Mr. Gibson breached his duty by failing to act reasonably, and not that he acted with any malice or ill intent. Additionally, the Court confirmed that s 44 does not require “attribution” to be established. This means there is no need to illustrate a chain of causation, leading from the breach to the incident.⁴³ The mere fact that an incident occurred, and the officer failed to uphold their duty during that particular period of time is enough for the officer to have breached s 44. Finally, as a breach of s 44 is a criminal offence, the standard of proof is “beyond reasonable doubt” and the burden of proving this high standard rests on the prosecution, in this case Maritime New Zealand.⁴⁴

Interpreting Section 44: The Scope of Reasonableness

The core of the High Court’s discussion was its approach to s 44. The Court made it clear that s 44 is not a test of “perfection or best practice.”⁴⁵ Duty holders do not have to be across every detail of work occurring under their supervision and are able to reasonably rely on the advice of others. The reasonableness of this reliance, however, is a factual matter for the Court’s evaluation and the standard is due diligence in all the circumstances, not just “the average of what others would do.”⁴⁶ Crucially, “reasonable conduct for the most part does not excuse [other] unreasonable conduct ... including unreasonable omissions.” This means that an officer’s past record of taking reasonable steps to uphold due diligence does not excuse instances where the duty was allowed to lapse.⁴⁷ Despite this, reasonableness should never be evaluated with “hindsight bias,” meaning the Court will avoid treating incidents as being more predictable than they were when they occurred, with the benefit of seeing the full picture.⁴⁸ Finally, a more “hands on approach” to management as Gibson was described as taking does not increase liability of the duty holder as opposed to an officer who is

³⁵ At [70.]

³⁶ *Maritime New Zealand Prosecutor v Anthony Michael Gibson* [2024] NZDC 27975 at [254].

³⁷ Above n 1 at [183].

³⁸ Health and Safety at Work Act s44(1).

³⁹ Above n 4 at [8].

⁴⁰ Above n 1 at [40].

⁴¹ Above n 1 at [9].

⁴² At [66].

⁴³ At [96].

⁴⁴ Above n 4 at [17].

⁴⁵ Above n 1 at [113].

⁴⁶ At [155] - [158].

⁴⁷ At [157].

⁴⁸ At [114].

minimally engaged, although it may increase that officer's factual awareness in practice as to some health and safety risks.⁴⁹

At this point, it is important to note the distinction between “work as imagined” and “work as done.” This factored heavily into the District Court’s analysis of the case and was carried over into the High Court’s reasoning. The two terms distinguish between the reality of the work done on the ground, and the work recorded in performance reports and other datasets. These terms illustrate that performing reasonable due diligence under s 44 does not stop at an obligation to review and monitor these cleaner records, but making sure the reality of work being done on the ground is assessed, monitored and matches the work “as imagined.”⁵⁰

Next, when applying reasonableness, the High Court addressed whether it was appropriate to make comparisons to equivalent duty holders like Mr Gibson. At trial, the District Court felt this was a distraction from the plain standards set by the statute at s 44.⁵¹ The High Court however held that this sort of comparison could be useful in establishing the reasonableness standard to be applied. In other words, a consideration of what a reasonable duty holder in the shoes of Mr. Gibson, given his available knowledge and skill, could be aided by comparing the conduct of equivalent duty holders across the country. The Court made it clear however that the poor conduct of other s44 duty holders could not be used in this sense as a defence, and that the exercise was not in itself determinative.⁵²

In discussing the scope of reasonableness, the Court also clarified there is no discernable difference in s 44 between what constitutes reasonable steps in a governance role as opposed to a management one, as the title of duty holder can cover a broad class of persons. CEOs for example have responsibilities that “straddle governance and management.” The requirements of due diligence and reasonableness therefore do not stop, or take on a different quality at the “governance” level, but extends to everything that officer has responsibility for, including where this extends to management.⁵³ The Court also opined that the similar wording in s 137 of the Companies Act to s 44 regarding directors duties and the difference between acting “reasonably” as opposed to “perfectly” was a useful tool for comparison, and a valid aid to the Court’s reasoning in due diligence cases. However, it was held this was not a mandatory assessment for the Court to make, and the District Court had therefore not made an error in failing to discuss it.⁵⁴

Application to Mr Gibson

Applying these standards to the case, the Court found that while Mr Gibson had many positive effects in his role and was described as a respected boss and “really good, good person” who had overseen the introduction of improvements which “enhanced workplace health and safety,” this background was relevant but not determinative.⁵⁵ The key issue was whether due diligence was reasonably exercised at the time of the incident. On this point the High Court found the District Court was entitled to rule that Gibson had not taken steps, as a reasonable officer in his circumstances would have, to monitor the compliance by workers with the 3-width rule, as well try to address the issues with the POAL’s management of these exclusion zones.⁵⁶

Relationship between the PCBU and Officers Regarding Section 44

Finally, a key argument from Gibson on appeal was that the District Court had treated him as a proxy for the port’s mismanagement. Gibson’s lawyers claimed the Court had done this by starting its discussion of Gibson’s liability by focusing on the POAL’s failures. Gibson therefore argued this had wrongly led the Court to conflate the two. The High Court however, disagreed, holding that this was a permissible analytical starting point, so long as it remained contextual and the Court was careful not to conflate the two. The Court also disagreed with the argument that the responsibilities of the Port’s Board had been conflated with Mr Gibson’s duty, again holding that an analysis of the Board’s “ultimate governance responsibility” did not preclude an analysis of whether the duties of an officer had been breached under s 44.

⁴⁹ At [111].

⁵⁰ Above n 4 at [243].

⁵¹ Above n 4 at [79].

⁵² Above n 1 at [132].

⁵³ At [160] - [163].

⁵⁴ At [113].

⁵⁵ At [144] - [145].

⁵⁶ Above n 1 at [182].

Conclusion

In general, it is important to note that Maritime New Zealand has been reasonably assertive in the prosecution of due diligence claims since the HSWA passed, potentially more so than other regulators like WorkSafe and particularly for severe breaches. Previous such examples include cases of directors overloading ships, despite knowing the maximum tonnage and causing threat to life,⁵⁷ or failing to assess crew competency, provide adequate training or ensure that proper safety equipment was in good working order.⁵⁸ Finally, a regulator's willingness to bring a claim will inevitably vary depending on the legal landscape. The failure to secure a conviction in the tragedy of Whakaari White island for example, where individual charges against three directors were dismissed based on a lack of evidence has perhaps fostered a reticence, leading to individual directors being charged in lieu of groups where there is less available evidence, a trend potentially reflected in *Gibson*.⁵⁹

Current Law, Overseas Jurisprudence and HSWA Amendment Bill

The Law Applicable to Officers in New Zealand Today

The obligations on officers in New Zealand are a combination of legislation and case law. In particular, the Health and Safety at Work Act 2015 (HSWA) and *Gibson v Maritime New Zealand* [2026] NZHC 813 have crafted the law that officers must comply with today.

Gibson is pivotal to understanding the due diligence obligations placed upon officers of a person conducting a business or undertaking (PCBU). *Gibson* provides guidance and clarity on an officer's due diligence obligations under s 44 of the HSWA. The law in New Zealand as a result of *Gibson* has changed considerably. Officers must understand the breadth of the obligations placed on them today.

To understand the applicable law, a person must be aware of whether they are an officer for the purposes of HSWA. Officers are those in a position of director, partnership (other than a limited partnership), any partner, chief executive,⁶⁰ trustee⁶¹ and other senior leadership positions.⁶² People in these roles are legally required as officers to comply with the HSWA and the guidance set out in *Gibson*.

It is important for officers to be aware of the constant changes in the health and safety law within New Zealand. The recent case of *Gibson* and the Health and Safety at Work Amendment Act 2026 reflects the ever-changing nature of this area of law and illustrates to officers that they must be aware of how their obligations evolve. Officers must ensure they are up to date with all requirements placed upon them. This is particularly important as New Zealand has seen a steady trajectory towards a higher standard of care since the Pike River Mine tragedy. This increase in the standard of care is evidenced in *Gibson*.

What *Gibson* means for officers practically

Given that officers are personally liable for their failure to exercise due diligence, officers must understand how *Gibson* alters the standard of care they are expected to meet. Officers should understand how the decision of *Gibson* impacts their role in the workplace from a practical perspective.

To act with due diligence, an officer must:

1. Ensure that work has been done, rather than intending to do the work or scheduling it.⁶³ This includes verifying that work has been done to detect non-compliance.⁶⁴ In circumstances where an officer is uncertain whether the work has been done or if any progress has been made, they should make enquiries.⁶⁵ It is not good enough to only have a system in place. Officers must be able to show how the system

⁵⁷ *Nino's LTD v Maritime NZ* [2020] NZHC 1467.

⁵⁸ *Maritime NZ Prosecutor v Jeremy Hatherly* [2022] NZDC.

⁵⁹ *WorkSafe New Zealand v Andrew Buttle, James Buttle, Peter Buttle* [2023] NZDC 18939.

⁶⁰ Health and Safety at Work Act 2015, s 18.

⁶¹ *WorkSafe New Zealand v RH & Jury Trust and others* [2023] NZHC 3871.

⁶² Mark Campbell, Emma Peterson and Jaiden Tucker "Gibson v Maritime NZ – officer due diligence conviction upheld by High Court" (21 April 2026) Russell McVeagh <[russellmcveagh.com](https://www.russellmcveagh.com)>.

⁶³ *Gibson v Maritime New Zealand* [2026] NZHC 813 at [69].

⁶⁴ At [165].

⁶⁵ At [179].

- recognises and manages the identified critical risks and that the system in place functions effectively.
2. Officers do not need to be experts in health and safety. Officers do need to obtain credible information and know when to challenge that information or advice.⁶⁶ It is not sufficient for an officer to say they simply relied on someone else without asking questions where necessary.
 3. To meet the due diligence requirements, an officer is not expected to complete subordinates' work.⁶⁷ An officer does not even need to be particularly familiar with the specific elements of their work.⁶⁸ *Gibson* states that the responsibility of an officer extends to taking reasonable steps to implement and monitor the health and safety measures of the PCBU.⁶⁹

It does not matter if an officer does everything else right

An officer today must understand that it is not enough to introduce health and safety initiatives,⁷⁰ be under significant burden whilst putting in a considerable effort,⁷¹ or to be a respected boss and good leader.⁷² An officer could be all of these things as well as diligent and conscientious,⁷³ and it may not be sufficient to find that they acted with the due diligence required. These words were all used to define Mr Gibson and the High Court still found that he failed in his duty as an officer. Judge S J Bonnar KC stated that "A good leader and a conscientious officer may have the best intentions in the world but may still breach that duty."⁷⁴ Ultimately, it does not matter how many positive, beneficial or effective steps an officer takes. The question is whether the officer has met the reasonable officer test under s 44(2).

Changes to New Zealand's Health and Safety Law

The Health and Safety Work Act 2015 is the main source of law that governs the obligations of officers in New Zealand. As this legislation came into force in 2015, recent changes have been recommended by the Act/National Government. Subsequently, on July 9, 2026, the Health and Safety at Work Amendment Bill received Royal Assent.⁷⁵ These changes to HSWA will come into effect on April 7, 2027.⁷⁶

Although this amendment is not current law, and it could be impacted by a potential change in government, understanding these changes is important. Officers need to be aware of this amendment as it makes alterations to their key responsibilities.

In the current Health and Safety at Work Act, the purpose is to provide a balanced framework that ensures the health and safety of workers by putting in place objectives.⁷⁷ These objectives range from "eliminating or minimising"⁷⁸ risks to "providing a framework for continuous improvement and progressively higher standards of work health and safety."⁷⁹ Under the Amendment Act, the purpose is to provide a balanced framework that ensures the health and safety of officers through prioritising the critical risks that arise from work.⁸⁰

The current legislation requires that all PCBUs must manage all risks to health and safety of workers so far as reasonably practicable.⁸¹ Per s 22A of the Amendment Act, critical risk means a risk associated with a hazard that if the risk occurs could result in death, notifiable injury, illness, a

⁶⁶ At [162].

⁶⁷ At [161].

⁶⁸ At [161].

⁶⁹ At [161].

⁷⁰ At [144].

⁷¹ At [144].

⁷² At [144].

⁷³ At [146].

⁷⁴ At [156].

⁷⁵ New Zealand Government "Health and Safety Reform" (22 July 2026) Ministry of Business Innovation & Employment <mbie.govt.nz>.

⁷⁶ New Zealand Government, above n 16, at 3.

⁷⁷ Health and Safety at Work Act 2015, s 3.

⁷⁸ Section 3(1)(a).

⁷⁹ Section 3(1)(g).

⁸⁰ Health and Safety at Work Amendment Bill 2026, s 3(1).

⁸¹ Health and Safety at Work Act, s 30(1).

notifiable incident or an occupational disease in schedule 2 of the Accident Compensation Act 2001.⁸² The purpose of the Amendment Act is distinct from the current legislation as it introduces the idea of a critical risk.

In the Amendment Act, for a PCBU to be able to manage critical risks, a distinction has been made between a small and large PCBU. The idea of distinguishing between the size of a PCBU is to ensure that smaller companies only have to comply with a fraction of the obligations, decreasing the burden on small companies. Under s 17 of the Amendment Act, a small PCBU is defined as a “business or undertaking of fewer than 20 workers carrying out work in any capacity.”⁸³ Practically, this means officers need to understand how their obligations change if their business grows or decreases in size and how this impacts the requirements placed on them. For example, a small PCBU is only required to comply with the critical risk provisions.⁸⁴ Small PCBUs are still required under the Amendment Act “to identify what their critical risks are, document those assessments, and prioritise them properly.”⁸⁵

Whereas large PCBUs are still required to manage risks as so far as they are reasonably practicable.⁸⁶ Practical concerns have been raised in regard to this area of the amendment. There are concerns as to how officers of PCBUs are supposed to effectively work together in circumstances where some are small and some are large.⁸⁷ An example of this may be if a small plumbing company of 10 people is operating on a major construction site that consists of 200 workers. This raises the question of whether the plumbing company is subject to small or large PCBU rules. This is why it is important for officers to understand the current and potential health and safety legislation.

Law from Australia

An officer understanding their obligations under the New Zealand legislation and case law is paramount. Although, an officer may decide to observe overseas cases and legislation to ascertain the direction our law may be moving in. New Zealand’s judiciary and legislature often look to other jurisdictions to learn and develop. This can be seen in the reference to Australia’s Health and Safety Law in *Gibson*.

Following the Pike River Coal Mine disaster in 2010⁸⁸ The New Zealand Government was forced to make drastic changes to health and safety requirements. Given the catastrophic and preventable nature of this tragedy, New Zealand recognised that change had to be made urgently. Consequently, New Zealand adopted the Australian model of health and safety, including the requirement of officers acting with due diligence.⁸⁹ The Report of the Independent Taskforce on Workplace Health and Safety recommended that as well as the Health and Safety Act 2015 being based on the Australian model, the law had to be extended to prevent “acute, chronic and catastrophic harm.”⁹⁰ The events of Pike River, the recommendations from the task force, decisions from the New Zealand Government and case law are all important factors that form the practical application officers must abide by in their role.

Law from the United Kingdom

UK health and safety law is distinct from New Zealand and Australia as it does not have the requirement for officers to act with due diligence.

Under Section 37 of the UK’s Health and Safety Work Act 1974, if an officer consents or allows the breach in health and safety, the officer and the organisation will be in breach of the legislation. Under s 37, an officer can also be prosecuted for acting negligently in allowing an offence to occur.⁹¹ Similarly to New Zealand, case law has determined that a company cannot structure their business to allow directors to be protected by ignorance.⁹²

The punishment for breaching Health and Safety Legislation in New Zealand is distinct from the UK. Failing to comply with New Zealand’s law can result in a fine up to \$600,000 for an individual officer

⁸² Health and Safety at Work Amendment Act s, 22A.

⁸³ Section 17.

⁸⁴ Section 25.

⁸⁵ Employment Team “Health and Safety at Work Amendment Act 2026” (22 July 2026) Anderson Lloyd <[al.nz](#)> at 7.

⁸⁶ Anderson Lloyd, above n 26, at 3.

⁸⁷ Anderson Lloyd, above n 26, at 14.

⁸⁸ Hon. Justice Graham Panckhurst, Stewart Bell PSM and David Henry CNZM *Royal Commission on the Pike River Coal Mine Tragedy Volume 1* (Department of Internal Affairs, 30 October 2012) at 3.

⁸⁹ Ministry of Labor *The Report of the Independent Taskforce on Workplace Health and Safety* (Minister of Labor, June 2012) at 20.

⁹⁰ At 20.

⁹¹ Health and Safety at Work Act 1974 (UK), s 37.

⁹² Health and Safety Executive “Legislation on Leading Health and Safety” <[hse.gov.uk](#)>.

and a potential imprisonment up to 5 years.⁹³ Officers in the UK who breach s 37 may be disciplined under s 2(1) of the Company Directors Disqualification Act 1986. This section authorises the Court to make a disqualification order against a director “in connection with the promotion, formation, management of a company.”⁹⁴ Disqualification is a ban from engaging as a director in the activities of a company.⁹⁵ Examples of activities that the person who breached s 37 is no longer allowed to engage with include being a director, managing a company or advertising the company.⁹⁶ Under s 3(b) of the Company Directors Disqualification Act, the disqualification can extend up to 15 years.⁹⁷

Conclusion

Officers in New Zealand must understand what it means to act with due diligence. It is not good enough to observe from afar or refrain from asking hard questions. Officers are required to understand what is happening within their organisation. In workplace health and safety, ignorance, excuses and failures cause tragic and irreparable damage. When the consequences include injury or death, hindsight is unacceptable. This is why the standard in New Zealand has increased to prevent future tragedies. If an officer is uncertain of how they should engage within their organisation to ensure their due diligence obligations are met, they should seek advice.

Closing Thoughts on Due Diligence in Workplace Health and Safety in New Zealand

The development of due diligence obligations on officers within health and safety in New Zealand has illustrated that tragic, deadly and preventable circumstances have driven the most effective change.

Defining events such as Pike River and *Gibson* have brought due diligence requirements into New Zealand’s legislation and subsequently developed the term through the courts. Over time, the standards placed on officers to satisfy due diligence requirements have intensified. The standard bestowed on officers puts in place more stringent and comprehensive standards that do not allow officers to distance themselves from accountability. By *Gibson* establishing new practical standards to ensure due diligence requirements are met, officers in New Zealand are forced to have a hands-on approach to avoid liability.

Although New Zealand has succeeded in strengthening its workplace health and safety practices by implementing due diligence obligations, it would be naïve to say this improvement entirely prevents deaths from occurring in the workplace. Legislation and case law cannot completely eradicate risk from the workplace. As discussed, foreseeing, mitigating and controlling the risk that is present helps to protect workers. Importantly, this protection is only as effective as an officer’s acknowledgement of their due diligence obligations and their willingness to comply.

Acknowledgements

We thank Dr Chris Peace for the opportunity to work on the commission for this paper.

No artificial intelligence was used in the writing of this paper.

We self-funded the work.

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⁹⁴ Company Directors Disqualification Act 1986 (UK), s 2(1).

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⁹⁶ At 3.

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