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Case review: Maritime New Zealand v A Gibson

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Abstract

The criminal prosecution of Anthony Gibson, the former CEO of Port of Auckland Limited (**POAL**), involved various allegations of breaches of the due diligence obligation under the Health and Safety at Work Act 2015 (**HSWA**) with the charge being proven in the District Court. The case involved leading experts who commented on deficiencies in the health and safety system which ultimately contributed to Mr Gibson being found guilty.

Key words: Gibson; Due Diligence; Officer; Conviction;

1. Introduction

On 30 August 2020 Pala'amo Kalati, a stevedore at Port of Auckland, was crushed and killed by a falling container. The impact of Mr Kalati's death on his aiga and their loss in this tragic event is acknowledged at the outset of this case review.

Approximately one year after Mr Kalati's death, in August 2021, charges were filed by Maritime New Zealand (**MNZ**) against both the POAL and Mr Gibson under the HSWA. POAL entered a guilty plea and was sentenced on 1 December 2023 (*Maritime New Zealand v Ports of Auckland Ltd* [2023] NZDC 26957).

The focus of this review is *Maritime New Zealand v A Gibson* [2024] NZDC 27975 which is the decision arising from Mr Gibson's 2024 defended hearing. There were several expert witnesses, three of whom approached matters from a health and safety systems perspective. Certain points made in the evidence may be of assistance to health and safety practitioners and officers when examining their own systems. Weaknesses in these areas contributed to the facts underpinning the District Court Judge's conclusion. Namely, that Mr Gibson had meet his due diligence duty in one respect but had fallen short in another.

2. Background

On 30 August 2020, Mr Kalati was working a nightshift at the Port of Auckland. His work involved fixing and removing metal lashing bars from shipping containers during loading and unloading. This work is carried out alongside loading or unloading operations which requires co-ordination with a crane driver who is operating far above the deck of the ship where the stevedores are working.

As Mr Kalati was carrying out this work, a crane lifted two shipping containers in the bay adjacent to him. The crane operator realised a third container was hooked up under the bottom container and began lowering them all back down. Tragically, before the containers could be placed down, the third container slipped free and slid across to where Mr Kalati was working fatally crushing him.

MNZ investigated the fatality and charged both the POAL and Mr Gibson with breaches of the HSWA. POAL was charged with breaching its duty to ensure the safety of workers and entered a guilty plea with sentencing occurring in December 2023.

Mr Gibson was charged with breaching his due diligence obligations as an officer of POAL. While officers had been charged in New Zealand before these tended to be smaller businesses with the officers involved in decision-making about day-to-day work activities alongside their workers. Mr Gibson was the first executive of a large corporate charged with this type of offence in New Zealand and defended the charge.

The trial ran from 8 April to 28 May 2024 with the decision issued on 26 November 2024. Judge Bonnar KC found Mr Gibson guilty and he was sentenced in February 2025. A fine of $130,000 and costs of $60,000 were imposed. An appeal against the conviction and sentence has subsequently been filed.

In his decision, Judge Bonnar KC provided detailed comment on the legal requirements surrounding due diligence. His Honour identified 12 general principles from the legislation and case law.

Two of these principles highlight a particular tension for officers who are also involved in management. The first is (*Maritime New Zealand v A Gibson* (2024) at para 80(c)):

> *"In the case of large, hierarchical organisations, the duty to exercise due diligence is not limited to governance or directorial oversight functions."*

The second principle is (*Maritime New Zealand v A Gibson* (2024) at para 80(e)):

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

Officers must navigate a role that goes beyond governance or oversight but not into day-to-day operations. They need to strike the balance between interrogating information and directing workplace decisions. This tension will need to be managed, informed by an understanding of health and safety systems, and the limitations inherent in processes such as audits or reviews that are intended to provide assurance. Health and safety managers and specialists will be called on to help officers resolve these challenges.

3. The experts

Different experts were called by both the prosecution and defence at the trial. These included:

1. Mr Roger Kahler;
2. Professor Sidney Dekker; and
3. Mr Craig Marriott.

Mr Kahler gave evidence for the prosecution. He has an extensive background in accident investigation and has appeared in Court as an expert witness since 1983. An engineer by trade he has worked as a safety specialist conducting thousands of accident investigations. His business, InterSafe, has developed an investigation process tool 8 Steps™ (InterSafe, n.d.). Mr Kahler has provided advice and guidance to a wide range of businesses across mining, construction, transport, security and maritime.

Professor Dekker is a lecturer in safety science at Griffith University in Australia as well as the faculty of aerospace engineering at Delft University of Technology in the Netherlands. He has published numerous books and articles including *Foundations of Safety Science A Century of Understanding Accidents and Disasters* (Dekker, 2019).

Craig Marriott is a well-known health and safety leader in New Zealand. He first worked in the United Kingdom in the nuclear industry developing and implementing safety cases before moving to New Zealand in 2008. Mr Marriott has worked as a health, safety and risk manager and consultant advising both national and international clients. He was part of the Better Governance project and most recently the lead author of the Institute of Directors and WorkSafe publication *Health and Safety Governance A Good Practice Guide* (Institute of Directors & WorkSafe, 2024).

These three experts gave evidence regarding health and safety systems at POAL and Mr Gibson's role within that framework. The judgment has summarised aspects of their evidence relevant to the legal issues. This review focuses on highlighting points which could help officers or health and safety practitioners seeking to find insights into how practically they can improve the processes within their own organisations.

4. Role of CEO as officer

Mr Marriott commented that, in his opinion, there is "*general confusion of the role of the CEO as officer*" (Marriott, BOE at [37]). He also referred to "*the grey area between*" governance and management as an area where there was a lack of clarity in the guidance available at the time of the incident (Marriott, NOE at 2119).

Mr Marriott explained his perspective "*that there is a distinct separation between the officer activities and the management activities as a worker within the PCBU. Otherwise,* […] *the Chief Executive becomes an individual proxy for the organisation"* (Marriott, NOE at 2118).

The position of CEO was described by Mr Kahler as (Kahler, NOE at 1079):

> *"The role of the CEO, in my opinion, is to systematise health and safety in an organisation in conjunction with creating a safety-focussed culture (which will result in a willingness to report near misses and incidents as well as being authorised to stop work with respect to a perceived significant safety risk), so that the CEO can […] gain assurance that people are not going to be seriously injured or experience fatality at work."*

Mr Kahler described the CEO as having an "oversight" role and said the "CEO is not expected to know how to do the work" rather the "CEO is to be in a place that the information feeding up gives assurance about what is taking place down through the organisation" (Kahler NOE at 1006).
Mr Kahler also clarified that a CEO does not necessarily know specific operational rules or controls.

When asked about the distinction between governance and operations Mr Kahler explained he saw governance extending into the senior executive team (Kahler, NOE at 1007):

> *"Governance is very much an oversight role. It is not just always limited to the board. You can have it embedded in parts of your organisation, but it would be simply wrong to say that an executive team and a CEO is simply […] about systems. They do have oversight. They do reflect. They do challenge."*

The essence of the issue as outlined by Mr Marriott are not resolved by Mr Kahler's systems-based approach. The question for those officers who sit across management and officer roles remains where does the due diligence element start and end or does it end at all? The decision itself suggests different levels of due diligence requirements; with CEOs who are involved in the day-to-day operations having a wider obligation compared with board members who are further removed from the work (*Maritime New Zealand v A Gibson* (2024) at para 55).

While this does push obligations further up towards the apex of organisations it seems CEOs may now have a larger due diligence burden than directors. To discharge their due diligence duty, officers will all require a greater level of 'safety literacy' so they can gain assurance the system is functioning as intended (Smith, 2024, p. 144).

5. Health and safety systems

Mr Kahler's evidence focused on the concept of the CEO's role within the organisational system for managing health and safety (Kahler, NOE at 1089):

> *[The CEO's role is] to have systems in place. I can't get away from the word "systems", it's to have in place systems that are increasing, significantly, the chances of these being captured, reported against, so you can get an assurance at the higher levels of the organisation and the board gets assurance, 'cos no one wants to see anyone die at work.*

The definition of business systems which Mr Kahler used and which Judge Bonnar KC referred to (Maritime New Zealand v A Gibson (2024) para [95]) was "A system is a framework that orders and sequences activity within an organisation to achieve a purpose, within a band of tolerance and variance that is acceptable to the owner of the system." The definition derives from Macdonald, Burke, & Stewart (2018) at p.161, whose definition is "a system is 'a specific framework for organising activities to achieve a purpose within which variation is acceptable to the system owner'".

Macdonald, Burke, & Stewart (2018) say at p.162:

> *"[T]he CEO and his or her team have the work of developing a long-term business plan that will achieve the purpose of the organisation while operating within policy standards. This is one of the reasons why work at this level is both abstract and complex. It has the potential to develop and improve the organisation or, when done badly, to endanger the very existence of the organisation."*

To translate health and safety policies (which are behaviour setting documents approved by the board) to the complex reality of managing work in a way that achieves operational success requires support from competent subject matter experts. And so, it is the space of developing a long-term plan and embedding health and safety within the success or demise of an organisation that health and safety specialists should expect to be involved.

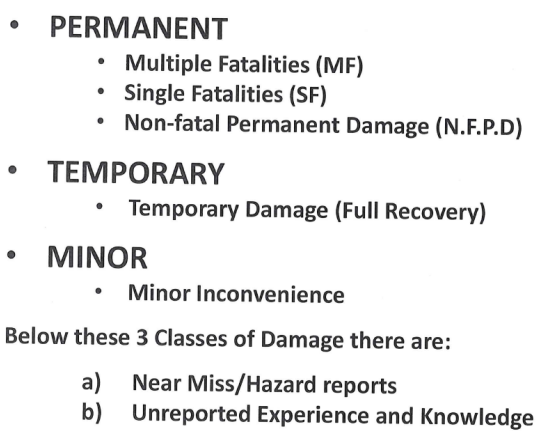
Indicators and insights

Within the system how the officer identifies what is working and where there are weaknesses requires the gathering and analysis of data. There is no one way to do this but certain central themes regarding multiple data points, shifting metrics and continuing to question to understand the limitations of the work emerged.

Professor Dekker preferred the term 'activities' to 'system'. He explained "*activities are measurable, operationalisable, I can see them, I can track them, I can talk to people about them*" (Dekker, NOE at 1877). While a seemingly minor point the emphasis on activities or actions which are tangible may help when looking to develop tools for verification and assurance.

Returning to systems Mr Kahler introduced the below classification system as providing a tool to gain insights to help "*shape how you approach the management of health and safety within a business"* (Kahler, NOE at 991).

Figure 1. A Personal Damage Classification



Source: Kahler, Exh 118

While the damage or injury and near miss categories will be well known and understood, Mr Kahler emphasised the importance of the 'Unreported Experience and Knowledge' category as being a "*powerful predictor of the permanent damage*" (Kahler, NOE at 993).

Mr Kahler went on to explain his experience that (Kahler, NOE at 993):

> *"what you find in the vast majority of fatalities that you go to, not all, but the vast majority is that what exists in the business is unreported experience and knowledge within work teams, and that information is not deliberately withheld. It has just become a cultural norm for a wide variety of reasons."*

To obtain this information businesses need to engage proactively and deliberately with workers (Kahler, NOE at 994):

> *"Depending upon the culture of the business, incident hazard reports can achieve it with varying degrees of success. You can have structured observations. You can have structured reviews. There is a range of strategies. Collectively, they increase the chances of a likelihood of you naming the problem. […] One will never do it."*

Mr Marriott also highlighted the importance of shifting indicators or metrics that are being tracked in reports (Marriott, NOE at 2153):

> *"So, one of the things I say to people is you know, you should review your indicators on a regular basis. […] If you've got reasonable confidence now that the thing you've been monitoring is under control then take it off that report and replace it with something else which is of concern. So, you're maintaining that, that level of concern with the most important things."*

The importance of not relying too heavily on one source of data or method of oversight was common ground and reinforces the difficulty of easily measuring safety within a business. Professor Dekker highlighted a phenomenon relating to minor injury statistics (Dekker, NOE at 1869):

> *"There is increasing research from the UK, particularly the construction industry, that suggests that sites and companies that have very low numbers of injuries actually have higher fatality numbers. […T]he explanations that science is trying to provide for this go back to organisational culture, the psychological safety, the openness but also the connection that CEOs have with how work actually gets done, how much risk secrecy there is on the ground floor, […] and thus not reporting injuries or hiding them or calling them something else, create such conditions that also lead the potential for fatalities to grow unchecked."*

The issue identified by Professor Dekker again reiterates the importance of multiple streams of data or information and the importance of lead indicators which may include items such as worker engagement or non-injury reporting. In this respect, Mr Marriott, referred to a technique he uses with board reporting (Marriott, NOE at 2102):

> *"When I work with boards, we often talk about a three line of assurance model. So, we're getting information from three different levels, and the key point is to say: "Well, where do they differ?" If they're all consistent, then I've got a really strong idea that things are going well. If they differ, then that's something for me to start to target".*

A robust reporting model that allows information to be tested and interrogated from different levels or perspectives within an organisation is best practice. How different size and scale organisations achieve this will vary, but the outcome of enabling an officer to test and interrogate information will remain the same. In any event, Mr Kahler observed that the data is only one part of the issue as "*what becomes critical is the level of discernment that you apply to it"* (Kahler, NOE at 1120).

While Professor Dekker gave a caveat that "the notion of 'appropriate' leading indicators wasn't a solved problem" in 2020 and "[s]cientific work on indicators (lagging or leading) which can reliably indicate a possible drift into failure is ever ongoing" (Dekker BOE at 14.2) various lead indicators were discussed. Professor Dekker listed off a range of potential lead indicators along with areas of agreement with Mr Kahler (Dekker, NOE at 1876):

> *"Audits and inspection results and what […is the business] doing with those. […] Progress on agreed safety plan actions, for example, Mr Kahler and I agree on that one. Progress of actions against annual safety wellbeing plan, Mr Kahler and I agree on that […]. Safety audit results, right, for example the ACC audit reports, yeah, those to me would be lead indicators".*

While these lead indicators will tell you whether an activity is occurring and improve the probability that the system is working Professor Dekker emphasised that *"[t]he leader would need to do more in order to know that those activities are effective, like talking to peers in the industry, like having meetings with the regulator"* (Dekker, NOE at 1878). So, lead indicators give the information about the business but activities beyond the business to gain assurance are also expected of leaders, who should be bringing those experiences back to the board room so the organisation can benefit from that knowledge.

Mr Kahler also referred to CEOs displaying non-systematised behaviours to influence work and worker culture positively. While recognising the positive symbolism of direct worker engagement he said that the CEO or other senior leaders cannot neglect the systems required to fulfil the policies as expressed by the board (Kahler, NOE at 1007). The distinction between the informal and formal systems with emphasise on the formal was a key element underpinning Mr Kahler's opinion.

Judge Bonnar KC highlighted Mr Kahler's evidence that regular reviews and audits are part of any effective system (*Maritime New Zealand v A Gibson* (2024) at para 98). The ACC audit was found by Judge Bonnar KC to be a "*compliance audit*" (*Maritime New Zealand v A Gibson* (2024) at para 163). In Mr Kahler's words "*it is not one that will give an organisation assurance about how work is being done*" (Kahler, NOE at 1264). Mr Marriott similarly said more generally about audits that (Marriott, NOE at 2102):

> *"One of the challenges we have, and this is a particular problem with a lot of audits that we see, is that they concentrate on the artifact rather than what it's actually doing in the field."*

The challenge of understanding the limitations of health and safety audits which are not standardised and come in different variations is something that should be grappled with by officers and health and safety professionals. Setting the scope and ensuring it goes far enough to gather insight beyond compliance with the policies (or artifacts) requires understanding of what the audit or review is

intended to achieve. This is again an area where better 'safety literacy' on the part of officers is expected (Smith, 2024).

Another limitation of audits for businesses to bear in mind was highlighted by Professor Dekker (Dekker, NOE at 1880):

> *"[T]he ability of audits to clearly predict for a leader where you are drifting into failure is limited, to put it that way, and in fact may give the leader the impression that certain activities require immediate attention, like sub-contractor management, […] and this is known in the literature since the 1970s, it's called a decoy phenomenon. So, the auditor says: "You really should focus on your […] sub-contractors" […]. So, a lot of investment gets made in sorting out that problem while – and there's only always limited resources than Rome starts burning in other areas"*

The challenge of managing limited resources in the safety space when an audit report arrives and drives them away from current projects will not be new for many practitioners (Marriott, NOE at 2104):

> *"if you optimise to make sure every document is up-to-date, that's not actually going to make operations safer because you're taking resources away from people that could be out there doing that but having an out of date document, not necessarily a problem."*

Engaging with officers who are prepared to recognise the risk of the 'decoy phenomenon' and support the completion of existing work before audit findings or other recommendations are prioritised will again require a mature and safety literate board.

6. Conclusion

The jeopardy created by the series of events in the years preceding 2020 increased the legal risk for Mr Gibson and the Board as a whole. As a result, Maritime New Zealand's decision to investigate Mr Gibson after Mr Kalati's death is unsurprising. While Mr Gibson had made reasonable efforts to discharge his duty the gaps within the system identified by Judge Bonnar KC meant a guilty finding was made in relation to the management of a critical risk within the business. Relevantly, Mr Gibson was not found to have fallen short in relation to his management of changes implemented during the Covid-19 pandemic.

The involvement of the CEO within the health and safety system and expectation on them to discharge their management tasks with their due diligence hat on remains blurred. They appear to have a greater responsibility than board members with the due diligence requirements filtering through into the operational elements of their role.

As a result, CEOs are likely to look to engage with their safety specialists to improve their 'safety literacy' and engage more closely with system development and management. In this regard, there are opportunities and risks as health and safety becomes more embedded within the overall organisational strategy. The need to engage with the way safety activities are measured, understand that any data point has its limitations and be prepared to move the metrics to improve the understanding of health and safety performance are challenges for officers and their subject matter experts to work through in their particular organisational context.

Integration of safety at the highest level of organisations was an intended outcome of the due diligence duty when it was incorporated in the HSWA. *Maritime New Zealand v A Gibson* (2024) keeps the momentum behind the need to deepen health and safety understanding within a boardroom.

7. Disclaimer

This article was self-funded by the author.

The author is a former lawyer who acted for one of the defendants referenced in this article, namely, Port of Auckland Limited.

The views expressed in this article are the author's own and do not reflect the views of his employer or any other organisation he is affiliated with.

8. References

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