Gibson: reporting and due diligence

The High Court's decision in *Gibson v Maritime New Zealand* provides useful guidance on the kind of reporting required of officers to meet their due diligence duties. The decision does not say that officers must personally manage operational controls. It does, however, make clear that due diligence depends on receiving enough information to know whether critical controls are understood and working in practice.

The case arose from the first New Zealand prosecution of a chief executive as an officer following a workplace fatality. While the facts involved a chief executive in a high-risk port environment, the reporting lessons are broader. They are relevant to any officer who relies on governance reporting to satisfy their due diligence duties under the Health and Safety at Work Act 2015.

Background

Mr Tony Gibson, the former chief executive of Ports of Auckland, was charged after the 2020 death of a 31-year-old stevedore, who was crushed by a container while unloading a ship at the Container Terminal. The prosecution followed four deaths in less than five years at Ports of Auckland. Ports of Auckland was separately charged and pleaded guilty.

Following a seven-week judge-alone trial in the District Court, Mr Gibson was convicted. The conviction was limited to two particularised failures:

- failing to take reasonable steps to ensure a clearly documented, effectively implemented and appropriate exclusion zone around operating cranes, and
- failing to take reasonable steps to verify the provision and use of the relevant resources and processes.

He was fined $130,000 and ordered to pay $60,000 in costs.

Mr Gibson appealed both conviction and sentence. The High Court dismissed the appeal, finding no miscarriage of justice and holding that the fine and costs were within an appropriate range.

Reporting that reflects work as done

For officers and boards, the key point is not that an officer must personally manage each operational control. Rather, governance and reporting systems must give officers reliable assurance about whether critical controls are working in practice. In high-risk environments, paper policies, delegated responsibilities and general health and safety reporting may not be enough if they do not test what is happening on the ground.

The concept is often referred to as "work as done". It asks whether the way work is planned and reported reflects how work is carried out by workers. That includes considering what happens on night shifts, under time pressure, or where different teams are coordinating around moving plant and containers. Officers need reporting which brings those operational realities into view.

This was discussed in depth in *Gibson*. Ports of Auckland had identified handling suspended loads as a critical risk. It had policies, training materials and reporting systems. However, following the fatality, it became clear that workers did not share a consistent understanding of the exclusion zone requirements.

Unsafe practices, particularly during the night shift, were not being reliably detected. The issue was not simply

whether a policy existed. It was whether the system was capable of showing whether that policy was understood and followed in practice.

The Court accepted that Mr Gibson had taken extensive positive steps in respect of health and safety leadership. Those steps included expanding the health and safety team, introducing reporting systems, and increasing safety observations. However, the Court found those steps did not adequately address the specific critical risk posed by suspended loads.

The question was not whether Mr Gibson had been generally active on health and safety. It was whether a reasonable officer in his position would have taken further steps to verify that the exclusion zone controls were clearly understood, effectively implemented and being followed in practice.

The Court also considered that, because of previous fatalities, Mr Gibson was on notice that Ports of Auckland's systems were not always identifying the gap between "work as planned/imagined" and "work as done".

What good reporting should do

The decision sits comfortably with the Institute of Directors and WorkSafe guidance, *Health and Safety Governance: A Good Practice Guide*. The guide says that health and safety governance should be based on understanding and managing risk, and cautions that a governance approach focused only on statistics will not necessarily improve outcomes. Instead, the guide encourages boards to focus on monitoring positive contributors to health and safety, such as resourcing, designing work well, training people and testing key health and safety controls.

Good governance reporting should do more than confirm that a policy exists, training has been completed, or safety observations are taking place. In practical terms, reports should explain what has been tested, what the testing has revealed, what issues remain unresolved, and whether agreed actions have been completed.

The more serious the risk, the more important it is that officers receive clear information about whether those controls are working in practice.

Reports should also draw on information from workers, near misses, audits, and areas such as night shift operations or contractor management where there may be a disconnect between how work is expected to be performed and what is happening in reality. Reporting of this kind is far more likely to support meaningful conversations around the board table.

Reasonable reliance still requires enquiry

The decision also shows that reliance on managers and specialists is permissible, but only where it is reasonable.

Officers do not have to personally carry out the work of health and safety managers. However, they cannot simply accept general assurances that systems are working if there are known issues, previous incidents, unclear controls, or signs that reporting may not reflect actual practice. Reasonable reliance requires enquiry, testing and follow-up.

Summary

For boards and other officers, the lesson is to design reporting that supports active assurance rather than passive receipt of information.

Gibson is a reminder that officer due diligence is not satisfied by the existence of systems alone. Officers need to know whether those systems are reviewing what they are meant to review, and whether the information coming back is good enough to support informed decisions.

Want to know more?

If you have any questions about this, please contact our specialist Employment Team.