ORDER PROHIBITING PUBLICATION OF NAMES, ADDRESSES, OCCUPATIONS OR IDENTIFYING PARTICULARS OF WITNESSES/VICTIMS/CONNECTED PERSONS PURSUANT TO S 202 OF THE CRIMINAL PROCEDURE ACT 2011. SEE PARAGRAPH [258]. SEE http://www.legislation.govt.nz/act/public/2011/0081/latest/DLM3360349.html

IN THE HIGH COURT OF NEW ZEALAND
AUCKLAND REGISTRY

I TE KŌTI MATUA O AOTEAROA
TĀMAKI MAKAURAU ROHE

CRI-2025-404-112
[2026] NZHC 813

BETWEEN	ANTHONY MICHAEL GIBSON Appellant
AND	MARITIME NEW ZEALAND Respondent

Hearing:	10, 11 and 12 June 2025 (with updated submissions received on 18 June 2025)
Appearances:	J R Billington KC, HMZ Lanham and G H Barton for the Appellant SAH Bishop, T G Bain and L K Eastlake for the Respondent
Judgment:	31 March 2026

JUDGMENT OF GAULT J

This judgment was delivered by me on 31 March 2026 at 4:00 pm pursuant to s 341 of the Criminal Procedure Act 2011.

Registrar/Deputy Registrar

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Introduction

[1] In the early hours of 30 August 2020, Mr Pala'amo Kalati – a worker at the Port of Auckland – tragically died when a shipping container fell on him as he was lashing containers on board the *MV Constantinos P*. Mr Kalati was 31 years old.

[2] Following Mr Kalati's death, Maritime New Zealand (MNZ) brought charges against the Port of Auckland Limited (POAL) and Mr Gibson – the Chief Executive Officer (CEO) of POAL – for breaches of the Health and Safety at Work Act 2015 (HSWA). As an officer of POAL, Mr Gibson was subject to a duty to exercise due diligence to ensure POAL as a "person conducting a business or undertaking" (PCBU) complied with its separate duties under HSWA.[1]

[3] POAL, the PCBU, pleaded guilty to failing to take reasonably practicable steps to ensure certain workers' safety, exposing those workers to a risk of death or serious injury.[2]

[4] Following a seven week judge-alone trial before Judge S J Bonnar KC in the Auckland District Court in April/May 2024, on 26 November 2024 Mr Gibson was found guilty of one charge of failing to exercise due diligence as an officer of POAL giving rise to a risk of serious injury or death under ss 44 and 48(1) of HSWA.[3] In particular, by the verdict, he failed to:

(a) take reasonable steps to ensure that there was a clearly documented, effectively implemented, and appropriate exclusion zone around operating cranes (referencing s 44(4)(c) of HSWA); and

(b) take reasonable steps to verify the provision of the relevant resources and processes specified above (referencing s 44(4)(f)).

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1 Health and Safety at Work Act 2015 (HSWA), s44(1).
2 Sections 36 and 48.
3 *Maritime New Zealand v Gibson* [2024] NZDC 27975, [2024] NZCCLR 561.

[5] Mr Gibson was acquitted of a separate particularised failure relating to an operational change made during COVID-19 in response to pandemic conditions and social distancing requirements.

[6] On 21 February 2025, Mr Gibson was sentenced to a fine of $130,000 and ordered to pay costs of $60,000 under s 152 of HSWA.[4]

[7] Mr Gibson appeals his conviction and sentence. On the conviction appeal, in broad terms Mr Billington KC, for Mr Gibson, submitted the case miscarried due to:

(a) the prosecution's mistaken reliance on Australian cases considering repealed statutes with a reverse onus on an officer;

(b) the prosecution's lead expert relying on a paper-based review (rather than undertaking interviews with staff and a thorough investigation); and

(c) focusing on an alleged need to develop best-practice systems, and a CEO having "ultimate responsibility" for "systems leadership", concepts and obligations which are not referenced in s 44 of HSWA, and thereby making Mr Gibson a proxy for POAL and its separate failings.

[8] Mr Billington emphasised that this is the first time an officer of a large and complex PCBU has been convicted of failing to exercise due diligence under HSWA. He submitted this case is distinct not just for the size and nature of the PCBU, but also for the character of the CEO.

[9] The sentence appeal is advanced on the basis that the sentence was manifestly excessive.

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4 *Maritime New Zealand v Gibson* [2025] NZDC 5440.

Factual background

[10] The relevant factual context can be adopted largely from Mr Gibson's appeal submissions.

[11] The Port of Auckland (the Port) – located on the Waitematā Harbour in downtown Auckland – is one of 10 container ports in New Zealand and the largest import port. Its business was – and still is – complex and broad, with multiple business units providing different services and operating 24/7.

[12] POAL is a port company as defined in the Port Companies Act 1988. Section 5 of that Act states "[t]he principal objective of every port company shall be to operate as a successful business".

[13] By 2019, POAL provided a range of services: marine (pilotage and tugs); cruise ships (berthage, exchange and security); multi-cargo (transmission shipment to the Pacific Islands of cargo, bulk commodities and vehicles); container terminal services (handling 700,000-900,000 containers per annum); and engineering and trucking logistics support. It had five primary business units. In 2020, POAL employed approximately 650 people and contracted various third parties.

[14] Befitting its size and complexity, POAL had a developed management structure. Across its operations, under Mr Gibson's management, POAL had an expansive health and safety system, comprising various resources and processes, including for the management of critical risks. That system was informed and supported by a specialist health and safety team (of 10 full-time employees led by a senior manager who, by May 2020, reported directly to POAL's Deputy CEO / Chief Financial Officer following a deliberate elevation of reporting), committees, document management and electronic data systems, external auditors and advisers and collaboration with other ports. It was developed over years, and like any system, was subject to continuous improvement.

[15] Governing POAL at the time was a board of highly qualified and experienced directors – three of whom had prior port experience. The Board was responsible for, among other things:

(a) governing, directing and monitoring the affairs of the business, which involved two primary focuses: organisational performance and organisational compliance with regulations, such as HSWA;

(b) setting and working on the strategic direction for the business; and

(c) defining the role and responsibilities of the CEO, and overseeing that role.

[16] The Board sat at the pinnacle of POAL and was the most senior health and safety committee for POAL, with ultimate oversight of health and safety.

[17] Mr Gibson was CEO of POAL from February 2011 to June 2021. He came from a shipping and logistics background.

[18] As CEO, he was responsible for the management of POAL and reported to the Board. Commensurate with the breadth and complexity of the company, he had several responsibilities from ensuring the company met its key objectives in its business plan to representing POAL on external bodies and holding directorships on subsidiaries. He was required to travel. By 2019, he worked 12 to 14 hours a day. His hours increased during COVID-19.

[19] During COVID-19, Mr Gibson was tasked with managing the Port's interactions with external organisations and agencies, including regulators.

[20] Mr Gibson had 10 direct reports. None gave evidence at trial. Only one was interviewed by MNZ during its investigation as part of the PCBU interview. That was Ms Powell, POAL's General Manager of Container Terminal Operations (CTOPs).

Loading and unloading containers at POAL

[21] CTOPs concerns POAL's container handling business. The proceeding focused on the loading and unloading of containers to and from container ships using stevedores and gantry cranes.

[22] Containers are secured to the decks of container ships and to one another using twist locks and metal lashing bars. The process of locking one container to another and connecting containers to the deck of a ship is known as "lashing". The reverse process is known as "unlashing". The stevedores responsible for this are known as "lashers". A crane moves unlashed containers off the ship, and when loading, moves containers onto the ship to be lashed.

[23] The following personnel were assigned to every shift:

(a) Lash Leading Hand – prior to COVID-19, lashers reported to a Lash Leading Hand who directed them around the vessel and to their points of work. The Lash Leading Hand could be responsible for up to 24 lashers over four different cranes during a shift. The Lash Leading Hand was in radio communication with the Ship Leading Hand.

(b) Ship Leading Hand – also known as the "foreman", the Ship Leading Hand was in control of the crane operations and work areas on the vessels. He or she was responsible for informing the crane operator about their points of work and where to manoeuvre in order to load and unload containers. They helped guide the crane by being the 'eyes and ears' of the crane operators. They had the ability to stop crane operations at any time and for any reason.

(c) Crane operators – operated the gantry cranes. The part of the crane that picks up the container is called the spreader.

(d) Straddle drivers – drove the straddle carriers that move containers from one part of the Port to another.

(e) Ship Supervisor – responsible for carrying out an initial inspection of a container ship to ensure that it was safe to work on, and – together with the Shift Operations Manager – briefing all stevedores on shift prior to commencing work on issues concerning terminal, straddle, lashing and health and safety matters. They carried out a second briefing for

stevedores (lashers) at the gangway to the ship as the stevedores commenced work on the ship. They were also specifically tasked with carrying out safety audits during each shift. They also dealt with incident reporting by stevedores.

(f) Shift Operations Manager – responsible for vessel and terminal obligations (planning work) and, to a lesser degree, concerned with the rostering and administration of stevedores. Together with the Ship Supervisor, they were responsible for briefing all stevedores on shift.[5] They worked from an office, but also visited the wharf and vessels as required. They also carried out safety observations.

[24] Above the Shift Operations Managers, two Senior Shift Managers were responsible for operational delivery. They reported to the Manager of Stevedoring, Mr Lander, who reported to the Senior Manager of Terminal Operations, Mr Hulme, who in turn reported to Ms Powell. CTOPs had been split off into a separate business unit in 2019 following the 2018 fatality of a straddle carrier driver.

Critical risk management and training of lashers

[25] POAL's health and safety system and policies recognised seven critical risks, one of which was handling loads. A number of controls were identified to manage this risk.

[26] One of these controls was a rule by which no person was to be within three-container widths (24 feet or approximately 7.3 metres) of an operating crane. Relatedly, no person was to ever work (or walk) under the crane's spreader or its swept path. This was known at POAL as the "three-container width rule".

[27] Operational Performance Coaches (OPCs) trained new lashers on how to lash safely. They also created standard operating procedures for safe operations in lashing and working around cranes. The OPCs performed a significant role in relation to

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5 The Shift Operations Manager carried out the primary briefing at the beginning of the shift and the Ship Supervisor carried out the gangway briefing.

health and safety within CTOPs. They also had a role in monitoring and raising levels of performance and reporting on any safety issues.

[28] Training covered theory and practically how to lash safely in a training area at POAL. After this, novice lashers (wearing white hats) were paired with more experienced lashers (wearing green hats) to continue hands-on training.

[29] Training assessment forms referred to the three-container width rule but training manuals did not. POAL by its conviction accepted these materials could have been clearer, and the trial Judge agreed.[6]

Loading and unloading containers during COVID-19

[30] During COVID-19, the Port was an essential service but was required to operate in line with social distancing and pandemic requirements. The Port never ceased to operate throughout COVID-19.

[31] Because of social-distancing requirements, CTOPs had to make operational changes. The change at issue in this case (but in connection to which Mr Gibson was not convicted) was the re-organisation of stevedores into bubbles and the removal of the Lash Leading Hand under the CTOPs Pandemic Plan dated 19 March 2020. The Lash Leading Hand – who ordinarily oversaw multiple gangs of lashers on the ship – could not operate in that way under pandemic conditions and POAL did not have enough Lash Leading Hands to supply one per bubble.

Mr Kalati's death

[32] On 30 August 2020, Mr Kalati was working the night shift as a lasher. He had worked at POAL since April 2020. In accordance with POAL policy, he underwent formal training and then completed 60 hours of work paired with a more experienced lasher before he was permitted to work freely with others. In late July 2020, he switched from the day shift to the night shift.

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6 *Maritime New Zealand v Gibson*, above n 3, at [318].

[33] Before going onto the vessel, Mr Kalati and LB – another lasher with whom he was paired – asked their Ship Leading Hand, KM, if they needed to lash containers in bays 5-7.[7] Containers there had been mistakenly unlashed during the previous shift. KM permitted them to do so.

[34] At the same time, a crane operator was lifting and unloading containers in bays 9-11, neighbouring bays 5-7. KM, as Ship Leading Hand, knew this. KM also knew about POAL's policy that lashers should not be within three-container widths of an operating crane. Directing them to work in bays 5-7 risked them being within three-container widths of the crane.

[35] While in the walkway between bays 5-7 and 9-11, Mr Kalati and LB worked separately, contrary to POAL's policy that lashers were to work in pairs, and contrary to the three-container width rule.

[36] The crane operator did not know that Mr Kalati and LB were there, and he was not able to see them on the cameras. He conducted a twin-lift of two containers. One of the twist locks of the containers that were lifted was not unlocked. This meant that a third container, beneath these two containers, was lifted at one corner as well. Before the crane operator could lower the containers, the third container dislodged and moved downwards and laterally. It crushed Mr Kalati and he died as a result.

Charges against POAL

[37] As mentioned, POAL, the PCBU, pleaded guilty to failing to take reasonably practicable steps to ensure certain workers' safety, exposing those workers to a risk of death or serious injury.

[38] POAL accepted that on 30 August 2020 it failed to ensure, so far as was reasonably practicable, the health and safety of workers and thereby exposed Mr Kalati and LB to a risk of death or serious injury. In particular, POAL admitted that it was reasonably practicable for the company to have not directed or permitted Mr Kalati

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[7] Permanent non-publication orders made in the District Court in respect of the names, addresses and identifying particulars of certain witnesses and/or port workers remain in place: see [258] below.

and LB to work in close proximity to a crane, while that crane was in operation lifting shipping containers. In respect of this charge, POAL admitted that it was liable for the conduct of its Ship Leading Hand who had directed Mr Kalati and LB to work in the bay adjacent to where the crane was operating.

[39] The second charge against POAL was directed to systemic failures. POAL accepted that, between 31 May 2019 and 31 August 2020, it failed to ensure, so far as it was reasonably practicable, the health and safety of stevedores working at the Fergusson container terminal, and thereby exposed those workers to a risk of death or serious injury. In particular, POAL admitted that it had failed to take the following reasonably practicable steps to:

(a) provide and maintain a safe system of work by developing and clearly documenting adequate and effective exclusion zones around operating cranes;

(b) provide effective training and instruction to workers on working safely around operating cranes;

(c) carry out effective supervision, monitoring, and audits to ensure that workers were complying with established safe systems of work and not developing unsafe work cultures;

(d) conduct an appropriate risk assessment relating to the removal of the Lash Leading Hand role in response to the COVID-19 pandemic; and

(e) provide effective training, instruction, and supervision to Ship Leading Hands and crane operators when requiring them to assume the responsibilities of Lash Leading Hands.

Charges against Mr Gibson

[40] Mr Gibson was charged under ss 44 and 48 of HSWA (and in the alternative, s 49). The primary charge alleged that during the charging period between 31 May 2019 and 31 August 2020:

being an officer of a PCBU with a duty to ensure, so far as is reasonably practicable, the health and safety of workers who work for the PCBU, while the workers are at work in the business or undertaking, namely being the Chief Executive Officer of Ports of Auckland Limited, having a duty to exercise due diligence to ensure that the PCBU complies with its duty, did fail to comply with that duty, and that failure exposed Ports of Auckland Limited's workers, namely stevedores working at the Fergusson Container Terminal, to a risk of death or serious injury, namely to the risk of being struck by objects falling from operating cranes.

Particulars:

[Mr Gibson] did fail to exercise the care, diligence, and skill that a reasonable officer would exercise in the same circumstances:

1. to take reasonable steps to ensure that Ports of Auckland Limited had available for use, and used, appropriate resources and processes to eliminate or minimise risks to health and safety from work carried out as part of the conduct of the business or undertaking [s 44(4)(c) verbatim], including by having:
   (a) clearly documented, effectively implemented, and appropriate exclusion zones around operating cranes;
   (b) clearly documented, effectively implemented, and appropriate processes for ensuring co-ordination between lashers and crane-operators; and
2. to take reasonable steps to verify the provision and use of these resources and processes [s 44(4)(f) verbatim].

[41] This reflected two of the six non-exhaustive obligations in s 44(4) of HSWA that an officer must take reasonable steps to achieve, in respect of one critical risk (handling loads), in one area of POAL's business (use of gantry cranes to load and unload shipping containers).

[42] Prior to trial, the prosecution withdrew a third particular, alleging a due diligence failing in not having "effective and appropriate processes for receiving and considering information regarding incidents, near misses, hazards, and risks and for responding in a timely way to that information".

[43] As Mr Billington submitted, fundamentally the case against Mr Gibson turned on a narrow focus on one aspect of POAL's complex operations. By charging in the way it did, the prosecution accepted that Mr Gibson otherwise complied with his due diligence obligations.

The relevant statutory scheme

[44] The relevant legislative framework can largely be adopted from the Judge's decision.[8]

[45] It is well known that the legislative impetus for what would become HSWA largely arose from the tragedy which occurred at the Pike River Coal Mine. The Royal Commission on the tragedy and the Independent Taskforce on Workplace Health and Safety established after that disaster identified New Zealand's comparative underperformance in ensuring the health and safety of workers and the need for major change to meet that challenge.[9]

[46] The Independent Taskforce recommended that New Zealand adopt the Australian model work health and safety laws, including the imposition of a positive due diligence obligation on officers of PCBUs.[10] Similarly, the Royal Commission considered that s 56 of the former Health and Safety in Employment Act 1992 (HSEA), which deemed officers of a body corporate which had committed an offence against HSEA to also be guilty of the failure if they "directed, authorised, assented to, acquiescent, or participated in the failure," was unfit to ensure that those exercising governance functions in an organisation play their part in establishing and maintaining an effective health and safety management system.[11]

[47] The legislative history makes clear that Parliament's intention in enacting s 44 of HSWA was to ensure that "[d]irectors and other officers in governance roles must be proactive, ensuring that the [PCBU] complies with its duties and obligations" and holding those decision-makers "accountable for the health and safety consequences of their decisions".[12]

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8 *Maritime New Zealand v Gibson*, above n 3, at [32]-[41]. See also *Stumpmaster v Worksafe New Zealand* [2018] 3 NZLR 881 (HC) at [13]-[20].

9 Rob Jager and others *He Korowai Whakaruruhau / A Protective Cloak: Executive Report* (Independent Taskforce on Workplace Health and Safety, April 2013); Graham Pankhurst, Stewart Bell and David Henry *Report on the Pike River Coal Mine Tragedy: Volume 2 Part 2 – Proposals for Reform* (Royal Commission on the Pike River Coal Mine Tragedy, October 2012).

10 Rob Jager and others, above n 9, at 4 and 20.

11 Pankhurst, Bell and Henry, above n 9, at 324.

12 (13 March 2014) 697 NZPD 16705.

[48] The purpose of HSWA is set out in s 3 in pt 1:

> **3 Purpose**
>
> (1) The main purpose of this Act is to provide for a balanced framework to secure the health and safety of workers and workplaces by—
>
> (a) protecting workers and other persons against harm to their health, safety, and welfare by eliminating or minimising risks arising from work or from prescribed high-risk plant; and
>
> (b) providing for fair and effective workplace representation, consultation, co-operation, and resolution of issues in relation to work health and safety; and
>
> (c) encouraging unions and employer organisations to take a constructive role in promoting improvements in work health and safety practices, and assisting PCBUs and workers to achieve a healthier and safer working environment; and
>
> (d) promoting the provision of advice, information, education, and training in relation to work health and safety; and
>
> (e) securing compliance with this Act through effective and appropriate compliance and enforcement measures; and
>
> (f) ensuring appropriate scrutiny and review of actions taken by persons performing functions or exercising powers under this Act; and
>
> (g) providing a framework for continuous improvement and progressively higher standards of work health and safety.
>
> (2) In furthering subsection (1)(a), regard must be had to the principle that workers and other persons should be given the highest level of protection against harm to their health, safety, and welfare from hazards and risks arising from work or from specified types of plant as is reasonably practicable.

[49] As Moore J said in *Whakaari Management Ltd v WorkSafe New Zealand*, the first of those objects – protecting workers and other persons against harm to their health, safety, and welfare – is of obviously especial importance.[13]

[50] Section 18 defines an "officer" in relation to a PCBU:

> **18 Meaning of officer**
>
> In this Act, unless the context otherwise requires, officer, in relation to a PCBU,—

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13 *Whakaari Management Ltd v WorkSafe New Zealand* [2025] NZHC 288 at [116].

(a) means, if the PCBU is—

(i) a company, any person occupying the position of a director of the company by whatever name called:

(ii) a partnership (other than a limited partnership), any partner:

(iii) a limited partnership, any general partner:

(iv) a body corporate or an unincorporated body, other than a company, partnership, or limited partnership, any person occupying a position in the body that is comparable with that of a director of a company; and

(b) includes any other person occupying a position in relation to the business or undertaking that allows the person to exercise significant influence over the management of the business or undertaking (for example, a chief executive); but

(c) does not include a Minister of the Crown acting in that capacity; and

(d) to avoid doubt, does not include a person who merely advises or makes recommendations to a person referred to in paragraph (a) or (b).

[51] Part 2 of HSWA contains the health and safety duties. Subpart 1 of pt 2 sets out key principles relating to the duties. Section 30 provides:

30 Management of risks

(1) A duty imposed on a person by or under this Act requires the person—

(a) to eliminate risks to health and safety, so far as is reasonably practicable; and

(b) if it is not reasonably practicable to eliminate risks to health and safety, to minimise those risks so far as is reasonably practicable.

(2) A person must comply with subsection (1) to the extent to which the person has, or would reasonably be expected to have, the ability to influence and control the matter to which the risks relate.

[52] Section 31 provides that a duty imposed on a person under the Act may not be transferred to another person.

[53] The duties of PCBUs are set out in sub-pt 2 of pt 2. Section 36 imposes a primary duty of care upon a PCBU to ensure, so far as reasonably practicable, the

health and safety of workers (and others), including those who work for the PCBU while the workers are at work in the business or undertaking.[14]

[54] Without limiting the generality of that primary duty of care, s 36(3) of HSWA provides that a PCBU must ensure, so far as is reasonably practicable:

(a) the provision and maintenance of a work environment that is without risks to health and safety; and

(b) the provision and maintenance of safe plant and structures; and

(c) the provision and maintenance of safe systems of work; and

(d) the safe use, handling, and storage of plant, substances, and structures; and

(e) the provision of adequate facilities for the welfare at work of workers in carrying out work for the business or undertaking, including ensuring access to those facilities; and

(f) the provision of any information, training, instruction, or supervision that is necessary to protect all persons from risks to their health and safety arising from work carried out as part of the conduct of the business or undertaking; and

(g) that the health of workers and the conditions at the workplace are monitored for the purpose of preventing injury or illness of workers arising from the conduct of the business or undertaking.

[55] Subpart 3 of pt 2 contains the duties of officers, workers and other persons. Section 44 imposes a specific duty on officers of a PCBU to exercise "due diligence" to ensure that the PCBU complies with its duties under the Act:

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[14] HSWA, s 36(1) and (2). Reasonably practicable is defined in s 22.

44 Duty of officers

(1) If a PCBU has a duty or an obligation under this Act, an officer of the PCBU must exercise due diligence to ensure that the PCBU complies with that duty or obligation.

(2) For the purposes of subsection (1), an officer of a PCBU must exercise the care, diligence, and skill that a reasonable officer would exercise in the same circumstances, taking into account (without limitation)—

(a) the nature of the business or undertaking; and

(b) the position of the officer and the nature of the responsibilities undertaken by the officer.

…

(4) In this section, due diligence includes taking reasonable steps—

(a) to acquire, and keep up to date, knowledge of work health and safety matters; and

(b) to gain an understanding of the nature of the operations of the business or undertaking of the PCBU and generally of the hazards and risks associated with those operations; and

(c) to ensure that the PCBU has available for use, and uses, appropriate resources and processes to eliminate or minimise risks to health and safety from work carried out as part of the conduct of the business or undertaking; and

(d) to ensure that the PCBU has appropriate processes for receiving and considering information regarding incidents, hazards, and risks and for responding in a timely way to that information; and

(e) to ensure that the PCBU has, and implements, processes for complying with any duty or obligation of the PCBU under this Act; and

(f) to verify the provision and use of the resources and processes referred to in paragraphs (c) to (e).

[56] It is common ground that the test outlined in s 44(2) imposes an objective test – the reasonable officer in the same circumstances, taking into account (without limitation) the nature of the business and the position and responsibilities of the officer.

[57] This reasonable officer test "to exercise the care, diligence, and skill that a reasonable officer would exercise in the same circumstances …" may be contrasted with the PCBU's primary duty "to ensure, so far as reasonably practicable, the health

and safety of workers …".[15] As New South Wales cases state in relation to their equivalent of s 44 (s 27 of the Work Health and Safety Act 2011 (NSW)):[16]

> [56] The section 27 duty imposed on officers is not to take all reasonably practical measures to ensure compliance by the PCBU and an officer is not required to ensure the health and safety of workers.
>
> [57] An officer is required to adhere to a minimum standard of behaviour involving a system which ensures compliance by the PCBU with its duties and obligations under the Act and to provide adequate supervision to ensure that the system is properly carried out. The [minimum] standard of behaviour and the system is to take reasonable steps to include the objectives in section 27(5)(a)-(g) [equivalent to s 44(4)(a)-(f)].

[58] That is not to doubt that due diligence to take reasonable steps imposes a high standard on officers, reflecting the purpose of HSWA. It is also evident from s 44(4) that due diligence includes taking reasonable steps in relation to the PCBU's processes, that is, its systems. Depending on the position and responsibilities of the officer, that may include leadership in relation to processes and systems. But s 44 essentially involves an evaluative factual assessment as to what is required.

[59] Subpart 4 of pt 2 contains offence provisions, including most relevantly s 48:

> **48 Offence of failing to comply with duty that exposes individual to risk of death or serious injury or serious illness**
>
> (1) A person commits an offence against this section if—
>
> (a) the person has a duty under subpart 2 or 3; and
>
> (b) the person fails to comply with that duty; and
>
> (c) that failure exposes any individual to a risk of death or serious injury or serious illness.
>
> (2) A person who commits an offence against subsection (1) is liable on conviction,—
>
> (a) for an individual who is not a PCBU or an officer of a PCBU, to a fine not exceeding $150,000:
>
> (b) for an individual who is a PCBU or an officer of a PCBU, to a fine not exceeding $300,000:
>
> (c) for any other person, to a fine not exceeding $1.5 million.

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15 HSWA, s 36(1).

16 *SafeWork NSW v Hetherington* [2019] NSWDC 11; endorsed in *SafeWork NSW v Doble* [2024] NSWDC 58 at [60].

[60] Of course, the meaning of this legislation must be ascertained from its text and in the light of its purpose and its context.[17]

Elements of the offence

[61] It is common ground that the applicable elements of the offence under s 48(1) HSWA were that:

(a) at all relevant times, POAL was a PCBU and was subject to the primary duty of care under s 36 of HSWA to ensure, so far as was reasonably practicable, the health and safety of workers at work in POAL's business or undertaking;

(b) Mr Gibson was an officer of POAL at all relevant times and was subject to the duty under s 44 of HSWA to exercise due diligence to ensure that POAL complied with its primary duty of care under s 36;

(c) Mr Gibson failed to comply with the duty under s 44 of HSWA; and

(d) Mr Gibson's failure exposed POAL's workers, namely stevedores working at the Fergusson Container Terminal, to a risk of death or serious injury, namely the risk of being struck by objects falling from operating cranes.

[62] The elements of the alternative offence under s 49(1) of HSWA were the same but excluded the final element, in [61](d) above.

[63] The first two elements (in [61](a) and [61](b) above) were not in issue on either charge.

The Judge's reasons for verdict

[64] The extent of the evidence meant the Judge's reserved judgment was lengthy. Having addressed the legislative framework and the elements of the charges, the Judge

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17 Legislation Act 2019, s 10.

recorded that determining whether Mr Gibson failed to comply with his duty under s 44 of HSWA required an assessment as to whether he failed to exercise the care, diligence and skill that a reasonable officer would have exercised in the circumstances to ensure that POAL complied with its primary duty of care under s 36.[18] The Judge said that in order to determine that mixed question of fact and law, he must consider:[19]

(a) What were the circumstances in which Mr Gibson was acting during the period reflected in the charges? The relevant circumstances include (without limitation) the nature of POAL's business and the nature of Mr Gibson's responsibilities as CEO.

(b) In those circumstances, what steps would a reasonably careful, diligent and skilful officer take to ensure that POAL complied with its primary duty of care?

(c) Did Mr Gibson fail to take those steps?

[65] The Judge said the focus of the enquiry under sub-paragraphs (b) and (c) above must, necessarily, be on the steps which the prosecution alleged that Mr Gibson failed to take, as particularised in the charging documents.[20]

[66] The Judge recorded that the charged offences are strict liability offences.[21] It was therefore unnecessary for the prosecution to establish that Mr Gibson intended to breach his duty under s 44,[22] or that he was reckless as to whether he was in breach of his duty.[23]

[67] The Judge also said that the fact that POAL breached its primary duty of care to ensure, so far as reasonably practicable, the health of safety of its workers did not, of course, lead to a conclusion that Mr Gibson failed in his duty. A PCBU can breach its duties despite proper efforts by its officer to do all that he or she could reasonably

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18 *Maritime New Zealand v Gibson*, above n 3, at [45].
19 At [46].
20 At [47].
21 At [48].
22 HSWA, s 54.
23 Compare s 47.

have been expected to do in the circumstances, having regard to what the officer knew, what they ought to have known, and their ability to make or influence decisions in relation to the relevant matter.[24]

[68] The Judge gave an extensive account of the circumstances in which Mr Gibson was acting, including the nature and structure of POAL's business, its health and safety systems, and Mr Gibson's position, responsibilities and experience. This included reference to POAL's major automation project that was underway during the relevant period. Dealing with "systems leadership", the Judge noted that in any large organisation effective systems are key to health and safety management. He said:[25]

> As CEO Mr Gibson was required to engage in effective systems leadership. He had a responsibility to ensure the resources and processes in place ensured compliance with POAL's duties under the HSWA. That required him to ensure that the information he received reflected work as done or "what people are doing on the ground".

[69] The Judge also addressed the risks involved in stevedoring and POAL's / Mr Gibson's awareness of the risks (including the relevant critical risk of handling loads), the importance of understanding "work as done" (rather than as planned or intended), POAL's previous health and safety convictions and that Mr Gibson was on notice of inadequate monitoring of work as done. The Judge further addressed the non-compliant safety culture and work practices of the night shift, the three-container width rule (training and workers' understanding of it), and COVID-19 and the CTOPs Pandemic Plan.

[70] The Judge then turned to the charges against Mr Gibson. In relation to particulars 1(a) and 2 (at [40] above), the Judge said the starting point was that POAL failed in its primary duty of care to ensure, so far as reasonably practicable, the health and safety of its workers.[26] The Judge concluded that, prior to Mr Kalati's death, there was a culture, particularly on the night shift, of stevedores engaging in unsafe practices or cutting corners, including non-compliance with the three-container width rule.[27]

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24 *Maritime New Zealand v Gibson*, above n 3, at [49].
25 At [211].
26 At [411].
27 At [258]-[269] and [412].

[71] The Judge concluded:

> [428] In respect of particulars 1(a) and 2 of the charges, therefore, I conclude that Mr Gibson had the capacity and the ability to influence the conduct of POAL in relation to its failures. He was in a position to ensure that reporting processes and policies were put in place to address those failures, before they occurred. As an officer, he had to ensure that effective reporting lines were in place and that the Executive and Board received appropriate recommendations from those with expertise in POAL's operations at the wharf or "shop-floor" level. He was required to take active steps to obtain adequate information about the nature of the work being undertaken, the risks associated with that work, the controls which were in place to address those risks, and as to what additional steps or controls were necessary to remove or minimise those risks.
>
> [429] POAL's systems should have made him aware of the nature of the risk which existed and how that risk needed to be addressed. It was Mr Gibson's role to ensure that the company's systems did so.
>
> [430] Further, on the facts of this case, Mr Gibson was not a hands-off or remote CEO, operating at a significant remove from POAL's day to day operations. He was personally aware of the relevant risks and what controls were or were not in place to address the risk.
>
> [431] For all of these reasons, I am satisfied beyond reasonable doubt that Mr Gibson failed to exercise the care, diligence and skill that a reasonable officer would have exercised in the same circumstances to take the reasonable steps reflected in particulars 1(a) and 2 of the charges. In those respects, I am satisfied beyond reasonable doubt that he failed to comply with the duty imposed on him under s 44 HSWA to exercise due diligence to ensure that POAL complied with its duties or obligations under the Act.

[72] In relation to particular 1(b) of the charge (at [40] above), however, the Judge was not satisfied beyond reasonable doubt that Mr Gibson failed to exercise the care, diligence and skill that a reasonable CEO would have exercised in the same circumstances, by failing to take reasonable steps to ensure that POAL had clearly documented, effectively implemented, and appropriate processes for ensuring coordination between lashers and crane operators (under the Pandemic Plan). The Judge could not be sure that Mr Gibson failed in his duty under s 44 in the manner described in particular 1(b) of the charge.[28]

[73] When later considering whether the failure exposed the stevedores to the risk of death or serious harm by being struck by objects falling from operating cranes, the Judge summarised his earlier conclusions in relation to the breach of s 44 in the following way:

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[28] *Maritime New Zealand v Gibson*, above n 3, at [475].

[499] I have, however, concluded that:

> (a) Mr Gibson was fully aware of the critical risk of handling suspended loads;
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> (b) He was, ultimately, responsible for health and safety and was tasked with a number of key health and safety responsibilities;
>
> (c) He was responsible for monitoring and reviewing the performance of his subordinates and POAL's systems. He was required to exercise systems leadership;
>
> (d) He was "hands on" in relation to health and safety issues;
>
> (e) He was aware of the lack of timely response by POAL to recommended improvements to health and safety accountability, monitoring and reporting, including reporting of incidents, near misses and non-compliance;
>
> (f) He was aware, or ought to have been aware, of the lack of timely progression of bow-tie analysis of critical risks;
>
> (g) He was on notice of POAL's on-going difficulties in adequately monitoring work as done and of the need for improvement of the monitoring of the night shift;
>
> (h) He was conscious of the desirability of additional technological controls in relation to work carried out by lashers on ships, to address POAL's reliance on behavioural controls, but failed to turn his mind to the need for additional hard, non-technological controls;
>
> (footnotes omitted).

[74] Finally, the Judge was also satisfied beyond reasonable doubt that Mr Gibson's breach of his s 44 duty, in relation to particulars 1(a) and 2 of the charge, made it materially more likely that POAL would breach its duty of care to ensure that stevedores were not exposed to the risk of death or serious harm. His failure thereby exposed the stevedores to the risk of death or serious harm by being struck by objects falling from operating cranes.[29]

Approach on conviction appeal

[75] The approach on a conviction appeal is well established. The appeal Court must allow an appeal against conviction if satisfied in the case of a judge-alone trial that the Judge erred in his or her assessment of the evidence to such an extent that a

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[29] *Maritime New Zealand v Gibson*, above n 3, at [500].

miscarriage of justice has occurred;[30] or if a miscarriage of justice has occurred for any reason.[31] Otherwise, the appeal must be dismissed.[32]

[76] A miscarriage of justice means:[33]

> … any error, irregularity, or occurrence in or in relation to or affecting the trial that—
>
> (a) has created a real risk that the outcome of the trial was affected; or
>
> (b) has resulted in an unfair trial or a trial that was a nullity.

[77] The inquiry involves a two-step process: was there an error, irregularity or occurrence and, if so, did either [76](a) or (b) arise in consequence?[34]

[78] In relation to [76](a), the Supreme Court has confirmed:[35]

> … That question "requires consideration of whether there is a reasonable possibility another verdict would have been reached". If the answer to that question is "no", that is the end of the matter and the appeal will be dismissed. If the answer to that question is "yes", … the appeal court then asks whether it is sure of guilt. If the answer is "no", the appeal will be allowed. If the answer is "yes", the court determines the error did not in fact create a real risk that the outcome was affected and the appeal will be dismissed…

[79] In relation to [76](b), which is contrary to the defendant's absolute right to a fair trial affirmed in s 25(a) of the New Zealand Bill of Rights Act 1990, the consideration requires an assessment of the circumstances of the trial overall.[36] As the Supreme Court said in *Condon v R*:[37]

> A verdict will not be set aside merely because there has been irregularity in one, or even more than one, facet of the trial. It is not every departure from good practice which renders a trial unfair … it is at the point when the departure from good practice is 'so gross, or so persistent, or so prejudicial, or so irremediable' that an appellate court will have no choice but to condemn a trial as unfair and quash the conviction as unsafe.

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30 Criminal Procedure Act 2011, s 232(2)(b).
31 Section 232(2)(c).
32 Section 232(3).
33 Section 232(4).
34 *Wiley v R* [2016] NZCA 28, [2016] 3 NZLR 1 at [24].
35 *Haunui v R* [2020] NZSC 153, [2021] 1 NZLR 189 at [67].
36 *Condon v R* [2006] NZSC 62, [2007] 1 NZLR 300 at [77]-[78].
37 At [78].

[80] The appeal proceeds by way of rehearing on the record.[38] The appellate court has the responsibility of considering the merits of the case afresh.[39] The appellate court must be persuaded that a miscarriage has occurred, but the weight it gives to the reasoning of the court below is a matter for the appellate court's assessment. No deference is required beyond the "customary caution" appropriate in cases where the trial judge has had the advantage of seeing the witnesses, such as where credibility is important.[40]

Analysis of conviction appeal

[81] Mr Billington submitted the wrongful conviction of a dedicated and "hands on" CEO in relation to health and safety, who was genuinely committed to staff safety at POAL, and who should otherwise be taken to have complied with his due diligence obligations, principally stemmed from the following:

(a) A prosecution case focused on the alleged failures of POAL to achieve a best practice health and safety system, with the flawed premise that these failures were attributable to failings by Mr Gibson to exercise "systems leadership" or ensure a "strategic" approach to health and safety at POAL.

(b) An error of law and fact by the Judge in holding that Mr Gibson was ultimately responsible for health and safety at POAL,[41] despite earlier in his judgment finding that the Board had ultimate oversight of health and safety.[42] As a consequence, the Judge attributed every perceived failure of POAL, and of the governance group as a whole, to Mr Gibson. Mr Gibson was but one officer, and not the most senior. The Judge ignored the circumstances that Mr Gibson acted in – at the direction of the Board.

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38 *Sena v New Zealand Police* [2019] NZSC 55, [2019] 1 NZLR 575 at [32].
39 *Austin, Nichols & Co Inc v Stichting Lodestar* [2007] NZSC 103, [2008] 2 NZLR 141 at [13] and [16].
40 At [13]; *Sena v New Zealand Police*, above n 38, at [38]-[40].
41 *Maritime New Zealand v Gibson*, above n 3, at [416] and [499(b)].
42 At [107].

(c) Overlooking that section 44 does not rely on attribution. The Judge's essential task – as required to determine any departure from a standard of care – was to focus on the circumstances Mr Gibson was acting in at the time, what steps he had taken, how they compared to what the "reasonable officer" would have done and whether it was reasonable for him to rely on the expert advice he did.

(d) Viewing the requirement to exercise due diligence through the wrong lens. The Judge preferred the approach taken in decisions decided under repealed Australian legislation,[43] even though that legislation attributed the PCBU's contravention to the officer and placed the onus on the officer to prove they had exercised "all due diligence" as a defence to a charge, which s 44 does not.

(e) Disregarding the assistance that a recent decision of the District Court of New South Wales on the Australian equivalent to s 44 provided.[44] The Judge's decision was out of step with that decision, and a subsequent decision of the Magistrates Court of Queensland issued since the verdict.

(f) An error of law in setting the standard too high. The Judge lost sight of the fact that s 44 requires the taking of reasonable steps to ensure, rather than actually ensuring, the PCBU's compliance. In this respect, the focus in the judgment on Mr Gibson needing to be strategic or highly systematic fundamentally misconstrued and misplaced the legal requirement to take reasonable steps in a governance role.

(g) An error of law in determining he did not need to know what other equivalent officers in the same circumstances were doing in New Zealand during the charging period to manage analogous critical risks.[45] The Judge ignored the defence evidence to the effect that

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43 *Maritime New Zealand v Gibson*, above n 3, at [56]-[68].
44 At [69]-[76].
45 At [78]-[79].

> Mr Gibson's actions were in line with, if not ahead of, equivalent officers during the charging period, at a time when health and safety management and governance were evolving.

[82] Mr Billington submitted these errors ultimately compounded on one another. They led the trial Judge to ignore relevant evidence, dismiss defence witnesses and overlook a lack of crucial evidence. The prosecution's approach was the antithesis of what the government sought to achieve following the Pike River disaster. As a result of the errors, a miscarriage of justice had occurred and the conviction should be overturned.

[83] In summary, Mr Gibson says on appeal that the "expansive" health and safety system at POAL, comprising resources (including people) and processes, developed during his tenure and in place during the charge period was evidence that he and other officers at POAL were exercising due diligence. And, at the very least, they raise the question of how the Judge could have been satisfied beyond reasonable doubt that Mr Gibson was not exercising due diligence at the time. Mr Billington acknowledged that the gravamen of the appeal is that the Judge essentially overlooked s 44(2).

[84] Before dealing with these submissions,[46] I note that in terms of the s 48 offence provision, the focus of the appeal is on the Judge's approach to s 44 – and particularly whether Mr Gibson failed to comply with his duty (s 48(1)(b)) – rather than the exposure to risk requirement in s 48(1)(c). It was not disputed that the Judge was correct to hold it was sufficient for s 48 to prove beyond reasonable doubt that the officer's breach of duty made the PCBU's breach of duty materially more likely and that the officer's breach exposed the stevedores to the risk of death or serious harm by being struck by objects falling from operating cranes.

Focus on the proved failures of POAL

[85] The Judge said the proved failures of POAL were the starting point for his analysis. Mr Billington submitted this reflected the prosecution approach, and that at trial the prosecution argued Mr Gibson had an obligation to ensure that POAL met

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[46] I deal with them largely, but not exactly, in the sequence of [81] above.

its duty. He submitted that under the prosecution's approach, Mr Gibson became a proxy for the Port and all its failings were laid at his feet. Ms Lanham, addressing the argument and evidence in more detail for Mr Gibson, characterised the Judge as focusing on the sufficiency of POAL's system rather than the steps taken by Mr Gibson. Mr Billington also characterised the Judge's approach as imposing strict liability rather than assessing due diligence to a reasonable standard.

[86] Before addressing the prosecution's approach, I make a preliminary observation about the extent of the evidence in this case. At trial, the notes of evidence exceeded 2,400 pages, and the exhibits exceeded 4,340 pages. Whatever the cause of this, the length of the seven week trial, and the length of the submissions on appeal, it is incumbent on both parties in health and safety prosecutions – as in other cases – to focus on the key issues, and to ensure that evidence is directed to those issues and that submissions are succinct. Accepting that health and safety prosecutions can be complex, they are not a special class of case justifying a different approach.

[87] I accept that the evidence of the prosecution's fact witnesses was directed at the PCBU's failures. MNZ called lashers, crane operators and one Ship Leading Hand directly involved in the accident, two OPCs, one Shift Operations Manager and the Manager of Stevedoring, Mr Lander. However, a number of other individuals who may have been able to provide evidence were not called. I address the submissions regarding so-called missing evidence separately below.[47]

[88] However, there was no error in referring to the proved failures of POAL as the starting point even though POAL's failures constituted only relevant background or context and did not prove any element of the charge against Mr Gibson. Moreover, unlike party liability under the Crimes Act 1961, s 50 of HSWA provides that an officer may be convicted when a PCBU is not. In any event, it is important not to treat a senior officer as a proxy for the PCBU by conflating the PCBU's failure to ensure compliance with the separate reasonable steps assessment required for an officer under s 44.

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47 See [116]-[142] below.

[89] Relevant to this, Mr Billington pointed to the Judge's criticism of POAL's Health and Safety Steering Committee (HSSC) as not being sufficiently strategic.[48] While the Judge's criticism of the HSSC (on expert review four years later) is not disputed, Mr Billington submitted the analysis was emblematic of a fundamental error in approach since s 44 does not require an officer to be "strategic", or to know more than his or her expert health and safety advisers. Accepting that the HSSC's shortcomings should not automatically be attributed to Mr Gibson, I do not consider the Judge's criticism of the HSSC conflated the separate duties. It is not a fair characterisation of the judgment to say that the length or frequency of HSSC meetings was used as evidence to convict Mr Gibson. Rather, the Judge said "it was Mr Gibson's role as CEO, and the senior POAL executive on the HSSC, to ensure that the Committee was adequately performing its functions".[49] Also, although the Judge said "an officer cannot assume that a PCBU is compliant with its duties under HSWA in the absence of being told otherwise",[50] that prefaced his later analysis of Mr Gibson's systems leadership. The statement was not inconsistent with accepting that Mr Gibson was entitled to place some reliance on his health and safety advisers. The issue is the extent of that reliance in the context of whether a reasonable officer would have taken further steps particularly in terms of "systems leadership", which the Judge subsequently analysed (and to which I will return).

[90] Mr Billington also pointed to paragraphs in the Judge's decision which might suggest he conflated the different duties. For example, the Judge said Mr Gibson:[51]

> … had a responsibility to ensure the resources and processes in place ensured compliance with POAL's duties under the HSWA. That required him to ensure that the information he received reflected work as done or "what people are doing on the ground".

[91] MNZ accepted this wording was infelicitous. However, reading the Judge's decision as a whole – in particular his acknowledgement of the distinct duties when stating general principles,[52] and his subsequent analysis in relation to the charges – I do not consider the Judge failed to apply s 44's discrete reasonable officer test.

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48 *Maritime New Zealand v Gibson*, above n 3, at [135]-[146] and [420].
49 At [420].
50 At [145].
51 At [211].
52 At [80(d)].

Ultimate responsibility for health and safety at POAL

[92] Mr Billington also emphasised the Board's ultimate oversight of health and safety and that Mr Gibson was carrying out the role the Board required of him. While Mr Billington did not dispute that the Judge was entitled to say the Board's views as to Mr Gibson's performance did not substantively assist,[53] he pointed to the Judge's finding that Mr Gibson "was, ultimately, responsible for health and safety" at POAL,[54] despite earlier finding that the Board had ultimate oversight.[55] Mr Billington challenged the finding that Mr Gibson was ultimately responsible for health and safety at POAL. He emphasised the cascading classification of duty holders under HSWA, where primary responsibility rests with the PCBU, followed by officers of the PBCU and finally, workers of the PCBU.[56]

[93] An underlying theme on appeal was the concern that Mr Gibson had been singled out for prosecution.

[94] I accept this cascading classification of duty holders, and a conceptual distinction between the governance and management responsibilities of an officer.[57] I also acknowledge that the Judge made only limited reference to the evidence of Mrs Coutts, POAL's Board Chair at the relevant time who gave evidence for Mr Gibson and who has a great deal of corporate governance experience. Her evidence about Mr Gibson's health and safety performance was very positive – he was "doing a lot". But the issue for the Judge in this case was whether Mr Gibson met the reasonable officer test. The Board's ultimate governance responsibility does not preclude liability on the part of senior managers such as the CEO (and/or others with relevant responsibilities). I accept that multiple people including Board directors and managers at POAL had health and safety responsibilities. Indeed, as well as Mr Gibson, other senior managers with health and safety responsibilities (including the senior manager leading the health and safety team) regularly attended Board meetings and directly provided health and safety reports. The full Board wanted to be

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53 *Maritime New Zealand v Gibson*, above n 3, at [108].
54 At [499(b)]; see above at [73].
55 At [107].
56 In ss 17-19. See also *Stumpmaster v Worksafe New Zealand*, above n 8, at [15].
57 But see [159]-[163] below. I accept too that an officer can also be a worker with separate (more functional) duties under s 45.

directly involved in health and safety, rather than having it addressed by a Board committee. However, MNZ did not charge Board members or other senior managers in this case, and so their conduct is only relevant background or context to the assessment of whether Mr Gibson met the reasonable officer test.

[95] Again, reading the Judge's decision as a whole, I do not consider the Judge erred in his assessment of Mr Gibson's level of responsibility for health and safety at POAL. The Judge's reference to ultimate responsibility for health and safety reflected an acknowledgment by Mr Gibson in evidence and in any event was tempered by the Judge's reference elsewhere in the judgment to Mr Gibson exercising "overall responsibility at the Executive level for health and safety matters at POAL".[58] Having heard evidence in relation to Mr Gibson's position and responsibilities as CEO, the Judge was correct to make this latter finding. Mr Gibson did have considerable control over the health and safety systems in place at POAL. This is not to suggest – and it was not MNZ's case – that Mr Gibson as CEO should have been across every single operational policy at POAL or the actions of every worker. Rather, the focus was on the reasonable steps that should have been taken to implement and monitor (and improve as necessary) the processes (system) for risk management of the critical risk of handling suspended loads. I address the Judge's application of the reasonable officer test further below.

Attribution

[96] Related to the discussion above on the proved failures of POAL, I agree that s 44 does not rely on attribution. That would be the wrong focus. But I do not consider the Judge's analysis suggested otherwise.

Comparative case law

[97] In relation to the correct approach to the "due diligence" requirement in s 44, there was some dispute as to the significance of comparative case law.

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58 *Maritime New Zealand v Gibson*, above n 3, at [111].

[98] As a preliminary point, I address Mr Billington's challenge to the Judge's statement that it is "clear" from HSWA and "existing authority" that an officer "cannot comply with his or her due diligence obligations by simply relying upon those with specific responsibilities for health and safety…".[59] Mr Billington noted the Judge cited no authority for that proposition and submitted it is contrary to:

(a) The Law Commission's statement of principle in the context of company law duties that directors "should be able to place some reliance on the reports and advice of others where it is reasonable and proper to do so", provided that they do not "shelter behind information and advice provided and abdicate or attenuate their responsibility for making final judgments".[60]

(b) *Inspector Aldred v Herbert*, which the Judge otherwise relied on, where the court held a director could rely on someone with relevant experience and expertise so long as the director was satisfied they could discharge those functions.[61]

(c) The recent Australian decisions in *Safework NSW v Doble* and *Guilfoyle v Walshaw*.[62]

(d) WorkSafe New Zealand's own guidance from February 2019 that an officer "may rely on information from others to meet their due diligence requirements. This includes information from senior managers, subject matter experts, line managers and supervisors", so long as that reliance was reasonable.[63]

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59 *Maritime New Zealand v Gibson*, above n 3, at [55].
60 Law Commission *Company Law: Reform and Restatement* (NZLC R9, 1989) at [521].
61 *Inspector Aldred v Herbert* [2007] NSWIRComm 170 at [61]. The standard of "all due diligence" referred to in that case is addressed further below.
62 *SafeWork NSW v Doble*, above n 16, at [264]-[265]; *Guilfoyle v Walshaw* MAG-00149166/21(1), 17 May 2024 at 20.
63 WorkSafe New Zealand *WorkSafe Position: Officers' due diligence* (February 2019) at 2.

(e) SafeWork Australia's Interpretive Guideline for s 27 of the Work Health and Safety Act, which similarly provides an officer can rely on others so long as that reliance is reasonable.[64]

[99] Accepting those statements, I do not consider the Judge contradicted them. It is important to see the Judge's reference to reliance in context:

> [54] The s 44 duties imposed on officers are not limited to governance obligations or functions.[65] Nevertheless, the requirement to take into account the circumstances against which the due diligence duty is to be assessed, including the nature of the business and the position and responsibilities of the officer, means that "due diligence" must be calibrated by reference to those factors and the other circumstances of the case. In *Sarginson*, Mander J held:[66]
>
> > Whereas a director in a large company will largely have a supervisory or oversight role that may limit their obligations of due diligence to the type of requirements set out in subs (4), many businesses will be much smaller and officers will have a much more hands-on role with direct involvement in the PCBUs operations and day-to-day work.
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> [55] A practical tension exists, therefore, between the purpose of the legislation, which is to sheet home the due diligence duty to those at the "apex of large hierarchical organisations" and the fact that officers in such organisations will be, by virtue of the nature of their role and the size of such organisations, removed from the day-to-day implementation of business systems, processes and health and safety standards. There may be several tiers of management sitting between the officer and those on the shop floor. It is clear, however, from the scheme of the legislation and existing authority, that an officer cannot comply with his or her due diligence obligations by simply relying upon those with specific responsibilities for health and safety in the management chain below them or by assuming, without proper enquiry, that the organisation's systems are adequately addressing health and safety risks.

[100] MNZ acknowledged that the Judge may have erred in the criticised phrase in the last sentence of [55] about relying and assuming. But the operative words are "simply" and "without proper enquiry". The Judge was not dismissing appropriate reliance on subordinates with specific responsibilities for health and safety in the management chain. Like directors, senior managers may rely on others where it is reasonable to do so.

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64 Safe Work Australia, *Interpretive Guideline – Model Work Health and Safety Act: The health and safety duty of an officer under section 27* (March 2020) at 6.

65 *Sarginson v Civil Aviation Authority* [2020] NZHC 3199, [2020] NZAR 429 at [123]-[124].

66 At [127].

[101] The Judge went on to consider four New South Wales cases in which prosecutions were brought against officers who were not "hands-on" directors of small corporate entities.[67] The Judge noted that three of those cases involved previous legislation which deemed a director liable for a company's offence unless the director established that they could not have influenced the company's conduct or that they used "all due diligence" to prevent the company from contravening the law.[68] In each of those three cases, the Court did not accept "all due diligence" had been exercised. While noting the reverse onus and the different phrase "all due diligence", the Judge rejected Mr Gibson's submission that these New South Wales cases under the repealed legislation did not assist in the interpretation of what constitutes "due diligence" in the context of HSWA.[69] However, the Judge noted that every case must turn on its own facts.[70]

[102] As MNZ submitted, cases decided under Australia's health and safety legislation can be of assistance in understanding how the duty of due diligence applies in practice because Parliament expressly drew from Australia's health and safety system in enacting HSWA. However, it is important to acknowledge the differences between those cases decided under the equivalent Australian model law and those decided under the previous Australian legislation.

[103] I accept that the three Australian cases decided under the previous legislation were of limited assistance in this case given the statutory differences. *Daly Smith* itself emphasised that "the words 'all due diligence' have a wider import than the words 'due diligence'".[71] As well as the statutory differences, there is a danger in seeking to deduce and apply general principles to what is essentially a fact specific assessment of due diligence in the particular circumstances of each case. Those three Australian cases did not involve similar circumstances, and MNZ's reliance on them was distracting. That is not to say that references to the need for a systemic approach to

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67 *Work Cover Authority of New South Wales (Inspector Mansell) v Daly Smith Corporation (Aust) Pty Ltd* [2004] NSWIRComm 349; *Inspector Kumar v Ritchie* [2006] NSWIRComm 323; *Inspector Aldred v Herbert*, above n 61; and *SafeWork NSW v Doble*, above n 16.

68 *Maritime New Zealand v Gibson*, above n 3, at [56].

69 At [65]-[66].

70 At [77].

71 *WorkCover Authority of New South Wales (Inspector Mansell) v Daly Smith Corporation (Aust) Pty Ltd*, above n 68, at [134].

identifying and managing safety risks in cases decided under the previous Australian legislation are irrelevant under the new regime.[72]

[104] The fourth Australian case referred to, *SafeWork NSW v Doble*,[73] followed New South Wales' introduction of the Work Health and Safety Act. Section 27(1) of that Act imposes the same duty on officers of PCBUs as is imposed under s 44(1) of HSWA, with an inclusive list of reasonable steps in s 27(5) similar to those in s 44(4). However, s 27 does not include the equivalent of s 44(2) which was added into s 44 during the parliamentary process.[74] In any event, SafeWork Australia's interpretive guideline for s 27 states that what amounts to taking reasonable steps will depend on the particular circumstances, including the role and influence able to be exercised by the individual officer.[75]

[105] Before the Judge, Mr Gibson placed reliance on *Doble* where, on the facts, the District Court of New South Wales concluded that the prosecution had not proved that Mr Doble failed in his duty to exercise due diligence.[76] MNZ submitted that *Doble* was incorrectly decided on the facts but, in any event, was distinguishable, given what were said to be failures on the part of the prosecution in that case to particularise its allegations and adequately direct the Court's attention to Mr Doble's actual failures – a misplaced reliance upon his compliance manager and a failure to properly interrogate and challenge the information he was receiving. The Judge accepted at least the latter submission.[77] He may also have been attracted to the former submission since he accepted it was "difficult to reconcile the Court's conclusion in *Doble* with the stated facts, the history and purpose of the legislation and the earlier Australian authorities in relation to the exercise of due diligence by directors".[78] The Judge also said:

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72 See for example a reference to such earlier statements in *SafeWork NSW v Hetherington*, above n 16, at [41]-[42], which was quoted in *SafeWork NSW v Doble*, above n 16, at [59].
73 *SafeWork NSW v Doble*, above n 16.
74 Speech by Michael Woodhouse at the second reading of the Health and Safety Reform Bill: (30 July 2015) 707 NZPD 5520.
75 Safe Work Australia, above n 64, at 6.
76 *SafeWork NSW v Doble*, above n 16, at [274].
77 *Maritime New Zealand v Gibson*, above n 3, at [73].
78 At [71].

> [76] Nevertheless, I accept the submission made on behalf of Mr Gibson that the Court in *Doble* correctly recognised that the duty on an officer to exercise due diligence does not mean that the officer must do everything that the PCBU must do to ensure compliance with its own duty and that a failure by the PCBU does not, of itself, demonstrate a failure by its officer to exercise due diligence.[79]

[106] Mr Billington criticised the Judge's treatment of *Doble*. I accept that *Doble* involved a closer statutory equivalent and correctly focused on the reasonableness of both the steps taken and Mr Doble's reliance on his chief health and safety advisor. As an example of that correct focus, *Doble* is helpful. But the fact specific assessment of due diligence in the particular circumstances of *Doble* is also of limited assistance in this case. It too did not involve similar circumstances other than at a level of generality. Further, MNZ's submission and the Judge's suggestion that *Doble* was incorrectly decided was another distraction.

[107] Mr Billington also referred to the recent Australian decision of *Guilfoyle v Walshaw*,[80] where the Magistrates Court of Queensland acquitted an officer – a managing director – who had relied on an operations manager responsible for health and safety. MNZ also submitted this case was wrongly decided. That was a further distraction.

[108] Mr Billington submitted that the following principles can be derived from *Doble* and *Guilfoyle*:

(a) There is a clear distinction between the PCBU and the officer, and what evidence is required to find a breach by each duty holder.

(b) Where a PCBU is not closely held, an officer cannot be expected to know everything occurring in the business. It is permissible to delegate certain health and safety functions and activities. It needs to be proven that it was not reasonable to rely on the experience and expertise of staff.

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79 *SafeWork NSW v Doble*, above n 16, at [264] and [266].
80 *Guilfoyle v Walshaw*, above n 62.

(c) When considering a breach of due diligence, the totality of the officer's conduct in respect of health and safety diligence should be looked at.

(d) The fact no resource constraints were placed on health and safety is evidence of due diligence.

(e) Further evidence of due diligence is taking an active interest in the work of the PCBU and health and safety initiatives. However, there is no obligation to micromanage.

(f) Officers who met regularly with staff responsible for, and knowledgeable about health and safety, were entitled to rely on that advice and updates, if such reliance was reasonable.

(g) The onus of proof rests with the prosecution. The absence of evidence factors against the prosecution, not the other way.

[109] Mr Billington invited me to articulate such principles. I would not describe all of these as principles, but I broadly accept the statements. They are consistent with high-level guidance provided to officers at the relevant time.[81] Of course, the onus is on the prosecution and each case must be decided on the evidence, but the correct approach under s 44 is to apply the statutory test without embellishment. I decline to articulate further principles in the abstract, but I address aspects of the above statements further when considering the evidence below. It is also unnecessary to comment further on the general principles relating to the exercise of an officer's duty of due diligence referred to by the Judge.[82]

[110] Later in the decision, the Judge said:[83]

> … Mr Gibson was, in many practical ways, a "hands on" CEO in relation to port operations and health and safety issues. He was not operating remotely from actual port operations or acting simply as a "head office based CEO". It is clear that Mr Gibson had both explicit and inherent responsibility for health and safety at POAL.

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81 See for example the MNZ guidance at [162] below.
82 *Maritime New Zealand v Gibson*, above n 3, at [80].
83 At [201].

[111] Mr Billington submitted the Judge held this against Mr Gibson, whereas in *Doble* the Judge treated evidence of Mr Doble being actively involved in health and safety as evidence of due diligence.[84] As indicated, assessment of due diligence requires consideration of the position and responsibilities of the officer. However, I accept it would be contrary to the purpose of the legislation to allow a CEO to remain remote from operations and so avoid responsibility for health and safety, while a CEO with the same responsibilities who takes a more "hands on" approach is judged to a higher standard. As Moore J observed in *Whakaari Management Ltd v WorkSafe New Zealand*, it cannot be that being responsible exposes a duty holder to greater risk of breaching their obligations than otherwise:[85]

> … It would be entirely antithetical to the purposes of HSWA if being responsible was a path to liability and being irresponsible (or electing not to be responsible) was an escape from it.

[112] In this case, as indicated, Mr Gibson had overall responsibility at the executive level for health and safety matters at POAL. His "hands on" approach to that management responsibility does not suggest he had direct responsibility for the actions of every worker.

[113] There was also discussion about the similarity between the wording of s 44(2) and the wording of s 137 of the Companies Act 1993. I accept that case law on directors' duties under the Companies Act is helpful in some respects, particularly regarding the concept of due diligence and the emphasis on whether a director acted reasonably as opposed to perfectly.[86] However, I do not accept the Judge needed to refer to that case law in this case. The Judge did not suggest the s 44 test was one of perfection or best practice. Also, reasonable reliance on advice is a component of the test, but is essentially a factual matter. So too is failing to take advice.

[114] I do accept the submission that when applying the reasonable officer test after an accident, the Court must be alive to the danger of hindsight bias. As the Supreme

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84 *SafeWork NSW v Doble*, above n 16, at [267]-[268].

85 *Whakaari Management Ltd v WorkSafe New Zealand*, above n 13, at [226].

86 *Maple Leaf Foods Inc v Schneider Corp* (1998) 42 OR (3d) 177 (ONCA) at 192, cited approvingly by the Supreme Court in *Yan v Mainzeal Property and Construction (in liq)* [2023] NZSC 113, [2023] 1 NZLR 296 at [209], albeit in the context of s 135 of the Companies Act 1993.

Court said in *Yan v Mainzeal Property and Construction (in liq)* in relation to applying ss 135 and 136 of the Companies Act:[87]

> Judges will recognise and adjust for the danger of hindsight bias. This means that they will identify the danger of treating a bad outcome as having been more predictable before the event than it actually was. And, it follows, judges will acknowledge that decisions that were reasonable when made may nonetheless turn out badly and that in difficult situations there will often be scope for more than one reasonable course of action.

[115] In this case, Professor Dekker (a defence expert witness) cautioned against hindsight bias and the prosecution experts were also questioned on this point. The Judge said he was conscious that one must guard against hindsight bias or hindsight reasoning.[88] I keep in mind the same caution.

Missing evidence

[116] I next address the so-called missing evidence mentioned above at [87] and the related submission that the Judge erred in law in determining that he did not need to know what other equivalent officers in the same circumstances were doing in New Zealand during the charging period to manage analogous critical risks.

[117] Mr Billington submitted there was insufficient evidence before the Judge about how POAL's Health and Safety Team, and key operational and management staff, carried out their health and safety work under Mr Gibson's management during the charging period and a complete lack of evidence as to their assessment of whether Mr Gibson took reasonable steps to make available adequate resources to create processes to ensure health and safety at POAL, such that the verdict was unsafe. As Mr Gibson's defence was, in part, that the system put in place to verify compliance with the three-container width rule was workplace observations inputted into PortSafe for review and tracking, Mr Billington submitted the lack of PortSafe records before the Court was a "glaring omission".

[118] I accept that MNZ did not call a Shift Supervisor. Nor was any person who directly reported to Mr Gibson called to give evidence. The most senior person in

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87 *Yan v Mainzeal Property and Construction (in liq)*, above n 86, at [273(d)].
88 *Maritime New Zealand v Gibson*, above n 3, at [331].

POAL called to give evidence was Mr Lander, who did not report to Mr Gibson directly and was three layers below him in the organisational structure. MNZ jointly interviewed Ms Powell and Mr Hulme for the PCBU interview (about POAL's container operations, not about Mr Gibson) but did not call them. MNZ did not interview or call the Senior Managers of Health and Safety who were employed during the charging period, nor anyone from the wider health and safety team. MNZ did not interview or call any Board members.

[119] Further, MNZ did not present evidence of what any other port in New Zealand was doing in respect of operating around cranes and verifying compliance, nor what any of their officers were doing by way of due diligence. Nor did MNZ call any witness from an overseas port.

[120] Additionally, as the Judge acknowledged, MNZ did not obtain access to PortSafe, POAL's computerised reporting data management system for health and safety which was introduced in late 2015, after HSWA came into force. PortSafe records were not before the Court. Nor were all minutes of health and safety meetings. The Judge declined to make any findings as to the claimed inadequacy of the MNZ investigation or speculate as to what other evidence might, potentially, have been placed before the Court, saying he was required to make findings on the evidence placed before the Court and only on that evidence.[89]

[121] Even so, such submissions run into the difficulty of speculating about missing evidence. As the Court of Appeal has said in the context of directions about the failure to call witnesses, any direction would need to extend to the nature of the inference to be drawn, and "[i]n most cases, judges conclude it is safer not to enter this particular minefield and instead instruct juries to decide the case on the evidence… and not to speculate on what others might have said if called".[90] Of course, the burden of proof remains on the prosecution and the judge needs to be sure before making ultimate findings. In this sense, I acknowledge the need for caution.

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89 *Maritime New Zealand v Gibson*, above n 3, at [161].
90 *R v Nobakht* [2007] NZCA 488 at [92], cited in *Anderson v R* [2021] NZCA 513 at [31].

[122] Dealing first with Mr Gibson's subordinate managers, even if the Judge went too far in finding there was substance in arguments that Mr Gibson was wrong to rely on Mr Eastgate, a senior manager, when Mr Eastgate had not been called as a witness, his involvement preceded the charge period and was only context to the Judge's subsequent analysis.[91]

[123] Of more significance was the Judge's finding that Manager of Stevedoring Mr Lander's 2019 restructuring proposal was wrongly frustrated or blocked by his superiors, Mr Hulme and Ms Powell, without hearing from them. I deal with the restructuring proposal below, but the issue is whether there was sufficient evidence before the Court – such as from Mr Lander – to reach that finding. The Judge acknowledged he had not heard from Ms Powell, Mr Hulme or anyone else as to why the 2019 restructuring proposal was blocked, and said there was no evidence upon which he could conclude Mr Gibson was made aware of it.[92] However, this did not preclude the Judge from addressing what reasonable steps Mr Gibson could and should have taken to improve risk management of handling suspended loads, and accepting Mr Lander's evidence. I address this further below.

[124] Mr Billington's characterisation of the Judge as sheeting home to Mr Gibson the alleged failings of any health and safety staff members (such as Mr Eastgate) or senior executives (such as Ms Powell) while giving no credit for staff the Judge considered to be competent (such as Mr Lander and Ms Costley) is misplaced. The focus must be on what reasonable steps Mr Gibson should have taken (remembering the burden and standard of proof).

[125] Further, as with the views of the Board,[93] I do not consider a lack of evidence of other managers' assessment of whether Mr Gibson took reasonable steps was problematic. Such opinions would not substantively assist. I do not accept the submission that it is striking the Judge did not think it necessary to hear from the staff directly involved in advising Mr Gibson on the design and implementation of the Port's safety system, and working with him on health and safety, in order to determine

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91 *Maritime New Zealand v Gibson*, above n 3, at [129]-[134].
92 *Maritime New Zealand v Gibson*, above n 3, at [286].
93 See above at [92].

if a failure of due diligence was proved beyond reasonable doubt. Again, the question requires analysis of the sufficiency of the evidence that was before the Court, addressed below.

[126] Turning to the evidence of practices on the ground, Ms Lanham suggested that the evidence of deliberate non-compliance with the exclusion zone was limited to three or four lashers. However, it was unnecessary for MNZ to call more lashers before the Judge was entitled to make the factual finding he did, albeit reference to a "culture" of non-compliance perhaps went too far on the evidence. It was not suggested that MNZ was aware of, but failed to disclose or call, evidence from other lashers contradicting such non-compliance.

[127] As for checks by Ship Supervisors, while no Ship Supervisor was called, there was evidence that they undertook checks each shift – at least one or two. The Judge did not suggest otherwise. Rather, it was accepted these checks were not effective. Thus, the absence of evidence from a Ship Supervisor was not problematic. Adducing PortSafe records may have avoided the need for the prosecution to ask witnesses to recall how many observations they did and input into PortSafe, but the absence of these records did not preclude the Judge from addressing the issue of whether, on the evidence that was before the Court, Mr Gibson should reasonably have taken further steps. The Judge was right not to speculate as to the contents of the PortSafe records. Moreover, while I accept that the checks that occurred each shift were uploaded into PortSafe and that PortSafe (and Mr Gibson's subordinates) did not disclose the non-compliance (found by the Judge), the Judge did not make any finding that was inconsistent with that acceptance. Mr Gibson claimed it was an error for the Judge to conclude that Mr Gibson could not reasonably rely on the PortSafe system for verification purposes without the Judge viewing it himself, but the Judge did not conclude that Mr Gibson could not reasonably rely on PortSafe as such. Again, I acknowledge that, in addressing further reasonable steps, the burden of proof remained on the prosecution and the Judge needed to be sure on the evidence before making ultimate findings.

[128] For similar reasons, the absence of other records that MNZ did not obtain/produce, such as records of online training by the OPCs, did not preclude the

Judge from addressing the issue of further reasonable steps. The same applies to the absence of CEO reports (some of which Mrs Coutts found). The Judge did not speculate as to the content of such absent documents or make adverse findings in relation to them. MNZ noted that it had requested from POAL some documents that were not provided, but the Judge (correctly) drew no adverse inference against Mr Gibson in relation to the absence of such documents (except in relation to the absence of an annual plan, addressed below at [174]). Again, I acknowledge that the Judge needed to be sure before making ultimate findings.

[129] Mr Billington also submitted there was no comparison with the actions of equivalent officers in similar PCBUs in New Zealand. He submitted that the Judge erred in determining that he did not need to know how such officers were managing analogous critical risks during the charging period, and verify this, to inform the assessment of what a "reasonable officer" would have done. Mr Billington described this as an evidential vacuum. While he accepted this itself did not give rise to a miscarriage of justice on the basis that materially relevant evidence was not put before the Court (as in *J (CA80/2016) v R*,[94] referred to in *Anderson v R*[95]) and he accepted the Judge should not speculate as to missing evidence, he submitted the Judge should have been cautious about it in the context of proof beyond reasonable doubt. Accepting the standard of proof, I interpolate that this is a difficult distinction.

[130] Mr Billington also submitted that, on the prosecution's own case, unquestionably there were resources and processes – comprising a system – that were in place. The issue was the effectiveness of those and whether Mr Gibson failed to take further reasonable steps in that regard. He submitted the case involved a qualitative enquiry which necessarily called for such evidence to be adduced. He submitted the Judge could not have been sure that Mr Gibson was deficient in carrying out his due diligence duties in the manner alleged without such evidence.

[131] I accept there was no factual evidence comparing what equivalent officers in similar PCBUs were doing at the time. As for the Judge's alleged error in determining

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94 *J (CA89/2016) v R* [2016] NZCA 528.
95 *Anderson v R* [2021] NZCA 513 at [37].

that he did not need to know what equivalent officers in the same circumstances were doing, the Judge addressed the issue as follows:

> [78] The defence referred me to a number of professional negligence cases relating to breaches of a professional's tortious duty of care.[96] It is submitted, based on those authorities, that in determining whether Mr Gibson breached his duty of due diligence under s 44 HSWA, I am required to determine what the accepted or common practices of equivalent officers were at the time, and then determine whether the prosecution has proved, beyond reasonable doubt, that Mr Gibson departed from those accepted or common practices.
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> [79] I do not accept those submissions. To uphold them would be to conclude that as long as an officer is operating at a standard comparable to relevant peers, there can be no breach of the section 44 duty, notwithstanding that standards might, generally, be inadequate. While the Court may be assisted by relevant evidence as to as to the state of knowledge of health and safety matters in the relevant industry at the time, the availability of industry standards or guidelines, and the practices of comparable officers and businesses, those matters are not determinative. Such a construction is consistent with the approach taken in health and safety cases concerned with breaches of a PCBU's duties under the HSWA.

[132] I acknowledge there may be cases where the evidence indicates that equivalent officers are not behaving reasonably – that is not a defence. Also, Mr Billington acknowledged there may be cases where the conduct is so egregious that no evidence of contemporary due diligence practices is required. However, I consider that at [79] of the judgment the Judge too readily discounted the relevance of evidence of what equivalent officers were doing at the time. As MNZ ultimately accepted before me, such evidence of common practice may be relevant to assessment – albeit not determinative – of what a reasonable person in the same circumstances as Mr Gibson would have done. Moreover, as the Court of Appeal said in *Attorney-General v Strathboss Kiwifruit Ltd*, "… the standard of care is typically determined on the basis of evidence from someone with sufficient knowledge and/or experience to be able to say what a reasonable person in the situation of the defendant would have done".[97] The approach taken in relation to the duties of PCBUs is different, but the reasonable officer test does not apply in that context.

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96 *McLaren Maycroft & Co v Fletcher Development Co Ltd* [1973] 2 NZLR 100 (CA), at 107-108; *Mason v Dodd* [2020] NZHC 1508; *Bindon v Bishop* [2003] 2 NZLR 136 (HC); *Attorney-General v Strathboss Kiwifruit Ltd* [2020] NZCA 98; *Sansom v Metcalfe Hambleton & Co* [1998] PNLR 542; *Dovuro Pty Ltd v Wilkins* [2003] HCA 51.

97 *Attorney-General v Strathboss Kiwifruit Ltd*, above n 96, at [428].

[133] Mr Billington contrasted the Judge's approach in [79] with his subsequent analysis in relation to particular 1(b) (appropriate processes for ensuring co-ordination between lashers and crane-operators under the Pandemic Plan), where the Judge held that there was no evidence on which he could rely to conclude that POAL was significantly out of step with industry practice around formalising change management processes. In doing so, the Judge noted that the prosecution's health and safety systems expert, Mr Kahler (an Australian health and safety accident investigator) "was unable to speak specifically as to New Zealand businesses generally when asked about the state of New Zealand businesses in their ability to undertake structured change management processes…"[98]

[134] The Judge's analysis in relation to each of the particulars indicates that, despite what he had said at [79], his subsequent findings as to reasonable steps reflected Mr Kahler's evidence. As Mr Billington submitted, MNZ's case in this regard primarily rested on Mr Kahler's evidence as to the reasonableness of Mr Gibson's conduct. The Judge accepted Mr Kahler's evidence in relation to the exclusion zone particular whereas the Judge said Mr Kahler could not speak to the pandemic particular.

[135] Mr Billington submitted that Mr Kahler had no relevant New Zealand or corporate governance experience at all, and that his evidence relating to POAL's failings (which Mr Billington submitted Mr Kahler attributed to Mr Gibson) fundamentally relied on what he thought a CEO should do, as opposed to what equivalent officers (who were diligent, careful and skilled) actually did in the same circumstances during the charging period. Ms Lanham characterised Mr Kahler's evidence as best practice, not reasonable practice.

[136] Thus, an important issue is whether Mr Kahler had sufficient knowledge and/or experience to be able to comment on what a reasonable person in the situation of the defendant would have done. Otherwise, while acknowledging the Judge's conclusions were not based solely on Mr Kahler's evidence, it is difficult to see a proper basis for

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98 *Maritime New Zealand v Gibson*, above n 3, at [473].

being sure in relation to the exclusion zone particular that Mr Gibson failed to take reasonable steps.

[137] I accept that Mr Kahler had no first-hand knowledge of the operation of the Port. The need for Port specific knowledge depends on the nature of the evidence. In cross-examination he acknowledged the POAL Board's health and safety role and the health and safety expertise and experience that some Board members brought to POAL (of which he had not been aware), albeit he opined that the Board was not asking the right questions. I also accept that Mr Kahler essentially did a desktop or document review. He acknowledged that, ordinarily when reviewing a company's health and safety system and providing advice, he would speak to all levels of management and the workforce. But here he was giving evidence as an expert witness, not providing POAL with advice or undertaking MNZ's accident investigation.

[138] As an expert witness, it was unnecessary for Mr Kahler to interview all personnel with relevant health and safety responsibilities directly – management or Board members. Rather than make factual assessments, the role of an expert witness is essentially to provide expert opinion to assist the Court in understanding other evidence or ascertaining any fact of consequence to the proceeding's determination.[99] Expert opinion must be based on facts, but it is for the Court to make the factual assessments. Criminal trials are not trials by expert – ultimately the factfinder must decide factual issues. As the Judge said, the suggestion that Mr Kahler's expert opinion evidence was based upon an incomplete factual picture would, of course, equally apply to all of the witnesses who gave expert opinion evidence, including those called by Mr Gibson.[100]

[139] Here, Mr Kahler said he read interview statements across a range of people from Mr Lander to the lashers. His overall impression and hypothesis (i.e. assumption) was that there was an established behavioural norm of non-compliance on the night shift. This aligned with the Judge's factual findings.

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99 Evidence Act 2006, s 25(1).
100 *Maritime New Zealand v Gibson*, above n 3, at [161].

[140] It is also for the Court to apply the relevant legal test, in this case in s 44. Section 44(2) requires consideration of the same circumstances, but it may often be that no factual evidence is available of what others are doing in the same circumstances. Evidence of what a reasonable person in the same circumstances would have done may well be evidence from an expert – with sufficient knowledge and/or experience – rather than from an equivalent officer in another PCBU. Further, in the context of a PCBU which has equivalents in similar overseas jurisdictions – particularly Australia which has a similar legislative regime – an overseas expert may well have sufficient knowledge and/or experience to be qualified to give evidence about what a reasonable person in the same circumstances would have done in New Zealand. Such an expert may also be able to give factual evidence about guidance and practice. Here, Mr Riding, MNZ's other expert witness who had experience in shipping, container operations and port safety, gave evidence of international guidance about port safety.[101]

[141] I have also acknowledged that MNZ's investigation did not interview all such relevant personnel. But that did not preclude Mr Kahler from giving expert evidence about the reasonable steps that Mr Gibson could and should have taken (based on assumed facts). The thrust of his evidence was that while Mr Gibson was dedicated, conscientious and diligent, he had not taken reasonable steps to put critical controls in place in relation to the appropriate exclusion zone around operating cranes.

[142] Given the nature of Mr Kahler's evidence, I do not consider he lacked the qualifications or experience to give expert opinion evidence about the reasonable steps Mr Gibson should have taken in relation to POAL's risk management system to manage the critical risk of handling loads including operating cranes. I will address the Judge's preference for Mr Kahler's evidence after referring to the defence evidence regarding reasonable steps.

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[101] There was Australian and UK guidance in relation to the safety of Port operations at the time, but the experts acknowledged it was high level. In any event, it is not disputed that POAL had the three-container width policy. The issue was with its implementation.

Setting the standard too high

[143] In relation to this ground, I have already addressed the submission that the Judge lost sight of the fact that s 44 requires the taking of reasonable steps to ensure, rather than actually ensuring, the PCBU's compliance; that is, the Judge conflated the different duties.[102] I deal with the remaining aspects in three parts:

(a) the positive steps Mr Gibson took;

(b) the submission that the focus in the judgment on Mr Gibson needing to be strategic or highly systematic fundamentally misconstrued and misplaced the legal requirement to take reasonable steps in a governance role; and

(c) the submission that the Judge ignored the defence evidence indicating that Mr Gibson's actions were in line with, if not ahead of, equivalent officers during the charging period, at a time when health and safety management and governance were evolving, and whether the competing evidence justified the Judge's conclusion that Mr Gibson had not taken reasonable steps in relation to the alleged failures.

Mr Gibson's positive steps

[144] As Mr Billington emphasised, the Judge held that during Mr Gibson's tenure, by his actions and leadership, a number of health and safety initiatives were introduced at POAL that "were positive and enhanced workplace health and safety".[103] He shouldered a "significant additional burden", and went to "significant efforts" to look after his staff during the COVID-19 pandemic, which spanned nearly half the charging period.[104] I add that the Board considered Mr Gibson's response to those unprecedented times had been exceptional, showing leadership qualities of mental tenacity to keep calm, stay on track and ensure that everyone was informed and engaged, while demonstrating an outstanding level of commitment and dedication to

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102 At [85]-[91] above.
103 *Maritime New Zealand v* Gibson, above n 3, at [199].
104 At [472].

staff. Mrs Coutts rated Mr Gibson in the upper quartile of the many CEOs she had worked with in terms of competency. As indicated, her evidence about Mr Gibson's health and safety performance was very positive – he was "doing a lot".

[145] I also accept that, as Mr Billington submitted, the evidence indicated frontline staff knew Mr Gibson. They volunteered that he was a "really good, good person", who led positive change and made POAL less hierarchical. He was a respected boss. He also had the support of the Board and was "considered to be a good leader who was dedicated to the port and its staff".[105] Mrs Coutts also gave evidence that Mr Gibson never hesitated to provide resources for health and safety, championed hard controls (that is, controls not reliant on behaviour) for critical risk management and treated it as an imperative that safety must always trump productivity at the Port.

[146] Mr Kahler accepted that Mr Gibson's general approach to his role was to be diligent and conscientious. Mr Kahler accepted that it was plain Mr Gibson was someone who cared for his workforce. Mr Kahler's assessment of Mr Gibson was that he was the type of CEO who would be down at the container terminal at 2 am if he thought there was a health and safety issue.

[147] As Mr Billington submitted, under Mr Gibson – and indeed, because of his diligence – a number of general health and safety initiatives were introduced at POAL. The Judge found that Mr Gibson's positive steps included introducing mandatory POAL leadership training, which included health and safety leadership;[106] seeking to "engage regularly with the workforce" by personally running 30 workshops a year with POAL staff to seek feedback on the company, importantly including health and safety issues;[107] instigating workplace surveys around culture;[108] and leading wellness initiatives.[109]

[148] There were also major resourcing and process improvements to POAL's health and safety system, and functional changes, which the Judge addressed as follows:

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105 *Maritime New Zealand v* Gibson, above n 3, at [199].
106 At [183].
107 At [187].
108 At [187].
109 At [188].

> [198] I have already addressed some of the initiatives which were introduced at POAL during Mr Gibson's tenure as CEO, many of which had a positive health and safety component. The defence emphasises:
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> (a) expansion of the health and safety team;
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> (b) his attendance and presentation of reports to the Board;
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> (c) the introduction of PortSafe;
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> (d) the engagement of external auditors;
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> (e) the introduction of health and safety KPIs for general managers and other managers;
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> (f) the introduction of the fatigue management system;
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> (g) the introduction of pre-employment fitness tests and PortFit classes, and an emphasis on personal wellness;
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> (h) the establishment of the HSSC;
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> (i) the introduction of OPCs;
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> (j) the training of stevedores to an NZQA unit standard;
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> (k) the introduction of crane simulators for training purposes;
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> (l) expenditure on significant port infrastructure projects;
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> (m) the introduction of the Have Your Say workshops;
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> (n) the introduction of workplace surveys;
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> (o) the introduction of health and safety leadership training;
>
> (p) the removal of consecutive eight hour shifts;
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> (q) the introduction of comprehensive job descriptions;
>
> (r) the introduction of lash platforms.
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> [199] I accept that such initiatives were positive and enhanced workplace health and safety. I also accept that Mr Gibson had the full support of the then Board and that he was considered to be a good leader who was dedicated to the port and its staff.

[149] I agree with the Judge that these matters were positive and enhanced workplace health and safety. Further, as Mr Billington submitted, they are relevant to the charge in that Mr Gibson's level of commitment to POAL and staff safety was plain.

[150] The introduction of lash platforms to enhance lasher safety is a pertinent example of a safety initiative introduced by Mr Gibson. This was a control introduced to help manage the critical risk of handling loads. The lash platform concept was developed after Mr Gibson observed twist-locks being placed and removed from containers suspended over the wharf (as is international standard practice) and became concerned this was unsafe. He set a project in motion to look for safer ways to remove twist-locks. A worldwide search revealed lash platforms. The platforms were described by one of the OPCs as "one of the best things" POAL ever did for safety.

[151] Mr Billington submitted it was remarkable that the Judge treated this evidence as a "double-edged sword" because, according to the Judge, the risk was only recognised after Mr Gibson's personal observation (rather than through a systemic process) and also demonstrated Mr Gibson was personally aware of the risks involved in working under suspended containers.[110] Mr Billington submitted that an officer cannot win. I accept it was not suggested Mr Gibson was unaware of the risk of handling loads in general terms, and I do not consider Mr Gibson's lash platform initiative itself indicated a relevant systemic deficiency.

[152] In addition, Mr Billington referred to further positive steps taken by Mr Gibson, such as his weekly meetings with his general managers at which health and safety issues in the departments were discussed and monthly meetings at which they completed a deep dive into critical risk; HSSC meetings; regular reviews of data in PortSafe; and safety walk-abouts. Mr Gibson also formed a strategic alliance with Lyttleton Port (joined later by SouthPort and Napier). One agreed workstream between the alliance was health and safety.

[153] Insofar as the Judge treated this evidence as irrelevant to determining the charge, that was an error. At least some of the various initiatives cited above were resources and processes directed at the critical risk of handling loads. Further, the more general evidence of Mr Gibson carrying out due diligence across the organisation was not irrelevant. In both *Doble* and *Guilfoyle*, the Court drew upon a broader range of factors to assess the particular alleged failures in those cases.

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110 *Maritime New Zealand v Gibson*, above n 3, at [218].

[154] I also accept the evidence that no resource constraints were ever placed on health and safety under Mr Gibson's management.

[155] I consider the prosecution case understated Mr Gibson's dedication and achievements, sometimes damning with faint praise such as stating MNZ "has always accepted that he did some things right, or at least made an effort to do so". This understated the positive steps Mr Gibson took (acknowledged on appeal) and the huge additional burden of COVID-19. The prosecution case also overstated criticism of Mr Gibson as someone who was "blind to obvious red flags", "failed both at being proactive and on follow-through" and lacked strategic systems leadership qualities in health and safety. For the most part, Mr Kahler accepted that the steps Mr Gibson had taken were positive – although he and MNZ referred to some of Mr Gibson's interactions with staff as "symbolic". I do not accept that characterisation. Hands-on involvement with staff workshops was a positive reinforcement by Mr Gibson of the importance of health and safety, going beyond good intentions. Attendance at team briefings or site visits would have enabled observation of health and safety processes. Further, I do not consider that Mr Gibson's focus was on people leadership to the exclusion of system improvement in health and safety.

[156] Even so, the ultimate question is whether Mr Gibson met the reasonable officer test. As the Judge said:[111]

> While these matters all speak positively to Mr Gibson's dedication, general leadership and good intentions, and provide background context, the issue in this case is simply whether I am satisfied that Mr Gibson failed in his duty of due diligence under s 44 HSWA in the ways particularised in the charges during the relevant time period. A good leader and a conscientious officer may have the best intentions in the world but may still breach that duty.

[157] That is not to say that evidence of positive steps taken is irrelevant, but such steps (which are no doubt reasonable steps in themselves) are not determinative of whether other steps would have been taken by a reasonable officer in the same circumstances. Focus on the reasonable steps taken – of which there were many – is insufficient. As Mr Billington acknowledged, reasonable conduct for the most part does not excuse unreasonable conduct in another part. That includes unreasonable

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111 *Maritime New Zealand v Gibson*, above n 3, at [200].

omissions. In the context of alleged omissions, the key question is whether a reasonable officer in the same circumstances would have taken further steps.

[158] I accept again that reasonable does not mean perfect. MNZ did not suggest that every omission is a breach of the due diligence duty. But nor does "reasonable" necessarily mean the average of what others would do. Common practice may or may not involve sufficient reasonable steps. In the particular circumstances of this case, these positive steps Mr Gibson took are relevant and important context but do not materially assist him in relation to whether he should have taken further reasonable steps. I acknowledge below Mr Gibson's involvement in more directly relevant steps monitoring the number of safety observations.

Reasonable steps in a governance role

[159] Mr Billington submitted the prosecution case, relying on Mr Kahler's evidence, missed the point that s 44 requires the taking of reasonable steps in a governance role. Relatedly, he submitted the focus in the judgment on Mr Gibson needing to be strategic or highly systematic fundamentally misconstrued and misplaced the legal requirement to take reasonable steps in a governance role.

[160] I do not accept that in the s 44 reasonable officer obligation there is a brightline or meaningful distinction between taking reasonable steps in a governance or management role. In HSWA, the term "officer" covers company directors and also "includes any other person occupying a position in relation to the business or undertaking that allows the person to exercise significant influence over the management of the business or undertaking (for example, a chief executive)".[112] Consistent with the spectrum of businesses outlined in *Sarginson* referred to above,[113] a CEO or managing director in a large business may well have responsibilities that straddle governance and management.

[161] Mr Gibson's CEO role had both governance and managerial components. He was not a director but, as the Judge said, he had overall responsibility at the

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112 HSWA, s 18(b), see above at [50].
113 See above at [99].

executive level for health and safety matters at POAL.[114] That does not mean he was expected to do his subordinates' work – or even to be familiar with all aspects of their work – but his responsibility extended to taking reasonable steps to implement and monitor (and improve where necessary) POAL's health and safety processes (systems).

[162] Accepting that New Zealand regulator guidance for officers at the relevant time was high level, MNZ guidance reflected this approach and emphasised the need to obtain credible information and challenge information where necessary:[115]

> How officers exercise their due diligence duty depends on the size of their operation, how it is run and the level of risk involved.
>
> Owner operators can exercise due diligence by being directly involved in health and safety within the maritime operation.
>
> …
>
> Land-based directors and chief executives don't have to be experts in health and safety, but they do need to make a reasonable effort to understand what questions they need to ask. Directors and chief executives may need to put in place structured processes to ensure that they meet their due diligence duty. They need to obtain credible information and follow up and challenge the information they are given where necessary. This is similar to the role that directors already play in tracking the financial performance of their companies - and they should place health and safety on an equal footing.

[163] What steps are reasonable must be determined having regard to the circumstances as required by s 44(2).

Evidence of further reasonable steps

[164] Before turning to the Judge's treatment of the evidence, I accept that while the charge separated particulars 1(a) and 2 as set out above at [40], the analysis section of the Judge's decision did not address those particulars separately.[116] Although those particulars involved somewhat different reasonable steps, I consider that addressing them together was permissible. Since particular 1(a) referred not only to resources and processes being available and documented but also to being "used" and

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114 *Maritime New Zealand v Gibson*, above n 3, at [111].
115 Maritime New Zealand *Officers' due diligence duties – Health and Safety at Work Act (2015): Guidance* (April 2016) at 2.
116 *Maritime New Zealand v Gibson*, above n 3, at [411]-[431].

"implemented", there was some overlap between it and particular 2, which related to verifying the provision and use of these resources and processes. As MNZ submitted, verification is essentially assessing whether the processes/system are working.

[165] In this case, the relevant reasonable steps are steps Mr Gibson should have taken during the charging period to ensure POAL:

(a) had and used resources (people, money, items) and processes – safe operating procedures including the three-container width rule, training, review etc. – to manage the critical risk of handling loads; and

(b) verified (monitored and measured) "work as done" to detect non-compliance, including with the three-container width rule.

[166] The focus in this case is on processes rather than resources.

[167] In relation to verification, I do not accept in the abstract the proposition suggested by Mr Marriott (an expert called by Mr Gibson) that directors lead the enquiry to verify the resources and processes provided because a CEO is too heavily involved in preparation to realistically take an objective view. I accept that the Board has an important role in strategic oversight of resources and processes and that a CEO cannot verify his or her own work, but verification of other operational matters (including monitoring and measuring reports of work as done prepared by subordinates) falls within management's purview. At least at a supervisory level, the CEO may be responsible.

[168] Mr Billington submitted the Judge ignored the defence evidence indicating that Mr Gibson's actions were in line with, if not ahead of, equivalent officers during the charging period, at a time when health and safety management and governance were evolving. He further submitted that the comparative evidence put before the Court from defence witnesses (Mrs Coutts and Mr Marriott) firmly rebutted Mr Kahler's evidence.

[169] The evidence of Mrs Coutts and Mr Marriott suggested that Mr Gibson was doing as much or more than anyone (equivalent) in New Zealand. Mrs Coutts considered that Mr Gibson was making good progress with health and safety. I have already accepted that Mr Gibson did take positive steps relevant to the charge.

[170] However, I do not accept the Judge ignored the defence evidence. A Judge need not refer to every piece of evidence. The real issue is whether the competing evidence justified the Judge's conclusion that Mr Gibson had not taken reasonable steps in relation to the alleged failures. As indicated above at [157], the key question is whether a reasonable officer in the same circumstances would have taken further steps, and reasonable does not necessarily mean the average of what others would do.

[171] I also accept that, in the period following the Pike River tragedy and the enactment of HSWA, the state of knowledge and skill among officers of New Zealand PCBUs as to how to exercise due diligence in designing and implementing a critical risk management system was evolving. Mr Kahler acknowledged PCBUs being surprised when taught about critical risks. Mr Marriott said that systems in New Zealand would likely have still been relatively immature in 2020, but he acknowledged in cross-examination that prioritising effective risk management of top risks was not new. Mr Kahler also accepted that POAL and Mr Gibson were on a "journey". Indeed, he seemed to accept that within another six months, the accident might not have occurred. Accepting the position was evolving, it is necessary to identify relevant steps in POAL's development or improvement of its system.

[172] In December 2017, the POAL Board had committed to the identification and management of critical risks to its workers. The seven critical risks had been identified. Even so, the Judge was entitled to accept Mr Kahler's evidence that the May 2018 and March 2019 reports relating to handling loads reflected "health and safety immaturity" rather than providing confidence that POAL had its critical risks effectively managed.[117] I note that these reports predated the charging period.

[173] I acknowledge that Mr Gibson was not responsible for the priorities set by the Board. In particular, while Mr Gibson did not suggest he was overruled by the Board,

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117 *Maritime New Zealand v Gibson*, above n 3, at [220]-[224].

the Board determined and directed that contractor management was to be the executive's (and thus Mr Gibson's) focus in terms of prioritising resources around implementing the 2018 KPMG audit recommendations. Broadly, that audit recommended POAL develop and implement a fit-for purpose contractor management framework, create clearly assigned responsibilities and accountabilities for its executive and senior managers, and improve its monthly health and safety performance reports. However, the Board's prioritisation in relation to implementing KPMG's recommendations is not a complete answer to the Judge's finding that Mr Gibson was aware POAL's executive failed to advance recommendations in a timely way.[118] Prioritising resources to one issue does not necessarily justify lack of progress with another issue. Nor did Mr Gibson suggest that. Rather, he (and Mrs Coutts) referred to monitoring in PortSafe to address the recommendation. Focusing on the charging period and accepting that the KPMG recommendations were in general terms, that POAL was without a permanent senior health and safety manager for six months before Ms Costley started in September 2019, and the impact of COVID-19, the Judge was nevertheless entitled to take into account the lack of progress.

[174] The Judge also found that there was a failure to have a specific annual health and safety strategy plan in place for the financial years ended 30 June 2020 and 2021.[119] The Judge found this amounted to a system failure that Mr Gibson was responsible for because under POAL's Health and Safety Manual he was to approve an annual plan.[120] While acknowledging on appeal that this may have been an oversight in Mr Gibson's functional duties, Mr Billington submitted it cannot be ignored that there was an overarching plan and there was no evidence the failure related to the exclusion zone and verification particulars. There was no clear explanation for the lack of an annual health and safety plan for the 2019/2020 year. As for the 2020/2021 year, Mrs Coutts recalled that the plan was reported to the Board in December 2019 but the plan document was not reported in February 2020 as some staff had been seconded into the pandemic team. Instead, Ms Coutts recalled Ms Costley, the senior manager of health and safety, presented the new health and

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118 *Maritime New Zealand v Gibson*, above n 3, at [417].
119 At [421].
120 At [156] and [401].

safety framework she wanted to implement that year. I accept, as Mrs Coutts emphasised, that an effective health and safety system requires consultation, not just a plan document written in isolation. A reasonable CEO with responsibility for approving an annual health and safety plan may have required the document for approval even during COVID-19 in 2020 but, in the circumstances, I leave to one side this failure to approve a strategy document when assessing specific reasonable steps in relation to exclusion zones.

[175] I acknowledge Mr Gibson's involvement in monitoring the number of safety observations. For example:

(a) introducing KPIs in performance agreements to increase safety observations in both the 2019 and 2020 financial years;

(b) his March 2020 CEO report indicating that observations for the month had focused on ship-based lashers and truck grid operations with a total of 139 observations; and

(c) his June 2020 CEO report stated:

> **Observations**
>
> There were 13 Dayshift and 8 nightshift lash observations in May. A programme of random unannounced lash observations has been instigated across night shift using a performance coach, and a representative from safety and wellbeing has been engaged to provide independent and objective input. In addition to the observations, data to evaluate the scale and frequency of the issue will be collected and a review undertaken to ensure practices and corrective training actions are undertaken.
>
> There were 114 dayshift and 89 nightshift observations across all competencies over the month; there will be additional observations made when undertaking rehearsal vessels at FN.

[176] Focusing specifically on the work of the stevedores, health and safety hazard reports concerning handling loads in 2016 and 2018 referred to team briefs at the beginning of each shift (and I accept there was a second gangway briefing). The reports also said a hazard board was always situated at the bottom of the gangway/accommodation ladder – relevantly stating only "[n]o working under the

hook". In addition, the reports prescribed at least one Ship Supervisor visit per shift and at least one health and safety representative walkaround per week. The reports indicated these visits/walkarounds were to be entered into PortSafe, and included a specific observation heading regarding staying clear of suspended loads. However, as indicated at [127] above, it was accepted these checks were not effective. The reports' concluding risk scores were high. Further, reference to these (limited) controls in documentation does not mean that Mr Gibson was advised they were always followed (or that he could have reasonably relied on such advice if given unless there was a proper basis for such advice).

[177] In April or May 2019, Mr Lander proposed a restructuring to put the stevedore workforce into crews, where each crew would have a responsible crew coach / team leader. This would have enabled more structured observation of their work 24/7. Mr Lander's proposal was declined – at the level of Mr Hulme or Ms Powell, without reference to Mr Gibson – on the basis POAL was only undertaking incremental change.

[178] Load handling arose for deep-dive consideration at the June 2019 Board meeting as part of a process of circulation between the identified critical risks. The one substantive comment in the Board minutes stated:

> Mr Ferguson advised that the reporting by third party stevedores is not sufficient. Safety and well-being staff are working with the teams and looking at ways to improve the level of reporting so that all can learn from lead indicators.[121]

[179] In the latter part of 2019, Mr Lander ran a scaled down trial of his restructuring proposal, which Mr Gibson was aware of and fully supported. Mrs Coutts said the Board was also impressed by it and wanted to implement the proposal at the same time as automation, as people could only handle so much change. She said they were expecting to be in automation in February/March 2020. Accepting that COVID-19 may also have interrupted progress in early 2020, in mid-2020 Mr Lander again formally proposed a workforce/OPC restructure. Again, this was declined. As the Judge concluded, Mr Gibson must have been made aware of this second restructuring

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121 Lead indicators are proactive, preventative measures such as the number of safety observations. They differ from "lagging" indicators which measure what has happened such as lost time injuries.

proposal. Notwithstanding that the proposal did not proceed, Mr Lander embarked on an observation initiative in July 2020 in which the OPCs were directed to work night shifts. This initiative did not continue. Accepting that this was during COVID-19 and that the restructure raised an issue with the OPCs' employment contracts, Mr Lander's health and safety initiative could not get traction. Mr Gibson ought to have been aware of, and made enquiries about, the lack of progress with an initiative that would improve understanding of "work as done" on the lashers' night shift.

Concluding analysis

[180] Ultimately, in order to reach a guilty verdict the Judge had to be sure that, in relation to the alleged failures during the charging period, Mr Gibson had not exercised the care, diligence, and skill that a reasonable officer would have exercised in the same circumstances. This involved assessing what further reasonable steps should have been taken.

[181] I do not accept that the Judge was searching for reasons to convict nor that, in context, his references to Mr Gibson not being strategic or exercising systems responsibility leadership applied the wrong test. Although the prosecution's broad focus was on the need to develop better systems, the Judge did not lose sight of the need to focus on reasonable steps – in the circumstances mandated in s 44(2) – that should have been taken in the context of the alleged failures. The Judge did not attribute all POAL's failings to Mr Gibson.

[182] Notwithstanding all of Mr Gibson's positive qualities and conduct, given the Judge's factual findings which aligned with Mr Kahler's assumptions and the benefit the Judge had of seeing and hearing the witnesses, I do not consider the Judge erred in favouring Mr Kahler's evidence over Mr Marriott's when assessing whether Mr Gibson should have taken further reasonable steps to implement safer processes (a safer system) in relation to exclusion zones.[122] I do not accept there was insufficient evidence available for the Judge to conclude that Mr Gibson omitted to take reasonable steps. The Judge was entitled to be sure that a safe system needed to

[122] Mr Marriott acknowledged in more general terms that reasonable steps to exercise due diligence at the time included ensuring that necessary processes were included in the health and safety strategy and plan.

include a means of monitoring and measuring performance. He was also entitled to find that Mr Gibson had not taken steps during the charge period that a reasonable officer in the same circumstances would have taken to implement an appropriate exclusion zone around cranes working over ships and to monitor and measure (verify) compliance by lashers on the night shift. In the same circumstances, a reasonable officer would have recognised shortfalls in POAL's management of exclusion zones and taken further steps to address those shortfalls.

[183] Without being in any way dismissive of all the positive steps by Mr Gibson (or by others at POAL), or suggesting that as CEO he personally was expected to know the detail of how lashing was undertaken and could not place any reliance on the internal and external processes in place, I emphasise the following matters (most of which were not in issue):

(a) As the Judge said, the evidence demonstrated that Mr Gibson was personally aware of the risks to stevedores working under suspended containers and the need, in that case, for additional controls to be put in place.[123] Although technological controls (geofencing) had been considered as a means of establishing exclusion zones around working cranes, this had not been implemented. Without suggesting available technology should have been implemented, this at least established, as the Judge said, that Mr Gibson was personally alert to the critical risk of workers working below suspended loads. He was personally aware of the importance of POAL exploring hard controls, rather than simply relying on behavioural controls, from at least 2016. As the Judge said, hard controls are not limited to novel technological controls.[124]

(b) As the Judge said, POAL's training materials and documentation in relation to three-container width exclusion zone policy were confusing and, often, inconsistent, and workers had different understandings of the operation of the rule. Further, and in any event, it is also clear that there was significant non-compliance with the policy, particularly on

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123 *Maritime New Zealand v Gibson*, above n 3, at [218].
124 At [329].

the night shift.[125] I accept, of course, it was not Mr Gibson's personal role to train or supervise the lashers. In addition, Mr Gibson was entitled to rely on expert advice as to the appropriateness of the policy itself. Even assuming he had no reason to doubt it was included in staff training, that does not mean he was advised that the policy was always followed (or that he could have reasonably relied on such advice if given unless there was a proper basis for such advice). Mr Gibson should have sought improved performance measures to monitor the effectiveness of the policy.

(c) POAL's systems for safety observations were inadequate in monitoring work as done (and non-compliance) on the night shift. There were insufficient lead indicators. At least in part, it was the responsibility of Mr Gibson to take reasonable steps to implement a system that monitored and measured such compliance. I acknowledge that the non-compliance was due to social pressures among the crew rather than productivity pressures from POAL.

(d) Although Mr Gibson did not have actual knowledge of the stevedores engaging in unsafe practices or cutting corners on the night shift, including not complying with the three-container width policy, he was on notice, at least from late 2018 following the straddle carrier fatality, that POAL had demonstrated ongoing difficulties in adequately monitoring "work as done", as the Judge said. As CEO, Mr Gibson should have been aware that appropriate systems and processes needed to be put in place to address POAL's previous failures in that respect.[126] This does not mean Mr Gibson did nothing following the straddle carrier fatality. But more could and should have been done to monitor and measure compliance in relation to the critical risk of handling loads. I accept the lasher non-compliance identified in 2014 does not, by

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125 *Maritime New Zealand v Gibson*, above n 3, at [305].
126 At [257].

itself, appear to justify concluding that POAL had been alert to the issue of lasher non-compliance "since" at least 2014.[127]

(e) A March 2019 report to the Board on handling loads included a table setting out numbers of incidents, near misses and non-compliance, but also stated: "[i]t is likely this table is not reflective of actual events occurring within POAL operational areas due to lack of overall reporting". While also dated shortly before the charging period, this indicates lack of monitoring of "work as done".

(f) Accepting that the OPCs were not the only personnel responsible for monitoring,[128] the Judge was entitled to take into account the delay in implementing Mr Lander's restructuring proposal that would have improved health and safety compliance on the night shift.

(g) As the Judge also said, Mr Gibson was aware, or ought to have been aware, that POAL's bow-tie assessments (a risk management tool) of critical risks, including the risk associated with handling overhead loads, were inadequate and not progressed in a timely manner.[129] At least in part (in a supervisory sense), this progress was the responsibility of Mr Gibson.

[184] The Judge was entitled to be sure that Mr Gibson had not exercised the care, diligence, and skill that a reasonable officer would have exercised in the same circumstances.

[185] Finally, I do not accept the Judge's approach places New Zealand out of step with the Australian approach in *Doble* and *Guilfoyle*.

[186] For these reasons, there has been no miscarriage of justice and the conviction appeal must be dismissed.

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127 *Maritime New Zealand v Gibson*, above n 3, at [260].
128 Ship Supervisors had a primary role – see [176] above.
129 *Maritime New Zealand v Gibson*, above n 3, at [229]-[231] and [423].

Sentence appeal

Sentencing under HSWA

[187] The maximum penalty for an officer of a PCBU convicted of an offence under s 48 of HSWA is a fine not exceeding $300,000.[130]

[188] Section 151 of HSWA states:

> **151 Sentencing criteria**
>
> (1) This section applies when a court is determining how to sentence or otherwise deal with an offender convicted of an offence under section 47, 48, or 49.
>
> (2) The court must apply the Sentencing Act 2002 and must have particular regard to—
>
> (a) sections 7 to 10 of that Act; and
>
> (b) the purpose of this Act; and
>
> (c) the risk of, and the potential for, illness, injury, or death that could have occurred; and
>
> (d) whether death, serious injury, or serious illness occurred or could reasonably have been expected to have occurred; and
>
> (e) the safety record of the person (including, without limitation, any warning, infringement notice, or improvement notice issued to the person or enforceable undertaking agreed to by the person) to the extent that it shows whether any aggravating factor is present; and
>
> (f) the degree of departure from prevailing standards in the person's sector or industry as an aggravating factor; and
>
> (g) the person's financial capacity or ability to pay any fine to the extent that it has the effect of increasing the amount of the fine.

[189] Section 7 of the Sentencing Act sets out the purposes of sentencing which a sentencing court may take into account. Section 8 sets out the principles of sentencing which the Court must take into account. Section 9 sets out aggravating and mitigating factors which the Court must take into account to the extent they are applicable.

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130 Section 48(2)(b).

Section 10 requires the Court to take into account offers, agreements, responses or measures to make amends.

[190] I have set out the purpose of HSWA at [48] above.

[191] The guideline judgment on sentencing for offending under s 48 of the Act, in the case of PCBUs, is *Stumpmaster v WorkSafe New Zealand*, a decision of the Full High Court.[131] The four-step methodology set out in *Stumpmaster* for sentencing under HSWA is as follows:[132]

(a) assess the amount of reparation;

(b) fix the amount of the fine by reference first to the guideline bands and then having regard to aggravating and mitigating factors;

(c) determine whether further orders under ss 152-158 of HSWA are required; and

(d) make an overall assessment of the proportionality and appropriateness of the combined packet of sanctions imposed by the preceding three steps. This includes consideration of the defendant's ability to pay, and also whether an increase is needed to reflect the financial capacity of the defendant.

[192] The Full Court in *Stumpmaster* held that offending by a PCBU could be categorised into four bands of culpability.[133] Those fine bands have, subsequently, been adjusted in the case of individuals who are a PCBU (who face the same maximum penalty as officers) – by simply dividing the *Stumpmaster* bands by five to reflect the lower maximum penalty – as follows:[134]

(a) Low culpability, up to $50,000.

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131 *Stumpmaster v WorkSafe New Zealand*, above n 8.
132 At [35].
133 At [53].
134 *WorkSafe New Zealand Ltd v McRae* [2018] NZDC 22096 at [13].

(b) Medium culpability, $50,000 to $120,000.

(c) High culpability, $120,000 to $200,000.

(d) Very high culpability, $200,000 plus.

[193] *Stumpmaster* identified a list of relevant factors for sentencing PCBUs:[135]

(a) The identification of the operative acts or omissions at issue. This will usually involve the clear identification of the "practicable steps" which the Court finds it was reasonable for the offender to have taken in terms of s 22 of HSWA.

(b) An assessment of the nature and seriousness of the risk of harm occurring as well as the realised risk.

(c) The degree of departure from standards prevailing in the relevant industry.

(d) The obviousness of the hazard.

(e) The availability, cost and effectiveness of the means necessary to avoid the hazard.

(f) The current state of knowledge of the risks and of the nature and severity of the harm which could result.

(g) The current state of knowledge of the means available to avoid the hazard or mitigate the risk of its occurrence.

[194] An issue arises in this case as to the application of those factors to officers.

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[135] *Stumpmaster v WorkSafe New Zealand*, above n 8, at [36], citing *Department of Labour v Hanham & Philp Contractors Ltd* (2008) 6 NZELR 79 (HC) at [54].

The Judge's sentence

[195] After summarising the reasons for verdict and the legal framework, the Judge addressed the first disputed issue at sentencing – whether the relevant factors from *Stumpmaster* applied to an officer. The Judge accepted MNZ's submission that the *Stumpmaster* factors remain relevant but require a degree of modification where the defendant is being prosecuted as an officer of a PCBU, because the officer's duty exists in relation to the PCBU's primary duty under HSWA.[136]

[196] As to the first step of the *Stumpmaster* methodology, the Judge accepted that previous arrangements between POAL and Mr Kalati's family properly addressed the harm caused and it was not necessary or appropriate to make any further orders for reparation.[137]

[197] As to the amount of the fine, the Judge again referred to his reasons for verdict and to POAL's sentencing. The Judge concluded that Mr Gibson's offending fell in the bottom half of the high culpability band. The Judge adopted a starting point of a fine of $140,000.[138] The Judge accepted there were no aggravating factors and applied a reduction of $10,000 to reflect Mr Gibson's "fall from grace".[139] The Judge declined to make a further reduction for co-operation through the trial.

[198] As to ancillary orders, the Judge concluded that $60,000 was an appropriate award of costs under s 152 of HSWA.[140]

[199] In terms of the final overall assessment step, the Judge concluded that the combined packet of sanctions of a fine of $130,000 and a costs award of $60,000 was a proportionate and appropriate outcome.[141]

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136 *Maritime New Zealand v Gibson*, above n 4, at [18]-[31].
137 At [38].
138 At [67].
139 At [73].
140 At [87].
141 At [88].

Approach on appeal

[200] Sentence appeals are governed by s 250 of the Criminal Procedure Act 2011. The Court must allow the appeal if satisfied that, for any reason, there is an error in the sentence imposed on conviction and a different sentence should be imposed.[142] Otherwise, the Court must dismiss the appeal.[143]

[201] When considering whether a different sentence should be imposed, I have regard to the end sentence – here the combined packet of sanctions – rather than the process by which it was reached. It is appropriate for the Court to intervene where the sentence being appealed is "manifestly excessive" and not justified by accepted sentencing principles.[144]

Discussion

[202] Mr Gibson appeals his sentence on the basis that it was manifestly excessive due to the following errors:

(a) the Judge erred in law by using the culpability factors from *Stumpmaster* pertaining to PCBUs to assess Mr Gibson's culpability as an officer;

(b) in any event, the Judge wrongly assessed culpability, and set a manifestly excessive fine by holding his conduct to be "in the bottom half of the high culpability band";

(c) the Judge gave an insufficient discount for Mr Gibson's personal mitigating features and conduct at trial; and

(d) the Judge erred in ordering costs of $60,000 pursuant to s 152 of HSWA, including by referencing grounds advanced under an application under s 364 of the Criminal Procedure Act.

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142 Criminal Procedure Act, s 250(2).
143 Section 250(3).
144 *Tutakangahau v R* [2014] NZCA 279, [2014] 3 NZLR 482 at [33]-[36].

[203] I deal with these grounds in turn.

Application of the Stumpmaster factors to officers

[204] The first ground is that the sentencing Judge erred in law by using the culpability factors from *Stumpmaster* to assess Mr Gibson's culpability as an officer.

[205] I acknowledge that the Full Court in *Stumpmaster* was addressing relevant factors for sentencing PCBUs. The Court did not have to address an officer's departure from the due diligence standard, and did not do so. Indeed, the Court declined to address the position of individuals.[145]

[206] In sentencing, as with Mr Gibson's breach addressed above in the conviction appeal, I accept it would be an error to conflate the separate duties of PCBU and officer. I also accept that the difference between the separate duties is likely more acute in cases involving large PCBUs (and so the issue of direct application of the *Stumpmaster* factors in previous sole-operator or small PCBUs cases may not have been material).[146]

[207] In any event, in this case the Judge accepted MNZ's submission that the *Stumpmaster* factors remain relevant but require a degree of modification where the defendant is being prosecuted as an officer of a PCBU.[147] The Judge did not use the *Stumpmaster* factors without modification. In particular, he reminded himself:[148]

> … that the duty imposed on an officer differs from that imposed on the PCBU. The assessment must be directed at what the officer should have done to ensure that the PCBU complied with its duty or obligation, with a focus on the individual officer's conduct, knowledge and efforts.

[208] I consider the Judge did not err in law by using the culpability factors from *Stumpmaster*. I do not accept the submission that this was a continuation of the Judge's misguided focus on the PCBU. It is unnecessary to craft a separate set of factors applicable to officers – and it is not my role to attempt a guideline judgment

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145 *Stumpmaster v WorkSafe New Zealand*, above n 8, at [21].

146 For example, in *Nino's Ltd v Maritime New Zealand* [2020] NZHC 1467 at [36] it was noted that Nino's and its sole director, while distinct legal entities, were clearly interwoven.

147 *Maritime New Zealand v Gibson*, above n 4, at [30].

148 At [32]. The Judge repeated a similar reminder at [57].

for sentencing officers. The important point in a case involving an officer's lack of due diligence (omission), as the Judge said, is that assessment of an officer's culpability must be directed at what the officer should have done to ensure that the PCBU complied with its duty. With that caveat, the *Stumpmaster* factors are a convenient list to use in the assessment of an officer's culpability for failing to exercise due diligence. They are readily adapted to refer to the acts or omissions of an officer relevant to that separate duty – that is, to reflect the differences between the duties under ss 36 and 44.

[209] Indeed, I have no issue with Ms Lanham's submission that the degree of departure from the standard of care is a relevant factor. I see this as a necessary modification or adaptation of the degree of departure factor in *Stumpmaster*, which reflects the mandatory factor in s 151(2)(f) of HSWA. The mandatory s 151 factors apply to convictions under s 48 irrespective of the duty breached – but the application of s 151 depends on the breach of duty in issue. Thus, the Judge's reference to the degree of departure from relevant industry standards was inapt insofar as it referred to the PCBU's degree of departure rather than Mr Gibson's degree of departure from his duty.

[210] I accept Ms Lanham's submission that the officer's state of knowledge and the extent to which the officer's failure caused the risk are relevant, but they too can be appropriately accommodated within the s 151 criteria and the *Stumpmaster* factors.

Mr Gibson's culpability

[211] The second ground is that, in any event, the Judge wrongly assessed culpability and set a manifestly excessive fine by holding Mr Gibson's conduct to be in the bottom half of the high culpability band.

[212] Ms Lanham emphasised that in relative terms this placed Mr Gibson's culpability only slightly below that of POAL. She submitted that Mr Gibson's failures had to be assessed against the totality of what he did to ensure exclusion zones around cranes were properly understood and adhered to at POAL. She submitted that the Judge erred in placing the offending in the high culpability band because he rejected

the submission that culpability is to be assessed in the context of how the officer exercised due diligence during the charging period.

[213] Ms Lanham also emphasised that MNZ's acknowledgements about Mr Gibson on appeal should be contrasted with their more critical approach at sentencing. She submitted that the starting point should have been no more than $50,000, reflecting the top of the low culpability band. She compared this case with *Nino's Ltd v Maritime New Zealand* where a "gross" departure was found to be at the top of the medium band.[149]

[214] I have already observed that MNZ overstated criticism of Mr Gibson at trial and I accept this continued at sentencing. However, I focus on the Judge's assessment.

[215] While I accept the degree of departure from the standard of care is a relevant factor, the Judge was correct to reject the submission that the extent to which the officer fell below the requisite standard must be assessed by reference to the officer's general compliance with the requisite standard "across the board".[150] The Court's focus must be on the nature and gravity of the breach, assessed in an holistic manner (as the Judge said), not on matters unrelated to the breach. Unrelated good conduct may well be relevant when it comes to assessing factors personal to the offender – such as previous good character – but is not relevant to the culpability of the offending itself. I accept, however, that what relates to the breach is fact-specific, depending on the nature of the due diligence failure in issue. In this case, the omissions found by the Judge comprised both specific and more general matters. I accept that positive steps taken in relation to each of these matters – specific or general – were relevant to assessing the nature and gravity of the breach.

[216] Therefore, I accept the relevance of positive steps taken, for example, to increase safety observations to ensure that workers were complying with established safe systems of work and not developing unsafe work cultures. As Ms Lanham submitted, this is not a case where Mr Gibson exercised no due diligence. Some of Mr Gibson's many positive steps were relevant to the degree of departure from the

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149 *Nino's Ltd v Maritime New Zealand*, above n 146, at [27] and [59].
150 *Maritime New Zealand v Gibson*, above n 4, at [34]-[35].

standard of care. He was party to POAL's journey towards a safe system. However, I do not accept the submission that the nature and gravity of the breach can be characterised as concerning one critical risk in one area of a complex PCBU, committed by an officer who otherwise carried out his s 44 duties and took various steps to provide vast resources and processes. That seeks to include due diligence in unrelated matters.

[217] Further, the PCBU's positive steps are likely only relevant to the nature and gravity of the officer's breach if the officer was involved in them or reasonably relied on them. Here, the existence of the three-container width exclusion zone policy adds little for the reasons set out above at [183](b).

[218] As indicated above, the extent of the PCBU's failure (or the failure of others) is not to be attributed to the officer, but may be relevant context in relation to the officer's due diligence failure.

[219] I agree with the Judge that the omissions most directly linked to the eventual fatality were Mr Gibson's failures to take reasonable steps to ensure that POAL properly understood and monitored work as done on the night shift and the failure to have additional hard or technical controls put in place to manage the risk of handling overhead loads.[151] The serious risk of harm resulting from handling suspended loads was identified as a critical risk. In his substantive judgment, the Judge found Mr Gibson's breach of his s 44 duty made it materially more likely that POAL would breach its duty of care in a manner giving rise to the risk of death or serious harm, albeit not an immediately operative cause of the risk and realised harm.[152] Risk of injury or death and whether death or injury occurred are mandatory factors to which the Court must have particular regard.[153]

[220] I accept the straddle carrier fatality did not pertain directly to the exclusion zone and Mr Gibson did respond to that fatality with health and safety improvements.

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151 *Maritime New Zealand v Gibson*, above n 4, at [41].
152 At [500].
153 HSWA, ss 151(2)(c) and (d).

His relevant failure was that he did not extrapolate the learnings from that fatality to the risk of lasher non-compliance at night and prioritise monitoring that.

[221] I also accept this was not a case where Mr Gibson had clear knowledge and guidance that more was needed in respect of his due diligence in relation to POAL's exclusion zone around cranes. I accept he did not have actual knowledge of the stevedores engaging in unsafe practices or cutting corners on the night shift. I also accept this was not a case of wilful blindness. But nor was it a "one off" lapse of judgement. Mr Gibson should have known that more needed to be done, particularly in relation to implementing and monitoring compliance with POAL's exclusion zone policy. Without characterising the omission as grossly negligent, failing to both recognise the need for further action and to take it was more than a minor departure from the standard of care expected of an officer in his position. It was an ongoing failure in relation to one of POAL's known critical risks. The degree of departure is relevant as an aggravating factor, but is only one of several mandatory factors to be considered under s 151 of HSWA.

[222] Another, related factor is the availability, cost and effectiveness of the means necessary to avoid the hazard. Even though Mr Lander's proposed crew restructure raised an issue with the OPCs' employment contracts, Mr Gibson was well placed before the fatality to support Mr Lander's initiatives and require other subordinates to verify that POAL's systems functioned as they should. Further, the ready availability of additional hard, non-technological controls was demonstrated by their swift implementation after the fatality.

[223] I also have regard to the principles and purposes of sentencing. As the Judge said, the relevant purposes of sentencing here are to hold Mr Gibson accountable for harm done to the victim and the community by the offending, to promote in Mr Gibson a sense of responsibility for that offending, to denounce the offending, and to deter others from committing like offences.[154]

[224] I was referred to several cases, but none of them involved an organisation of POAL's scale or as many people exposed to serious health and safety risk. *Nino's Ltd*

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154 *Maritime New Zealand v Gibson*, above n 4, at [15].

v Maritime New Zealand involved the capsize of an overloaded fishing boat – with no physical harm – in a business of around 50 staff.[155] The sentencing Judge described the offending as a "gross departure" from industry standards.[156] Appeals against sentence by the PCBU, the sole director/senior officer and the skipper were dismissed. For the sole director, a starting point of $120,000 (top of the medium band) was upheld. Although it was accepted the sole director/officer (and the skipper) was not aware of the load limit, it was also a case where the officer should have known of an obvious risk.[157]

[225] Parity with POAL is relevant here. Judge M-E Sharp considered POAL's offending fell into the higher end of the high culpability band and set the starting point at $850,000.[158] As Judge Bonnar said, this would equate to $170,000 under the bands applicable to the sentencing of individuals.[159] However, as the Judge accepted, it is relevant that the starting point adopted for POAL was a global one, that POAL was convicted of offences of which Mr Gibson was not and that the particulars of the offence in the case of POAL were framed more broadly.[160] The Judge's starting point of $140,000 for Mr Gibson was approximately 18 per cent below $170,000.

[226] Overall, having regard to the omissions most directly linked to the realised fatality, and the other general and less serious omissions, I do not accept that Mr Gibson's offending was in the low culpability band (up to $50,000). In particular, I do not accept that the degree of departure from industry standards reinforces that his culpability was low. As indicated, in the context of an officer's breach, it is the departure from industry standards relating to the officer's standard of care that matters. The risk and realised harm – Mr Kalati's tragic death – are also relevant. I also do not accept the submissions that there was no such evidence and/or the defence evidence was to be preferred for essentially the same reasons as in the conviction appeal.

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155 *Nino's Ltd v Maritime New Zealand*, above n 146.
156 *Maritime New Zealand v Nino's Ltd* [2020] NZDC 2536 at [31].
157 *Nino's Ltd v Maritime New Zealand*, above n 146, at [55]-[56].
158 *Maritime New Zealand v Port of Auckland Ltd* [2023] NZDC 26957 at [41]. Although the judgment referred to MNZ's submission that culpability sat at the higher end of the *Stumpmaster* very high culpability band (at [39]) and the Judge's reference to the highest band of culpability (at [42]), the Judge also referred to MNZ's submission seeking "Towards the top end of the high culpability band." (at [40]). Given the figures, the latter is the intended band.
159 *Maritime New Zealand v Gibson*, above n 4, at [60].
160 At [66].

Reference to the lack of evidence of industry practice relating to hard controls and the exclusion zone at other New Zealand ports conflates the separate duties and also conflates industry practice with industry standards.

[227] Even so, I consider the Judge's assessment that the offending was in the bottom half of the high culpability band somewhat overstated the culpability. That indicates a starting point range of between $120,000 and $160,000. I consider the offending was nearer the bottom of the high culpability band, which equates to the top of the medium culpability band ($120,000). Even so, while the starting point of $140,000 may have been stern, I do not consider it was outside the appropriate range.

Reduction for Mr Gibson's personal mitigating features and conduct at trial

[228] Mr Barton addressed this part of the appeal for Mr Gibson. He submitted that the Judge's seven per cent reduction gave insufficient credit for Mr Gibson's personal mitigating features and conduct at trial and that Mr Gibson was entitled to at least a 10 to 15 per cent credit for these factors.

[229] I first observe that in *Stumpmaster* the Full Court noted there had been routine standard discounts in previous cases and emphasised that proper analysis of the basis for credit is required.[161]

[230] Mr Barton emphasised Mr Gibson's good character references that had been provided for sentencing. Those references came from POAL staff, others who worked with him at POAL or elsewhere, and personal friends. I accept those references are very positive. I also acknowledge they reflect Mr Gibson's good character.

[231] The seven per cent reduction for Mr Gibson's "fall from grace" may have reflected the Judge's observation that applying a discount for previous good character did not sit easily with the policies and purposes underlying sentencing in a case like this.[162] I accept that the offence is one of strict liability and therefore does not require proof of knowing moral culpability. I also accept that many officers of large PCBUs will be of previous good character. However, s 9(2)(g) of the Sentencing Act requires

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161 *Stumpmaster v WorkSafe New Zealand*, above n 8, at [57]-[67].
162 *Maritime New Zealand v Gibson*, above n 4, at [71].

the Court to take into account any evidence of the offender's previous good character to the extent it is applicable in the case. Of course, the appropriate reduction may be tempered according to competing statutory purposes, principles and factors. The competing considerations require judges to dispense individualised justice in the sense that sentencing decisions must reflect a careful evaluation of the circumstances of the offending and of the offender.[163]

[232] While the Judge's finding that Mr Gibson was on notice of POAL's failings in monitoring work as done while he was CEO was relevant to his culpability, taking it into account to temper the reduction for previous good character risked double counting and attributing POAL's previous convictions – or "safety record" in terms of s 151(2)(e) – to Mr Gibson. However, I accept the reduction for previous good character could be tempered given Mr Gibson's omissions in the charging period extended over a period of 15 months.

[233] The seven per cent reduction for previous good character was not generous, but nor was it out of range.

[234] I do not consider the Judge erred in declining to give credit for Mr Gibson's co-operation at trial. I accept that Mr Gibson did not require oral evidence from any staff working on the night Mr Kalati died. There was also an agreement under s 9 of the Evidence Act 2006 to reduce the need for evidential detail. However, the Judge was best placed to assess whether Mr Gibson's overall co-operation at trial warranted a reduction.

Costs award

[235] Section 152(1) of HSWA provides:

> **152 Order for payment of regulator's costs in bringing prosecution**
>
> (1) On the application of the regulator, the court may order the offender to pay to the regulator a sum that it thinks just and reasonable towards the costs of the prosecution (including the costs of investigating the offending and any associated costs).

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163 *Berkland v R* [2022] NZSC 143, [2022] 1 NZLR 509 at [89].

[236] It is common ground that, if costs are awarded under s 152, they need to be considered as part of the overall packet of sanctions.[164]

[237] In relation to the Judge's award of costs of $60,000, Ms Lanham submitted that the Judge denied Mr Gibson natural justice. MNZ had separately sought costs under s 364 of the Criminal Procedure Act (which provides for costs orders in the event of significant procedural failure without reasonable excuse) in respect of the late disclosure of Mr Dekker's expert evidence. After telling counsel that he did not need to be addressed on s 364, the Judge declined to make an order under s 364 but said there was some merit in MNZ's submission that the conduct of the defence at trial contributed to the length of the trial and increased costs. In that respect, the Judge referred to the parties' respective submissions addressing s 364 and the issues concerning late significant amendments to the defence expert evidence, immediately prior to that expert being called at trial.[165]

[238] It is unclear whether the Judge's indication to counsel at the sentencing hearing not to address s 364 deprived Mr Gibson of the opportunity to make submissions on the late disclosure in the context of s 152. However, Mr Bain for MNZ did not dispute there may have been a natural justice issue. Another possibility is that there was simply a misunderstanding between the Judge and counsel as to what was meant by not needing to address s 364. Whatever the explanation, as Mr Billington submitted, it may not have been justified to attribute counsel's trial conduct to Mr Gibson.

[239] More substantively, Ms Lanham submitted that the costs award was not justified on the facts. In relation to the late disclosure of Mr Dekker's expert evidence, I accept that since his evidence was admitted – and indeed the prosecution relied on it – the costs of dealing with it were not wasted. It may also be that the prosecution's amendment to the charge approximately 10 working days before trial necessitated amendment to defence expert briefs at a late stage. Mr Kahler's amended report following the charge amendment was apparently served only eight working days before trial. Prior to that, at a judicial teleconference, it had been agreed that the defence briefs would be served in the following week. I also accept that amendment

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164 *Stumpmaster v WorkSafe New Zealand*, above n 8, at [25].
165 *Maritime New Zealand v Gibson*, above n 4, at [83].

of the defence briefs during trial may have resulted at least in part from additions to the prosecution case, with exhibits added on several occasions.

[240] Ms Lanham also submitted the Judge did not provide Mr Gibson's counsel with the opportunity to respond to other matters he took into account – that the defence did not agree to pre-trial expert witness conferencing and declined to permit MNZ to refer directly to the defence expert evidence when leading the prosecution experts. The basis for this submission was not substantiated and a denial of natural justice is not made out. However, I accept that at least the second of these criticisms of the defence might have been misplaced.

[241] In any event, a costs award under s 152 is not dependent on any such criticism of the defence. As the Full Court said in *Stumpmaster*, a s 152 costs order is not reserved for cases where extra punishment is merited. There is nothing in the legislative scheme to suggest that, and costs orders in the regulatory context are commonplace.[166]

[242] Ms Lanham also raised other matters weighing against a $60,000 costs award by reference to the factors identified by the Court of Appeal in *Balfour v R*.[167] That case involved costs under s 4 of the Costs in Criminal Cases Act 1967, which also contains a discretionary power to order a convicted defendant to pay such sum as the Court thinks "just and reasonable" towards the costs of the prosecution. In determining what level of contribution is "just and reasonable" the Court identified the following factors as likely relevant:[168]

> … the nature of the charges; the complexity of the trial; the time spent on the case; the conduct of the parties; the extent of the success of the prosecution; the sentence imposed; the defendant's financial position; and whether the defendant was legally aided. …

[243] In relation to the present case, Ms Lanham raised the following matters:

(a) the Judge held that Mr Gibson had an arguable defence;

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166 *Stumpmaster v WorkSafe New Zealand*, above n 8, at [107].
167 *Balfour v R* [2013] NZCA 429 at [135].
168 At [135].

(b) this was the first case of its kind;

(c) MNZ lost on half its case – the pandemic particular;

(d) despite the agreed facts document, the prosecution led this evidence, repeatedly; and

(e) the trial significantly overran its length.

[244] Even accepting these matters, the Judge was best placed to assess their significance in the context of the proceeding.

[245] In terms of quantum, Ms Lanham noted the amount exceeded the $40,000 award in *Worksafe New Zealand v Inflite Charters Ltd*,[169] which the Judge cited. Ms Lanham submitted the Judge did not explain why costs beyond this were justified for an officer, not a corporate PCBU. In that case, concerning the Whakaari White Island tragedy, Judge E M Thomas said:

> [39] There has developed something of a rule of thumb that [prosecution costs awarded] might be somewhere around 50 per cent of the actual costs of a prosecution. Sometimes that is applied, sometimes it is not, it depends on the circumstances. …
>
> [40] In the more serious cases we have seen come before our courts costs awards of around $20,000 have been made. …

[246] Judge Thomas said the case before him was far more significant in its scope and in the costs incurred than any of those previous "more serious" cases. As indicated, he awarded $40,000. That case involved a guilty plea.

[247] Subsequently, In *Civil Aviation Authority v The Alpine Group Ltd*, Judge R J Walker awarded $64,766.94 (50 per cent of the legal costs and expert report costs) which the parties had agreed (subject to the Court's determination).[170] That case also involved a guilty plea.

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169 *Worksafe New Zealand v Inflite Charters Ltd* [2022] NZDC 5627.
170 *Civil Aviation Authority v The Alpine Group Ltd* [2022] NZDC 20040 at [118].

[248] Sometimes the Court has allowed expert witness costs as well as a contribution towards the prosecutor's own legal costs. In *WorkSafe v Idea Services Ltd*,[171] the defendant pleaded guilty at trial during the prosecution case. Judge J D Large awarded costs of $43,382.71 (50 per cent of legal costs) and $9,240 for expert witness costs (66 per cent).

[249] As in *Inflite Charters*, this case involved a prosecution against more than one defendant. POAL pleaded guilty and the sentencing Judge ordered it to pay $90,000 towards the costs of the prosecution given that the prosecution was "shared" between two defendants.[172]

[250] Since the case against Mr Gibson went to trial, MNZ's further costs were very substantial – irrespective of which party contributed to the length of trial. The Judge accepted the prosecution costs incurred were appropriate.[173]

[251] At least in the cases cited, any rule of thumb of around 50 per cent of the actual costs of a prosecution appears reserved for modest cases. It was not appropriate in *Inflite Charters* and was not appropriate here. Indeed, MNZ did not seek that, nor 66 per cent of its expert witness costs. It sought a contribution to costs of $180,000. As indicated, the Judge awarded $60,000. I do not accept MNZ's submission that the Judge erred by benchmarking the costs against those awarded in other cases. The Judge was entitled to take into account that the award sought by the prosecution far exceeded any previous awards. Accepting that costs should be decided on a case-by-case basis, I consider the Judge's award was appropriate and certainly within range given the nature of the case, the amount of the fine, the purpose of s 152 and MNZ's actual legal costs, even if a reduction was appropriate given Mr Gibson's arguable defence and the not guilty verdict on the pandemic particular.

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171 *WorkSafe v Idea Services Ltd* [2021] NZDC 15269.

172 *Maritime New Zealand v Port of Auckland Ltd*, above n 158, at [65].

173 *Maritime New Zealand v Gibson*, above n 4, at [85]. Excluding costs before POAL's sentencing, MNZ's total legal costs (excluding disbursements) were approximately $440,000. Expert witness costs were approximately $255,000.

Proportionality

[252] Ms Lanham submitted that on overall proportionality grounds the combined sanction of $190,000 was too high. She referred to *Maritime New Zealand v C 3 Ltd*,[174] where Judge N J Sainsbury ordered costs of $20,000, saying that the PCBU had been generously treated in not having to pay costs on a previous occasion so that MNZ was entitled to a significant contribution. Judge Sainsbury noted it needed to be a contribution that was reasonable and did not inappropriately inflate the overall penalty.

[253] Ms Lanham also submitted that $190,000 was disproportionate as, in effect, it set the penalty at the top end of high culpability band and just below the very high culpability band.

[254] While costs need to be considered as part of the overall packet of sanctions, that does not mean the combined amount should be assessed by reference back to the starting point culpability bands. That would largely negate the statutory purpose and four-step methodology in relation to awarding costs.

[255] There was no suggestion that Mr Gibson could not pay a substantial fine.

[256] Stepping back and assessing the overall packet of sanctions, I consider that $190,000 is not manifestly excessive.

[257] Accordingly, the appeal against sentence is dismissed.

Non-publication

[258] The permanent non-publication orders made in the District Court in respect of the names, addresses and identifying particulars of the following witnesses and/or port workers remain in place:[175]

(a) [LB];

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174 *Maritime New Zealand v C 3 Ltd* [2022] NZDC 2106 at [104].

175 *Maritime New Zealand Ltd v Gibson* District Court Auckland CRI-2021-004-6221, Minute dated 21 May 2024.

(b) [KM];

(c) [REDACTED];

(d) [REDACTED];

(e) [REDACTED];

(f) [REDACTED];

(g) [REDACTED];

(h) [REDACTED]; and

(i) [REDACTED].

Gault J

Solicitors / Counsel:
Mr J R Billington KC, Ms HMZ Lanham and Mr G H Barton, Barristers, Auckland
Mr E A Boshier (appellant's instructing solicitor), Duncan Cotterill, Auckland
Ms SAH Bishop, Mr T Bain and Ms L K Eastlake, Luke Cunningham Clere, Office of the Crown Solicitor, Wellington