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IN THE DISTRICT COURT
AT AUCKLAND

I TE KŌTI-Ā-ROHE
KI TĀMAKI MAKAURAU

CRI-2021-004-006221
[2024] NZDC 27975

MARITIME NEW ZEALAND
Prosecutor

v

ANTHONY MICHAEL GIBSON
Defendant

Hearing:	8 April – 28 May 2024
Appearances:	S Bishop, T Bain, L Eastlake and S Hartley for the Prosecutor J Billington KC, H Lanham and E Boshier for the Defendant
Judgment:	26 November 2024

RESERVED JUDGMENT OF JUDGE S J BONNAR KC

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The death of Pala'amo Kalati

[1] In the early hours of the morning of 30 August 2020, Mr Pala'amo Kalati was working his nightshift as a lasher at the Port of Auckland. A lasher is a person who lashes and unlashes stacked shipping containers to the deck of a container ship by the use of metal lashing bars.

[2] Mr Kalati had been working at the port since April 2020. On the morning of 30 August, he was partnered with a fellow lasher, LB. Mr Kalati, LB and other port workers were working in a team or "bubble" by reason of the then Covid-19 pandemic. The team were in the process of unloading containers from the MV Constantinos P which had arrived in Auckland from Brisbane on 29 August 2020.

[3] At 2am Mr Kalati and LB began a rotation of their shift and commenced working on board the vessel. They approached the ship leading hand in their team and asked whether they needed to re-lash containers located at bays 5-7 of the deck of the vessel. Those containers had been mistakenly unlashed by the dayshift. They were directed by the ship leading hand to do so. Mr Kalati began working in the walkway positioned between bays 5-7 and 9-11 on the ship. At that time, containers located in bays 9-11 were being unloaded from the ship by one of the port's gantry cranes.

[4] The port company, Ports of Auckland Limited (**POAL**), had a policy in place that workers, including lashers, should not be located within three container widths (that is, 24 feet or approximately 7.3 metres) of an operating crane. Mr Kalati was working within that exclusion zone.

[5] The crane operator commenced lifting two containers in the penultimate row of containers in bay 9-11 on the seaward side of the ship, the port side of the vessel. Those containers were located in the second tier of containers up from the deck of the ship, with other containers below them. The crane operator was not aware that Mr Kalati and LB were in the walkway next to the bays he was working and was not able to see them from his position in the crane.

[6] One of the twist lock mechanisms on the bottom of the container immediately next to the walkway had not been unlocked. That container was still locked to the

container below at one corner. As the crane operator commenced lifting the two containers from the second tier, the container below was also lifted at that corner. The crane operator recognised that something was wrong with the lift and stopped lifting.

[7] Tragically, however, before the crane operator was able to again lower the containers, the twist lock mechanism failed under the bottom container's weight. That container fell downwards and moved laterally towards Mr Kalati, who was in the process of lashing a container in bay 7. The falling container crushed and killed Mr Kalati. He was 31 years old at the time of his death.

[8] I acknowledge Mr Kalati and I acknowledge the tragic loss suffered by his whanau.

Ports of Auckland Limited is charged and convicted

[9] Following an investigation, Maritime New Zealand (**MNZ**) charged POAL with two offences under s 48(1) of the Health and Safety at Work Act 2015 (**HSWA**). POAL subsequently pleaded guilty to those charges and was convicted.

[10] In terms of the first charge, 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, it admitted that it was reasonably practicable for the company to have not directed or permitted Mr Kalati 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.

[11] The second charge 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 Ferguson 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:

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

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

(c) to 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) to conduct an appropriate risk assessment relating to the removal of the lash leading hand role in response to the Covid-19 pandemic; and/or

(e) to 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

[12] Mr Gibson was the Chief Executive Officer (**CEO**) of POAL from February 2011 until the end of June 2021.

[13] MNZ has charged Mr Gibson, as an officer of POAL, with two charges alleging breaches of ss 48(1) and 49(1) HSWA between 31 May 2019 and 31 August 2020. The charges are laid in the alternative. Both charges allege that Mr Gibson failed to comply with the duty imposed upon him, under s 44 of the HSWA, to exercise due diligence to ensure that POAL complied with its duties or obligations under the HSWA.

[14] In relation to both charges, MNZ alleges that Mr Gibson failed to exercise the care, diligence, and skill that a reasonable officer would exercise in the same circumstances:

(a) to take reasonable steps to ensure that POAL 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, 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 coordination between lashers and crane operators;

(b) to take reasonable steps to verify the provision and use of those resources and processes.

[15] The charge laid under s 48(1) HSWA alleges that, by failing to comply with his duty under s 44, Mr Gibson thereby exposed POAL's stevedores to a risk of death or serious injury, namely, the risk of being struck by objects falling from operating cranes.

[16] The alternative charge, laid under s 49(1) HSWA, alleges the same failure of duty particularised at [14], but does not allege that the failure thereby exposed any workers to a risk of death or serious injury.

General principles

Onus of proof

[17] The starting point is the presumption of innocence. I must treat Mr Gibson as innocent until the prosecution has proved his guilt. The presumption of innocence means that Mr Gibson did not have to give or call any evidence and does not have to establish his innocence. The prosecution must prove that Mr Gibson is guilty beyond reasonable doubt. Proof beyond reasonable doubt is a very high standard of proof which the prosecution will have met only if, at the end of the case, I am sure that he is guilty.

[18] It is not enough for the prosecution to persuade me that Mr Gibson is probably guilty or even that he is very likely guilty. On the other hand, it is virtually impossible to prove anything to an absolute certainty when dealing with the reconstruction of past events and the prosecution does not have to reach that standard.

[19] A reasonable doubt is an honest and reasonable uncertainty left in my mind about Mr Gibson's guilt after I have given careful and impartial consideration to all of the evidence. In summary, if, after careful and impartial consideration of the evidence, I am sure that Mr Gibson is guilty I must find him guilty. On the other hand, if I am not sure that he is guilty, I must find him not guilty.[1]

Prejudice & sympathy

[20] I must come to my verdict solely upon the evidence that was put before me in the trial. I must put aside any feelings of prejudice or sympathy, one way or the other. That is particularly so in this case involving, as it does, the tragic death of Mr Kalati, and in which I have also heard evidence of other serious injury incidents and a previous fatality at the port.

Evidence

[21] I have considered all the evidence which has been placed before me, including the evidence of the various witnesses who gave oral evidence, the recorded statements and interview transcripts of other witnesses, the exhibits produced and the agreed statement of facts. In weighing that evidence, I have regard to the submissions made to me by counsel. It is for me to decide, however, what evidence I accept and do not accept.

Defendant giving evidence

[22] Mr Gibson chose to call and give evidence in this case. He did not have to do so. The fact that he did so does not change who must prove the allegations. It is the prosecution who has the task and Mr Gibson does not have to establish his innocence. The question remains the same at all times: has the prosecution proved Mr Gibson's

[1] *R v Wanhalla* [2007] 2 NZLR 573 at [49] (CA).

guilt beyond reasonable doubt? What Mr Gibson said in evidence is evidence like all other evidence in the case. By deciding to give evidence he did not have to prove anything.

[23] Mr Gibson denies the offences. In particular, he denies that he failed to exercise due diligence to ensure that POAL complied with its duties or obligations under the Act. Further, he says that if he is found to have failed in that duty, his failure did not thereby expose POAL's stevedores to a risk of death or serious injury.

[24] If I accept his evidence on those central issues then that will be a complete answer to the prosecution case and I must find Mr Gibson not guilty. If what he says leaves me unsure, then I must also find him not guilty because I will have been left with a reasonable doubt. If I do not accept Mr Gibson's evidence on those critical issues, then I must not leap from that assessment to a finding of guilt, because to do so would be to forget who has to prove the case. In that circumstance I must assess all the evidence that I accept as reliable and ask myself whether that evidence satisfies me of Mr Gibson's guilt on either of the charges beyond reasonable doubt.

Inferences

[25] It is necessary for me to draw inferences in order to determine various factual issues in this case including, in particular, whether Mr Gibson exercised due diligence to ensure that POAL complied with its primary duty of care to ensure the safety of workers. It is for me to decide whether I am prepared to draw the necessary inferences. Any inferences I do draw, however, must be conclusions flowing logically from facts which I accept are reliably established. It is not permissible to guess or speculate.

Expert evidence

[26] Both parties called expert evidence.

[27] The prosecution relied on the evidence of Mr Riding and Mr Kahler. Mr Riding is the Managing Director of Marico Marine, a marine consultancy and technology company based in the United Kingdom and New Zealand. He has significant experience in the marine industry, including in shipping, container

operations and port safety. Mr Kahler is the Principal Consultant at InterSafe, a safety consulting company specialising in accident analysis, hazard studies, audits, industry training and advice to the legal profession. He has extensive experience in accident investigation, across many industries, and in health and safety management and systems.

[28] The defence called evidence from Professor Dekker and Mr Marriot. Professor Dekker is Professor and Director of the Safety Science Innovation Laboratory at Griffith University in Brisbane, Australia, and a Professor in the Faculty of Aerospace Engineering at Delft University of Technology in the Netherlands. He is an expert in safety science, involved in research and work over many years in understanding human error, accidents and safety, across a range of different industries. Mr Marriott is an independent health and safety consultant. He provides advice on matters relating to the management and governance of health and safety to a range of organisations in both the public and private sectors. He has significant experience in the nuclear and energy sectors and in safety and risk assessment consultancy generally. He has worked in consultancy roles with over 50 New Zealand organisations.

[29] The expertise and experience of the experts in their various fields was not in dispute, although both parties made submissions as to the extent to which I should rely on the opposing experts' evidence.

[30] Properly qualified experts are permitted to give opinion evidence on subjects within their areas of expertise which are beyond my general knowledge as the fact-finder in this case. An expert's opinion is not inadmissible simply because it may go to, or touch upon, the ultimate issue to be determined in a proceeding.[2]

[31] I have regard to the various experts' qualifications and experience in assessing their evidence. It is, however, for me to assess what weight and importance I give to the evidence of the experts, to the soundness of the factual basis of their opinions and to the other evidence given in the case. This is not a trial by expert.

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[2] Evidence Act 2006, s 25(2).

The legislative framework

[32] It is well-known that the legislative impetus for what would become the 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 the 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.[3]

[33] The Independent Taskforce recommended that New Zealand adopt the Australian model health and safety law, including the model law's imposition of a positive due diligence obligation on officers of Persons Conducting a Business or Undertaking (**PCBU**s).[4] 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 for the purpose of ensuring that those exercising governance functions in an organisation play their part in ensuring that the organisation has an effective health and safety management system in place.[5]

[34] The legislative history makes clear that Parliament's intention in enacting s 44 was to ensure that "directors 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".[6]

[35] The purpose of HSWA is set out in s 3:

> **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—

[3] Rob Jager & others *He Korowai Whakaruruhau / A Protective Cloak: Executive Report* (Independent Taskforce on Workplace Health and Safety, Wellington, April 2013); Graham Pankhurst, Stewart Bell & 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, Wellington, October 2012).
[4] *Executive Report*, above, at 4 & 20.
[5] *Report on the Pike River Coal Mine Tragedy,* above n 2, at 324.
[6] (13 March 2014) 697 NZPD 16705.

(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.

[36] 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,—

(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).

[37] Section 36 imposes a primary duty of care upon a PCBU to ensure, so far as reasonably practicable, the health of safety of workers who work for the PCBU while the workers are at work in the business or undertaking.

[38] Without limiting the generality of that primary duty of care, s 36(3) 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.

[39] Section 44 HSWA 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:

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.

(3) ....

(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).

[40] Subpart 1 of Part 2 sets out key principles relating to duties imposed under the HSWA. 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.

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

The elements of the offences

[42] The elements of the offence under s 48(1) HSWA, as applicable here, are that:

(a) At all relevant times, POAL was a PCBU and was subject to the primary duty of care under s 36 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 the Act 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 HSWA.

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

[43] The elements of the offence under s 49(1) HSWA are identical but exclude the final element above.

[44] The first two elements are not in issue on either charge. It is accepted that POAL was, at all material times, a PCBU and subject to the primary duty of care imposed under s 36. It is further accepted that, at all material times, Mr Gibson was an officer of POAL and subject to the duty imposed under s 44.

[45] Determining whether Mr Gibson failed to comply with his duty under s 44 HSWA requires 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 of the Act.

[46] This is a mixed question of fact and law. In order to determine the issue, the questions I must consider are:

(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?

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

[48] The charged offences are strict liability offences. It is not necessary for the prosecution to establish that Mr Gibson intended to breach his duty under s 44 or that he was reckless as to whether he was in breach of his duty.

[49] The fact that POAL breached its primary duty of care in this case to ensure, so far as reasonably practicable, the health of safety of its workers does 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 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.

Due diligence

[50] As above, the s 44 duty requires an officer to exercise "due diligence" to ensure the PCBU complies with its duties under the Act. Section 44(2) makes clear that the due diligence obligation requires the officer to exercise the care, diligence, and skill that a reasonable officer would exercise in the same circumstances. Subsection (4) further defines due diligence to include (non-exhaustively) the taking of reasonable steps to do or ensure the matters identified in subparagraphs (a)-(f).

[51] Here, the prosecution case is principally focused on Mr Gibson's duties under s 44(4)(c) and (f) to take reasonable steps:

1. To ensure that POAL had available for use and did use appropriate resources and processes to eliminate or minimise risks to health and safety from work carried out as part of its business; and

2. To verify the provision and use by POAL of those resources and processes.

[52] The section must be interpreted from its text and in light of the Act's purpose and context.[7]

[53] In *Sarginson v Civil Aviation Authority* the High Court held that the duty imposed by s 44 is "designed to apply to a wide range of businesses and organisations, small and large, with both flat and hierarchical structures. [8] It is "aimed at ensuring the responsibility for health and safety extends to those at the apex of large hierarchical organisations".[9] The section fulfils the legislative purpose of recognising that directors and officers have "the influence power, power and resources to take initiatives and set patterns" in an organisation and that "if directors and senior managers are unable to find time to take a positive interest in safety and health, it is unrealistic to suppose that this will not adversely the attitudes and performance of junior managers, supervisors and employees on the shop floor".[10]

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[7] Legislation Act 2019, s 9.
[8] *Sarginson v Civil Aviation Authority* [2020] NZHC 3199 at [126].
[9] Above, at [125].
[10] *Inspector Ken Kumar v David Aylmer Ritchie* [2006] NSWIRComm 323 at 325.

[54] The s 44 duties imposed on officers are not limited to governance obligations or functions.[11] 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:[12]

> 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.

[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.

[56] In this context, the parties refer to four New South Wales cases in which prosecutions were brought against officers who were not "hands-on" directors of small corporate entities. Three of those cases pre-date the enactment in New South Wales of the Australian model law.[13] The pre-existing legislation 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

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[11] *Sarginson v Civil Aviation Authority,* above n 8, at [123]-[124].
[12] Above n 8, at [127].
[13] *Work Cover Authority of New South Wales (Inspector Mansell) v Daly Smith Corporation (Aust) Pty Ltd & Smith* [2004] NSWIRComm 349; *Inspector Kumar v David Aylmer Ritchie*, above n 10; *Inspector Aldred v Herbert & Ors* [2007] NSWIRComm 170.

company from contravening the law.[14] The onus was on the director to establish, on the balance of probabilities, the exercise by them of all due diligence.

[57] In *Inspector Mansell v Daly Smith Corporation (Aust) Pty Ltd & Smith,* Mr Smith was the owner and managing director of a labour hire company which operated several branches. In relying upon the defence provided in the Act, Mr Smith submitted that he used all due diligence in order to ensure that his company had discharged its health and safety responsibilities. He further submitted that he had put a system in place to manage health and safety risks and that he adequately supervised compliance with that system. The Court held:[15]

> … Mr Smith did not have such a system in place. He (or rather DSC) had a policy in place. Mr Smith had been directly responsible for that policy being developed. But what he did not do was exercise all due diligence to ensure that that policy became the basis for an entrenched systemic process within DSC designed to ensure the worksites to which the company's employees were sent were safe and free of risks to safety. The management staff at DSC, particularly at branch level, were ill-equipped to do the task that the company's occupational health and safety obligations demanded let alone the company's own policy.
>
> On the evidence before me, Mr Smith took no proactive steps to 'adequately supervise compliance' with the company's policy let alone any system contingent on it. He certainly viewed [DSC's General Manager] as having that responsibility but beyond asserting that belief, there is no evidence that Mr Smith took any steps that could be characterised as all due diligence in that he adequately supervised compliance with any system designed to ensure that the company's policy was being carried out in furtherance of its occupational health and safety obligations.
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> …
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> I accept the import of the submissions of counsel for the prosecution that the words 'all due diligence' have a wider import than the words 'due diligence'. Certainly, in order to discharge his onus, Mr Smith must establish that, on balance, he did all that was required to ensure the putting in place of a system of work within DSC designed to identify and manage risks to safety in his employee's worksites. On that approach, I accept the submission on behalf of the prosecution that that is not done by merely hoping others would or could do what they were told, but also ensuring they have the skills to execute the job they are required to do and then ensuring compliance with that in accordance with the safe standards established. Compliance requires a process of review and auditing, both formal and random, in order to ensure that the safe standards established are in fact being adhered to and under ongoing review. Both in relation to his management employees and in relation

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[14] Occupational Health and Safety Act 1983 (NSW), s 50 (repealed).

[15] *Work Cover Authority of New South Wales (Inspector Mansell) v Daly Smith Corporation (Aust) Pty Ltd & Smith,* above n 13, at [131-132] and [134].

> to employees such as Mr Rowe, Mr Smith did not do that. As such, his defence as to all due diligence must fail.

[58] In *Inspector Ken Kumar v David Aylmer Ritchie,*[16] Mr Ritchie was a director and the chief executive officer of a group of some 30 companies. As CEO, he was responsible for 1600 employees across 80 worksites in Australia and New Zealand. He resided in Auckland. One of the group's employees was killed while working in one of the companies' businesses in New South Wales.

[59] At the time of the fatality Mr Ritchie was responsible for the entire business, which was structured into seven divisions. The company which employed the deceased worker was one of 8-10 businesses within one division, the Container Division. The day-to-day operation of the various divisions was managed by a General Manager and each General Manager, in turn, relied upon employees with extensive experience and expertise in their field. As CEO, Mr Ritchie reported to a board of non-executive directors. Mr Ritchie relied upon his General Managers to keep him informed about what was happening in each aspect of the business. The group also employed a Human Resources Manager who was responsible for health and safety across all divisions. Mr Ritchie met with the Human Resources Manager on average two to three times per week. He received monthly reports from the heads of each division and a monthly meeting of the executive committee took place. The monthly reports and the executive meetings were specifically required to deal with health and safety issues and that became a specific agenda item for the executive committee meetings. As a result of that process and the receipt of reports, Mr Ritchie was informed of incidents, safety audits and the safety regulation of the divisions. There were regular workplace audits to ensure workplace safety and the group, as a whole, was meeting regulatory requirements.

[60] Mr Ritchie reported directly to the board each month by way of a report prepared with the assistance of the company secretary. That report dealt with health and safety matters and relied on reports from the divisions and, also, Mr Ritchie's discussions with divisional regional managers. Mr Ritchie was not personally involved in the occupational health and safety systems of any particular business as he

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[16] *Inspector Ken Kumar v David Aylmer Ritchie*, above n 10.

lacked the specialist knowledge and expertise to undertake that role. The relevant experience, knowledge and expertise was held by the General Managers of the divisions who relied on their own specialists with knowledge of the relevant industries and best practice. Mr Ritchie had no general knowledge of the work methods and procedures employed in the relevant company at the time of the fatality.

[61] Mr Ritchie submitted that he was too remote from the particular operation to effectively influence the conduct of that company.[17] In the context of whether he had exercised all due diligence to prevent the company's contravention,[18] he submitted that he had done all that could reasonably be expected of him and that it would be unrealistic to require more of a person in his position in an organisation as large as this particular group of companies. The Court rejected those submissions:[19]

> Mr Ritchie was in a position to have reports made to him and policies endorsed addressing each and every aspect of this comprehensive failure by the company. This did not necessarily involve him or require him to become involved in day to day operations in a hands-on way but required effective reporting lines and recommendations from those with expertise in aspects of this specialist operation. He was a Director of a company that had as part of its operation the cleaning of ISO tanks, some of which contained chemicals and materials that were hard to remove. As a Director, he had to be active diligent in requiring information about the nature of that business, the chemicals being addressed, the risks thrown up by having to work with those chemicals, obtaining expert advise as to the best way to remove risks from the operation and ensure the safety of employees at each site. The system should have made him aware of the existence of [the relevant chemical] and how that was to be properly and safety dealt with when cleaning tanks at any of its sites.

[62] The Court went on:[20]

> Mr Ritchie then submits, in the alternative, that, being a director, he used all due diligence to prevent the contravention by the corporation. In support of this submission, Mr Ritchie relies upon the extensive systems of safety operated by the company and also his own significant involvement in the creation and maintenance of that system. None of that evidence, however, demonstrates to the civil standard that Mr Ritchie had used all due diligence to prevent the contravention by the corporation. His ignorance of the nature of the wash operation, the chemicals used, the dangers exposed by the use of those chemicals, the need to properly earth the wash facility and the absence of appropriate protective clothing … means that it is quite impossible to make a finding that he used all due diligence in his regard. Once this incident had occurred, the company was able to move quickly and thoroughly to address

[17] The first defence provided by s 50 of the Occupational Health and Safety Act 1983.
[18] The second defence provided by the section.
[19] *Inspector Ken Kumar v David Aylmer Ritchie*, above n 10, at [173].
[20] Above n 10, at [177] and [178].

> the risks in their various and numerous facets. If the hallmark of this defence is that the defendant would need to show that he had laid down a proper system to provide against contravention of the Act and had provided adequate supervision to ensure that the system was properly carried out, then Mr Ritchie's defence case fails. The evidence does not disclose a director's mind concentrated on the risks of this operation or addressing systems so that those risks will be exposed to the directors in order that they might take steps to address those risks. It cannot be said in the present case that the contravention was due to simple human error of an otherwise particularly well-equipped worker who, had he abided by the system laid down, would have avoided the risk inherent in the operation.
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> …
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> In the light of the duties imposed by the Act, it would be unusual for this defence to be made out simply by a director saying that he or she was too busy with the other aspects of the business, or indeed with other businesses, to take steps to ensure the safety of persons at the corporation's place of work. The evidence relied upon by the defendant does not establish that he was unable to influence the conduct of the corporation in relation to its contravention – quite to the contrary, that evidence points to both capacity and ability to influence the conduct of the corporation in relation to the contravention of the Act. The evidence shows no more than that Mr Ritchie was very busy. It is difficult to understand why a hands-on director, running his own company and being very busy, for example, with the financial aspects of that company, might nevertheless be in a position to influence the conduct of the company in relation to the contravention of the Act but that a head office based director, remote from the workplace in a larger organisation, would be able to establish a defence. It seems rather that there needs to be demonstrated something that is particular about either the status or circumstances of the director that leads such a director to be unable to influence the conduct of the corporation in relation to a particular breach. In the present case, Mr Ritchie had the status and there had been circumstances in which he had influenced the conduct of the corporation in relation to safety matters so that it might not come into contravention of the Act. In relation to this particular contravention there was nothing about his status or his circumstances that stopped him from being able to influence the conduct of the corporation in relation to the contravention but rather, he chose a course of involvement in safety that primarily left safety issues in the hands of others: in making that choice, in my view, he is not able to make out a defence under s 26(1)(a).

[63] In *Inspector Aldred v Herbert & Ors* the defendants were directors of a company which owned and operated a hotel.[21] A local boy, who was not a guest of the hotel and who did not have permission to be on the premises, was electrocuted after swimming in the hotel pool. He had come into contact with a badly corroded metal conduit pipe carrying electrical cabling. The company had breached its duties under the relevant legislation by reason of its failure to maintain the electrical cabling housed inside the metal pipe, its failure to ensure that appropriate safety equipment

[21] *Inspector Aldred v Herbert & Ors*, above n 13.

was fitted to the electrical circuitry and its failure to conduct an adequate risk assessment in relation to the electrical cabling. The company had also failed to implement an adequate maintenance program. The directors sought to rely on the relevant statutory defences, including that they used all due diligence to prevent the contravention of the statute by the company.

[64] The evidence was that the directors knew nothing of how to run a hotel and had, therefore, appointed experienced managers to do so in their stead. They did not expressly address matters of maintenance. The directors submitted that they had employed others with relevant experience in hotel management and maintenance and had to rely on the judgment of those they had employed with the relevant expertise. The Court held that the directors were entitled to rely on others who possessed the relevant experience and expertise only if they satisfied themselves that those other persons, to whom the vital functions of detecting and obviating risks to safety had been delegated, could discharge and were discharging that function. The Court held:[22]

> The application of the above considerations to the evidence here does not reveal directorial minds concentrated on the likely risks to safety involved in running a business or in addressing procedures or processes to expose any risks to safety. According to the defendants they had no knowledge of, and would have been unable to predict any risks to safety arising from the electrical cabling installation located in the semi-enclosed area near the pool and they did not possess the relevant expertise which would have, or might have, enabled them to identify and address those risks. Instead the defendants have maintained that it is sufficient for them to make out the defences under s 26(1) by taking the actions that they did, namely, employing competent managers whom they believed possessed the relevant experience and expertise. But this measure only amounts to a preliminary step and, in my view, more is needed in order to have taken appropriate precautions to the extent required to make out the defence that they used all due diligence to prevent the contravention of the corporation.
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> Nor in my view does "all due diligence" (or "…being in a position to influence", the contravening conduct of the corporation) require as a minimum or threshold requirement that the directors have played a "significant and hands on role" in the corporate defendant's operations or that they have responsibility for day-to-day decision making. ... Much will depend on the circumstances of each individual case. Liability will be attracted where, as here, circumstances reveal that the directors played a limited direct role in the operation of the business, preferring to leave the decision-making, relevantly in relation to safety matters, to the management team but without at the same time making consistent and on-going enquiries aimed at ensuring that

[22] Above n 13, at [66-67].

> management was both capable and competent of discharging the corporation's statutory obligations as to safety.

[65] Mr Gibson submits that the Australian cases decided under the previous legislation are of no or limited assistance. He points out that the repealed legislation placed an onus on directors to establish that they used "all due diligence" to prevent the contravention while, in the present case, the onus is upon the prosecution to establish, to the criminal standard, that Mr Gibson failed to exercise due diligence. Further, he submits that "all due diligence" imports a higher standard of diligence than "due diligence".

[66] I do not accept the submission that the New South Wales cases under the repealed legislation do not assist in the interpretation of what constitutes "due diligence" in the context of the present statute. It does not follow, by reason of the removal of a reverse onus defence and the substitution of a positive duty on officers, that previous cases addressing the concept of due diligence are no longer generally relevant. In the context of statutes dealing with health and safety in the workplace, the same issues will arise notwithstanding that the burden of proof may have shifted.

[67] Further, it is clear from the history and scheme of the HSWA that Parliament intended the duty to exercise due diligence to require an officer to take the same sorts of steps that the Courts identified as having not been taken by the directors in the previous cases. The due diligence requirements prescribed in s 44(4) are the types of actions or steps which the directors were found to have failed to take in the earlier cases.

[68] It is arguable that the words "all due diligence" have wider import than "due diligence".[23] However, in the context of a strict liability public welfare regulatory offence, where there was, at that time, an onus on a defendant to establish the availability of the defence, I consider that the use of the word "all" simply reflects what, in the New Zealand context, would be described as an obligation on a defendant to establish "total absence of fault" because, in such cases, absence of fault is a

[23] Refer *Work Cover Authority of New South Wales (Inspector Mansell) v Daly Smith Corporation (Aust) Pty Ltd & Smith,* above n 13, at [134].

defence, rather than fault being an ingredient of the offence.[24] The use of the phrase "all due diligence," in that context, does not materially alter the analysis of what, in fact, constitutes the exercise of due diligence.

[69] The fourth Australian case to which I have been referred, *SafeWork NSW v Doble,* followed the introduction in New South Wales of the Work Health and Safety Act 2011.[25] Section 27 of that Act imposes the same duty on officers of PCBUs as is imposed under s 44 HSWA.

[70] Mr Gibson places reliance on *Doble* where, on the facts, the District Court of New South Wales concluded that the prosecution had failed to prove that Mr Doble failed in his duty to exercise due diligence. MNZ submits that *Doble* was wrongly decided on the facts but, in any event, is distinguishable, given what is said to be failures on the part of the prosecution in that case to particularise its allegations and to 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 – particularly having regard to the fact that Mr Doble's company had received a number of recent improvement notices from the regulator, highlighting the issue which led to the subsequent fatality and which comprised the company's failure to ensure the health and safety of its workers.

[71] I accept that it is 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.

[72] In its analysis of what the s 27 duty requires of an officer*,* the Court relied on a number of sources, including the three cases to which I have previously referred, with apparent approval.[26] The Court did not suggest that the previous cases were no longer relevant or of assistance in determining the scope of the due diligence duty.

[73] There is, in my view, force in MNZ's submission that the Court's conclusion in *Doble* arose, at least in part, from the failure of the prosecutor there to adequately

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[24] *Civil Aviation Department v MacKenzie* [1983] NZLR 78 (CA).
[25] *SafeWork NSW v Doble* [2024] NSWDC 58.
[26] Above at [50-52] and [58-60].

particularise its allegations and to focus the Court's attention on what it suggested Mr Doble had failed to do. The Court said:[27]

> ... the Doble Summons does not actually plead what Mr Doble should have done to discharge his duty of due diligence. To put it in terms of the legislation, the Doble Summons does not particularise the ways in which Mr Doble failed to exercise due diligence, beyond essentially saying that he should have done something to ensure that Miller complied with its duty. What that something was is not elucidated in the Doble Summons or in the opening submissions ... or closing submissions … for SafeWork.

[74] The Court was left in the position of largely relying on the evidence given by Mr Doble's compliance manager.[28] The Court held that there was no suggestion in the evidence that the compliance manager was anything other than conscientious or that Mr Doble had any reason not to place confidence in him carrying out his work health and safety duties.[29] These findings underpin the Court's ultimate conclusion in *Doble*, albeit that MNZ argues that such findings were wrong on the facts of the case.

[75] Further, the Court noted the failure of the prosecutor to tender appropriate documentary evidence, such as management committee meeting minutes, to support a potential submission that the lack of appropriate entries in the minutes demonstrated a failure by Mr Doble to exercise due diligence.[30]

[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.[31]

[77] None of the Australian cases are, of course, binding on me. I accept, however, that they are of assistance in interpreting the scope of the s 44 duty to exercise due diligence. Having said that, every case must turn on its own facts.

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[27] Above n 25, at [261].
[28] At [263].
[29] At [265].
[30] At [269].
[31] At [264] and [266].

Professional negligence cases

[78] The defence referred me to a number of professional negligence cases relating to breaches of a professional's tortious duty of care.[32] 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.

[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.

Summary of principles

[80] In summary, the legislative framework, purpose and history, together with the authorities to which I have been referred, support the following general principles relating to the exercise of an officer's duty of due diligence:

(a) An assessment of whether an officer has exercised due diligence must, necessarily, be fact and circumstance dependent.

(b) The duty applies to all officers across all PCBUs, large and small, with both flat and hierarchical structures. The fact that an officer may

[32] *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.

operate at the head of a large, hierarchical organisation does not mean that the officer's obligations are diminished.

(c) In the case of large, hierarchical organisations, the duty to exercise due diligence is not limited to governance or directorial oversight functions.

(d) The officer's duty under s 44 is, however, distinct from the duties imposed upon the PCBU. The officer is not required to do everything that the PCBU is required to do to comply with its duties. A failure by a PCBU to comply with its duties does not, of itself, mean that its officers have not complied with their duties to exercise due diligence.

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

(f) Where there are others within the PCBU with assigned health and safety obligations or roles, or who may have more specialised skills or experience in the work carried out, an officer must ensure that such persons have the necessary skills and experience to properly execute their roles and must adequately and regularly monitor their performance to ensure that they are properly discharging their functions in ensuring the PCBU's compliance with its duties.

(g) The officer must also acquire and maintain sufficient knowledge of the operations of the PCBU and the work actually carried out "on the shop floor" to adequately identify and address actual workplace hazards and risks.

(h) An officer does not satisfy the due diligence duty by merely putting in place policies or procedures as to how work is to be carried out. The officer must ensure that entrenched and adequate systemic processes are put in place to ensure that the PCBU complies with its duties. In any large organisation, the existence and adequacy of such systems are key.

(i) An officer must ensure that there are effective reporting lines and systems in place within a PCBU to ensure that necessary information in relation to health and safety, workplace risks, hazards and controls flows to the officer and others in the organisation with governance and supervisory functions. Again, the existence of appropriate systems to monitor, record and direct the flow of relevant information is key, especially in larger organisations.

(j) An officer cannot assume that the PCBU is compliant with its duties under the HSWA in the absence of being told otherwise, or simply assume that the information they receive from their subordinates as to the adequacy or effectiveness of the PCBU's health and safety system and hazard controls is accurate and sufficient. An officer must be proactive in relation to health and safety issues and in a position to properly monitor, verify and interrogate the information they receive.

(k) Due diligence also requires the officer to engage upon, or arrange, an effective process of monitoring, review and/or auditing of the PCBU's systems, processes and work practices to ensure that those systems and processes are achieving their purposes and that relevant safety standards and policies are, in fact, being adhered to.

(l) A court will obtain assistance from evidence 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. However, the Court must objectively determine the reasonableness of the officer's actions

> or omissions in the relevant circumstances. It is not a case of simply comparing the officer's conduct with that of other officers in similar positions. It is no sufficient answer to a charge alleging breach of the s 44 duty to suggest that the officer's conduct was of a standard generally acceptable in the relevant industry at the time. If the officer's actions objectively fall below the standard required by the statute it does not assist the officer that comparator officers may also have routinely been falling below that standard.

The circumstances in which Mr Gibson was acting

The nature and structure of POAL's business

[81] POAL is a limited liability company, incorporated on 27 September 1988. The sole shareholder of POAL is Auckland Council.

[82] POAL is a port company within the meaning of the Port Companies Act 1988. It is involved in a range of services, including passenger services, marine services (for example, pilotage and harbour control), multi-cargo handling, bunkering, engineering, and container handling.

[83] The port is located on the Waitemata Harbour in downtown Auckland and is configured into two main terminals and additional multi-cargo wharves. The Fergusson Container Terminal is POAL's main container handling terminal. It is equipped with cranes capable of loading and unloading containers to and from container ships.

[84] The port is the largest import container port in New Zealand. In 2020, POAL employed approximately 650 employees across its various business units. Approximately 250, or around 40%, of POAL's employees were stevedores. In addition, third party stevedoring companies and contractors operated at the port. Nevertheless, by international standards, POAL's container business constitutes a relatively small container terminal operation.

[85] The various types of work carried out by POAL included:

(a) Container terminal handling services, including delivery, transit, storage and shipment of a wide range of import and export cargos. These operations were principally undertaken on the Fergusson Wharf.

(b) Bulk cargo handling services including the handling of vehicles, cement and iron sand. These services were primarily undertaken on the Freyberg, Jellicoe, Bledisloe, Marsden and Captain Cook wharves.

(c) Marine services, including pilotage services, towage, hydrography and bunkering services.

(d) Operation of freight hubs in South Auckland, Waikato, Bay of Plenty and Manawatu.

(e) Supply chain management services.

(f) The provision of services and facilities to support the cruise ship industry. These services are provided on the Princes and Queens wharves.

(g) Investment in subsidiary companies and other investments in port-related activities.

[86] At an operational level POAL was structured into several business units:

(a) Container operations, responsible for stevedoring and wharfage for the import, export and storage of shipping containers.

(b) Vehicle handling, comprising stevedoring and wharfage for the import and export of vehicles, including light vehicles, high and heavy vehicles and bulk vehicles.

(c) Multi-cargo operations, involving the stevedoring and wharfage in relation to the import and export of a variety of breakbulk (or general) cargo, dry and liquid bulk cargo, and containers carried by muti cargo ships.

(d) Marine services, including towing, lines handling and the provision of pilotage services to shipping lines and cruise ships.

(e) Other business units involving the management of port-related operations, subsidiaries and investments.

[87] At relevant times, POAL's board was comprised of eight directors, chaired by Mrs Elizabeth Coutts. The directors were all highly qualified, with significant corporate experience. Three of the directors had relevant experience in the operation of ports.

[88] POAL's executive team comprised:

(a) Mr Gibson as CEO.

(b) Mr Wayne Thompson, Deputy CEO and Chief Financial Officer.

(c) POAL's General Manager: Marine, Engineering and General Wharf Operations.

(d) POAL's General Manager: Commercial Relationships.

(e) POAL's General Manager: Infrastructure and Property.

(f) POAL's General Manager: Supply Chain.

(g) Ms Angelene Powell, POAL's General Manager: Container Terminal Operations (**CTOP**s).

(h) POAL's General Manager: Public Relations and Communications.

(i) POAL's General Manager: Sustainability.

(j) POAL's Chief Information Officer.

[89] Each General Manager led one of the port's business units, which meant every business unit was represented at the Executive level.

[90] POAL's container handling business operated seven days per week, 24 hours per day. Stevedoring operations were conducted in two shifts. The dayshift started at 7am and the nightshift at 7pm.

[91] The management structure of the CTOPs business unit was as follows:

(a) Mr Jonathan Hulme acted as Senior Manager, Terminal Operations and reported to Ms Powell.

(b) The Manager of Stevedoring reported to Mr Hulme. As at 30 August 2020, that role was held by Mr Michael (Mick) Lander.

(c) Ship Operations Managers (sometimes referred to as Shift Operations Managers) reported to the Manager of Stevedoring. The Ship Operations Managers worked from an office at the wharf during day and night shifts. They were responsible for vessel and terminal obligations and, to a lesser degree, involved with the rostering and administration of stevedores. The Ship Operations Managers were tasked with briefing stevedores at the beginning of each shift concerning terminal, straddle and lashing operations, and health and safety matters. The Ship Operations Managers worked primarily within the office at the wharf but would also visit the wharf worksites as required.

(d) Ship Supervisors reported to the Ship Operations Managers. Ship Supervisors primarily worked in the office, alongside the Ship Operations Managers, but Ship Supervisors would more regularly visit the wharf worksites during a 12-hour shift. Ship Supervisors would

carry out an inspection of a vessel when it first arrived at the port to ensure that the vessel was safe to work. Ship Supervisors were also tasked (along with the Ship Operations Manager) with the briefing of all stevedores prior to work commencing on each shift. Ship Supervisors also dealt with incident reporting by the stevedores.

[92] The actual loading and unloading of containers to and from ships is undertaken by workers in various roles:

(a) Lashers are responsible for lashing and unlashing containers to the decks of container ships by the use of metal lashing bars. Lashers are also responsible for the placement and removal of the twist lock mechanisms to and from the bottom of containers. This work takes place on lashing platforms, which form part of the structure of the gantry cranes. A container being loaded onto or unloaded from a vessel is lifted to the lashing platform, where lashers fit or remove the twist lock mechanisms as required. Teams of six lashers worked in two-hour rotations throughout their shift. During any two-hour rotation, and depending on the nature of the work required, two lashers (per crane) could be assigned to work as a pair on the ship, another two could be working as a pair on the lashing platform, and the remaining two lashers would be on a break.

(b) Crane operators, as their title makes clear, operate the gantry cranes to pick up and drop containers from and to the vessel, the lashing platform and the wharf. They sit in a cabin in the crane where they have visibility of the spreader, a piece of equipment suspended from the crane and which attaches to the top of either one 40 feet container or two 20 feet containers at the same time (the latter is referred to as a twin lift). Crane operators do not always have good visibility of the access walkways between the bays of containers on the vessel, as those walkways are narrow and may be dark.

(c) Straddle drivers operate mobile straddle container carriers which move containers around the port, essentially transporting containers to and from the cranes for loading and unloading.

(d) Prior to the implementation by POAL, on 19 March 2020, of a CTOPs Stevedoring Pandemic Plan in response to the then Covid-19 pandemic, lashers were supervised by a lash leading hand. The lash leading hand's role was to direct the lashers to their various points of work on the vessel or the lashing platform as necessary. Prior to the CTOPs Pandemic Plan, the lash leading hand could be responsible for up to 24 lashers working on a vessel over a shift, operating in the rotating teams of six, assigned to up to four separate gantry cranes. The lashers reported to the lash leading hand. The lash leading hand communicated the lashers' positions on the ship to the ship leading hand and crane operators using a handheld radio. Individual lashers did not have access to radios while working on a vessel.

(e) Ship leading hands, sometimes referred to as "foremen" or "ship foremen," acted as "the eyes and ears of the crane operators". The ship leading hand was in radio communication with the crane operator and the lash leading hand. The ship leading hand's role was to inform the crane operator of their points of work and where to manoeuvre to load and unload containers. If necessary, the ship leading hand could be required to enter a personnel cage, a 24-foot container sized work platform, which would be attached to the crane spreader and which was used to transport personnel and equipment between high and low work situations, sometimes as part of routine duties but, also, to troubleshoot any issues with containers which could not be readily accessed by the lashers from the deck of the vessel. The ship leading hand was in control of the crane operations and associated work areas at all times. The ship leading hand had the ability to stop crane operations at any time, for any reason. Most crane operators were also trained to act as ship leading hands and could undertake the work of a ship leading hand as necessary.

[93] POAL also employed operational performance coaches (**OPCs**). OPCs had previously been known as trainers. OPCs did not routinely work in a hands-on stevedoring role unless they were called upon to do so by reason of their levels of experience and skill, in order to deal with some particular issue. The OPCs were, otherwise, responsible for training and observing the performance of workers. They reported on health and safety issues or concerns as necessary.

[94] Stevedoring operations at the container terminal constituted the largest business unit within POAL. Stevedoring accounted for approximately two-thirds of POAL's total revenue, with approximately 40% of POAL's employees being stevedores.

POAL's health and safety systems

Systems generally

[95] Systems are the means by which a business translates its policies and objectives into reality. Policies are statements of intent. They express the standards of practice and behaviours that are required of people who work for the organisation.[33]

[96] There is no significant dispute as between the parties as to the essential features of an effective system. I accept the evidence of Mr Kahler as to the definition of a system and the features of effective business systems.

[97] A system is a framework that orders and sequences activity within an organisation to achieve a purpose, within a band of tolerance and variance that is acceptable to the owner of the system.[34] Examples of systems in the health and safety context include incident management systems, standard operating procedure management systems, critical risk management systems and operator performance management systems.

[98] For a system to be effective there must be an ability to monitor and measure the performance of the system. Common metrics which act as indicators of the

[33] NoE 1006 (Kahler).
[34] NoE 1005; Exhibit 118.

effectiveness of the system's functions as designed include the use of leading and lagging indicators, performance measures and data analysis.[35] Any effective system should also incorporate regular review and audit processes.[36]

POAL's Health and Safety Manual

[99] POAL's Health and Safety Manual set out the health and safety systems in place at POAL.[37] Its purpose, as described, was to establish and maintain effective management of workplace health and safety matters. The Health and Safety Manual assigned roles, responsibilities and accountabilities for the Board, CEO, Executive, Health and Safety Steering Committee (**HSSC**), Managers, Health and Safety Committees and workers.

[100] The 2019 Health and Safety Manual contained 13 health and safety standards which, relevantly, included 'Annual Health & Safety Improvement Plans', 'Key Performance Measures' and 'Hazard/Risk Management'.

[101] The health and safety policies and procedures contained within the Health and Safety Manual were approved by Mr Gibson as CEO.

POAL's Board

[102] In the health and safety context, POAL's Board was responsible for setting the policies for the business and maintaining broad oversight of the health and safety system.

[103] That entailed the Board approving policy, ensuring legislative governance requirements were met, monitoring overall safety compliance and minimising corporate and business risk.

[104] Within that role, the Board had statutory obligations to: ensure the availability and use of appropriate resources and processes to eliminate or minimise health and safety so far as reasonably practicable; ensure that POAL had appropriate processes

[35] NoE 1012.
[36] Exhibit 118.
[37] Exhibit 37.

for receiving and considering information regarding incidents, hazards and risks; and ensure that these processes were enacted in a timely manner as appropriate to the level of risk.

[105] Doing so required POAL's Board to keep up to date with health and safety matters at POAL as well as maintain an understanding of the nature of POAL's business and the associated hazards and risks.

[106] There were 10 board meetings per year. Mr Gibson attended board meetings and provided a CEO's report to the Board. The Deputy CEO as well as Health & Safety staff from POAL would attend board meetings.

[107] POAL's Board had ultimate oversight over the health and safety systems at POAL. Mr Gibson submits that the fact that the Board had such oversight and, specifically, oversight of his performance as CEO, is highly relevant to assessing whether he exercised due diligence.

[108] The fact, however, that Board members, as officers of POAL, may have considered that Mr Gibson was performing his duties properly is not the issue in this case. Whether there were failings on the part of the Board or, indeed, any other officer of POAL does not fall for determination by me. The views of the then Board, as expressed in evidence by Mrs Coutts, does not substantively assist me.

[109] As above, it is not disputed that Mr Gibson was an officer of POAL. Neither is it disputed that he exercised influence and responsibility over health and safety matters at POAL. The evidence presented at trial demonstrated that he exercised considerable influence. I am not required to determine whether the Board, as officers of POAL, also failed to exercise due diligence. No Board member has been charged. This case concerns Mr Gibson's exercise of due diligence as CEO. The fact that the Board may have approved his approach to health and safety is not determinative as to whether Mr Gibson failed in in relation to the exercise of his duty under s 44 HSWA.

The Executive

[110] As noted earlier, the Executive included Mr Gibson as CEO, Mr Thompson as Deputy CEO, and the General Managers of the eight business units. The Executive held weekly meetings which included a review of health and safety performance. The Executive's health and safety responsibilities included: accounting to the Board for legislative compliance; reviewing health and safety performance of middle management; approving POAL's health and safety management system and related processes; monitoring health and safety performance at weekly meetings; demonstrating leadership and driving a development of safety culture; ensuring appropriate resources were allocated; ensuring health and safety objectives formed an appropriate part of business plans and operational reports; ensuring business units implemented their health and safety plans; ensuring that all practicable steps were taken to manage hazards and appropriate risks; and ensuring that incidents with injury consequences or the potential for serious injury were formally investigated, findings were distributed to relevant parties and appropriate actions were taken to prevent reoccurrence.[38]

[111] As CEO, Mr Gibson exercised overall responsibility at the Executive level for health and safety matters at POAL. He was the key figure to whom the Board delegated responsibility for the implementation of Board policy. I will return to the health and safety aspects of Mr Gibson's role later.

[112] As Deputy CEO and Chief Financial Officer, Mr Thompson also played a key role in the management of POAL. Additionally, from May 2020 to August 2020, Mr Thompson oversaw the performance of the Senior Manager of Health & Safety in the organisation. Again, the fact that Mr Thompson also played a significant role in managing health and safety at POAL does not reduce or minimise the scope of Mr Gibson's statutory duty under s 44 HSWA.

[113] Each General Manager had responsibility for operational health and safety in their respective business units.

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[38] Exhibit 37.

Container Terminal Operations (CTOPs)

[114] I have previously described the management structure and operational roles within the CTOPs business unit.[39]

[115] Prior to 2019, CTOPs formed part of a general marine, multi-cargo, engineering and container terminal business unit. Following a straddle carrier driver's fatality in August 2018 CTOPs was, in 2019, split off into a separate business unit helmed by a dedicated General Manager.

[116] During the charge period, Ms Powell was the General Manager of the CTOPs business unit. Reporting to Ms Powell was Mr Hulme, the Senior Manager of Terminal Operations, who had responsibility for the Container Terminal.

[117] Michael (Mick) Lander was the Manager of Stevedoring, responsible for stevedoring operations and the stevedores that worked within those operations.[40] He did not have experience in stevedoring, but instead had a background in the Ministry of Justice and New Zealand Police.

[118] Responsible for operational delivery were two Senior Shift Managers, who were highly experienced and had technical knowledge of wharf operations.

[119] Below them, with responsibility for the "hands-on" running of stevedore operations, with a 24-hour presence, were Shift Operations Managers.[41]

[120] Ship Supervisors were tasked with carrying out safety audits on every shift, and had access to CCTV footage from the gantry cranes. They supported the Shift Operations Manager in "rais[ing] levels of performance in regards to safety and productivity", managing staff while on shift and providing quality assurance.[42]

[121] OPCs performed a significant role in relation to health and safety within the CTOPs unit. The OPCs received considerable training and obtained various

[39] See above, at [90] to [93].
[40] NoE 466 (Haretuku).
[41] NoE 466.
[42] Exhibit Q.

qualifications.[43] By 2019, POAL's OPC training programme was said to be industry-leading, with other New Zealand ports interested in POAL's training and training manuals.[44] OPCs would be involved in the review of training programmes and procedures,[45] and create and update standard operating procedures (**SOP**s).[46]

Health & Safety Team

[122] During the charge period POAL also had in place a dedicated Health & Safety team of 10 full-time employees. The role of the team was to ensure that POAL had, and maintained, an appropriate health and safety system. The Health & Safety team provided specialist advice to guide POAL's health and safety systems and supported each of its business units.

[123] A senior manager led the Health & Safety team. Oversight of the senior manager was the role of a General Manager. The senior manager reported to the Board by way of a monthly report and would attend Board meetings.

[124] In the period from 2014 to 31 August 2020 there were four senior managers.

[125] From 2014 to approximately September 2017, Steve Groenewegen was the senior manager of the Health & Safety team. Mr Groenewegen was instrumental in introducing a Health and Safety Steering Committee (**HSSC**), the Health and Safety Manual, health and safety strategies, the requirement for business units to embed health and safety in their annual business plans, and weekly executive meetings where health and safety was discussed by the General Managers and Mr Gibson.[47]

[126] From November 2017 to March 2019 Will Eastgate held the position of senior manager. During that period, Mr Eastgate advanced contractor management controls at POAL as well as introducing health and safety targets for the business units against which their performance could be measured. Mr Eastgate advanced critical risk management at POAL through the identification of seven "critical risks" by December

[43] Exhibit P.
[44] NoE 1479 and 1490 (Gibson).
[45] Exhibit 31.
[46] NoE 710 (Tahiwi).
[47] NoE 1498-1501 (Gibson).

2017 and then, in 2018, by placing a "primary focus" on the management of critical risks, including through bow-tie assessment processes.

[127] Following Mr Eastgate's departure in March 2019, the position of interim senior manager was held by Jay Ferguson for a six-month period. Critical risk management was also a focus of Mr Ferguson during his tenure.

[128] From 30 September 2019, Melanie Costley held the position of Senior Manager of Health & Safety. Mrs Costley had previous experience working in a port environment and at Air New Zealand. Mrs Costley introduced a number of initiatives, including increasing the information made available to the board in monthly reports to better monitor performance, establishing a health and safety standard in relation to the structure of Board reporting, and commencing work on establishing leading indicators as a significant reporting measure. Mrs Costley's efforts to introduce greater reliance upon leading indicators were, however, delayed or diverted by other matters. First, as a result of POAL's management and Executive focussing on an initiative to significantly automate POAL's container operations (**the automation initiative**) and then by the Covid-19 pandemic. When work in establishing and embedding leading indicators as a reporting measure recommenced, by October 2020, Mr Kalati had already suffered his fatal accident.

[129] I note that the prosecution is critical of Mr Eastgate's leadership of the Health & Safety team during his tenure from November 2017 to March 2019 and submits that Mr Gibson had misplaced confidence in Mr Eastgate through that period. MNZ points to apparent failures during Mr Eastgate's leadership of the Health & Safety team, including a lack of timeliness in introducing leading indicators and other systematised means of obtaining insight into "work as done", a failure to produce key performance indicator (**KPI**) matrices for managers, and inadequately developing responsibilities and accountabilities for the general and senior managers.

[130] The prosecution submits that those failures are attributable to Mr Gibson as he did not sufficiently interrogate Mr Eastgate's performance, as is required of a reasonable CEO. Mr Gibson spoke favourably of Mr Eastgate and placed reliance on his advice. It is submitted that, based on a lack of progress on reporting measures,

systems-management and responses to audit recommendations, Mr Gibson ought to have been on notice that Mr Eastgate was failing to adequately implement the policies of the Board. In such circumstances, a reasonable CEO needed to properly analyse and interrogate Mr Eastgate's performance.

[131] By comparison, MNZ submits that the most significant progress made in POAL's health and safety systems, including the use of leading indicators as a means of obtaining insight into "work as done" occurred during Mrs Costley's leadership.[48] The prosecution also submits that Mrs Costley brought an "extra dimension" to her advice, as compared to Mr Eastgate, through her focus on the systems of the business.[49] It is submitted that Mr Gibson failed to appreciate that the extra dimension to Mrs Costley's work was that focus on business systems. Instead, Mr Gibson was broadly equivocal in his assessment of Mrs Costley compared to Mr Eastgate, attributing any additional aptitudes she possessed to her previous experience in the industry.[50] This was to be contrasted with Mrs Coutts' assessment of Mrs Costley's performance.[51]

[132] The defence does not accept that Mr Gibson misplaced his confidence in Mr Eastgate and submits that different senior managers naturally bring different skills and experiences to their roles.

[133] There is substance in the prosecution submissions. On the evidence I heard, I accept that there was a distinct lack of progress on the part of POAL in creating clearly assigned responsibilities and accountability for the executive team and senior managers, which had been clearly recommended in a 2018 KPMG audit report. Further, I accept that there was a lack of timely development of lead indicators as a reporting measure, despite that having been committed to by POAL as early as May 2018.[52] I return to the recommendations set out in the 2018 audit report and POAL's response to them later in this judgment.[53]

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[48] Prosecution closing submissions, at [236].
[49] Prosecution closing submissions, at [238].
[50] Prosecution closing submissions, at [237]; NoE 2063 (Gibson).
[51] NOE 2261 & 2352.
[52] Exhibit 41.
[53] See below, at [168] and following.

[134] Any failure on the part of Mr Gibson to recognise the lack of progress on these matters during Mr Eastgate's tenure falls outside the timeframe of the present charges and, therefore, cannot be considered, of itself, a failure to exercise due diligence in terms of the present charges. These matters do, however, form part of the context and background circumstances against which Mr Gibson's conduct within the charged time period is to be measured.

Health & Safety Steering Committee

[135] The HSSC was the functional body for overseeing occupational health and safety management within POAL. It was formed with the intention of providing a high-level forum for the adoption, review and continual improvement of POAL's health and safety policy.

[136] The HSSC membership included Mr Gibson, all operational General Managers, all senior operational managers, the General Manager – People, Systems and Technology, and the Health & Safety team manager. Other managers and workers could attend by invitation, as appropriate. The functions of the HSSC broadly included: interpreting and implementing company strategy; reviewing high-level issues and managing responses to operational issues as they arose; formulating company health and safety policy; monitoring organisational performance against company policy and procedures; and allocating appropriate resources.[54]

[137] POAL's Health and Safety Manual required members of the HSSC to attend all meetings of the committee unless specifically excused by Mr Gibson.[55]

[138] Relying on the evidence of Mr Kahler, the prosecution submits that prior to and during the period reflected in the charges the HSSC was failing to discharge its obligations, in that it was not operating as a strategic oversight committee as POAL's Health and Safety Manual required. First, HSSC meetings generally involved a significant number of attendees but meetings would last, at most, for 90 minutes and some would be completed within 45 minutes. The HSSC should, in its meetings, have

[54] Exhibit 37.
[55] Exhibit 37.

been interrogating the health and safety content of the business plans of all eight of POAL's business units for a six-month period. Mr Kahler expressed the opinion that effective, high-level, strategic meetings should have taken significantly longer if the committee was operating as designed.

[139] Second, the matters discussed during HSSC meetings, as reflected in the committee's minutes, including such matters as receiving reports on missed time workplace incidents, did not reflect discussion of high-level or strategic health and safety issues, policy or direction. These matters should, in Mr Kahler's opinion, have more appropriately been reported and considered at regular operational meetings, rather than at infrequent strategic meetings. The failure to exercise a strategic role meant that the HSSC was not actually interpreting or implementing company strategy, nor formulating POAL's health and safety policy. The HSSC was also not monitoring performance against company policy by means of the development and use of leading indicators. The sole function of the HSSC which the committee appeared to be discharging, of those set out in the Health and Safety manual, was the review of high-level issues and the management of responses to operational issues.

[140] Third, the prosecution points out that the documentation available to the Court indicates that only seven HSSC meetings were held between 30 August 2017 and 30 August 2020. Mr Gibson did not attend two of those meetings and did not attend HSSC meetings from 14 November 2019 to 21 July 2020. There was only one HSSC meeting during the period reflected in the charges. The prosecution submits this undermined the HSSC's ability to drive change or to monitor the status quo and sent a signal that the HSSC meetings were unimportant.

[141] The defence disputes that the HSSC did not meet as it should have during the charging period. In that respect, the defence relies on evidence suggesting a meeting was scheduled for 14 May 2019 and on two reports of the Health & Safety team, apparently reporting to the HSSC, for the September to October 2019 period. I do not accept that such evidence demonstrates that HSSC meetings actually took place, as opposed to having been scheduled or planned. In any event, the lack of documentation or minutes in relation to any such meetings, if they were held, would indicate a failure

on the part of the HSSC to adequately document any work carried out by it and to report to the Executive team and Board.

[142] Fourth, the prosecution notes that the HSSC minutes did not identify action points, assigned to an accountable person, for the implementation of any actions until a meeting of July 2020 meeting. The action points which were assigned in that meeting were not mentioned again at any subsequent meeting.

[143] The prosecution submits that the failure of the HSSC to properly perform its functions as a strategic health and safety committee is attributable to Mr Gibson. It was Mr Gibson's role as CEO, in accordance with his accepted responsibility for systems leadership, to ensure that the HSSC was effective, focussed on the systems of the business, and operating in a format and with a frequency that enabled it to discharge its functions.[56]

[144] The defence submits that the establishment of the HSSC is an example of positive change in health and safety which occurred during Mr Gibson's tenure as CEO.[57] The defence submits that HSWA does not prescribe the formation of such a strategic committee, and that the HSSC was one of the resources utilised by POAL to effect health and safety processes implemented under Mr Gibson's leadership.[58] The defence further submits that no-one ever raised with Mr Gibson that the HSSC may not be operating sufficiently strategically, that skills and knowledge have developed in the years since the enactment of HSWA, and that senior executives are now more knowledgeable as to how to lead such committees in a strategic manner.[59] In support, the defence refers to the evidence of Mrs Coutts and Mr Marriott, who stated that "[n]ot many organisations are good at actually managing strategy, particularly in health and safety".[60]

[145] I do not consider it an adequate answer to the prosecution evidence and submissions to suggest that no-one ever raised with Mr Gibson that the HSSC was not

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[56] Prosecution closing submissions, at [203].
[57] Defence closing submissions, at [204.8].
[58] Defence closing submissions, at [302].
[59] Defence closing submissions, at [637 – 639].
[60] NoE 2372 (Coutts); NoE 2133-2134 (Marriott).

acting strategically. As previously noted, an officer cannot assume that a PCBU is compliant with its duties under HSWA in the absence of being told otherwise and the fact that other organisations may not be good at managing health and safety strategy does not assist.[61]

[146] I will return to the issue of systems leadership later in this judgment.

Operational Health and Safety Committees

[147] Health and Safety Committees, mandated under HSWA, existed at an operational and business unit level. Issues could be escalated from business unit Health and Safety Committees to the HSSC as necessary.[62]

[148] The CTOPs Health and Safety Committee meeting would generally take place on a monthly basis.

Health and Safety Representatives

[149] Health and safety representatives are a mandated role under HSWA. They represent workers in matters relating to health and safety, among other functions, and there are mandatory requirements around representation of workers on health and safety committees. Worker representatives attended the CTOPs Health and Safety Committee meetings.

Health and Safety Strategy

[150] The Health & Safety team produced a Safety & Wellbeing Strategy which set out an overarching strategy for the 2018 to 2021 period.[63] The document produced in evidence appeared to be a Power Point presentation. Having regard to the nature of the document, Mr Kahler described it as "more a statement of objectives" or "a statement of almost vision or aspiration".[64]

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[61] See above, at [79].
[62] NoE 1551 (Gibson).
[63] Exhibit 54.
[64] NoE 1103.

[151] The Health & Safety team was also responsible for producing an annual Health & Safety Strategy Plan (also referred to as annual improvement plans or annual plans). The Health and Safety Manual required the CEO to approve the annual Health & Safety Strategy Plan.[65]

[152] No documents were placed before the Court evidencing the existence of a annual Health & Safety Strategy Plan for either of POAL's financial years ending 30 June 2020 or 2021. There is a degree of confusion in the evidence relating to whether or not there were no plans in existence for both of those years or just one of them.[66] Mrs Coutts' evidence was that she could not recall any year without a plan other than 2020, and the lack of a plan in that year arose by reason of the Covid-19 pandemic.[67] On the other hand, Mr Gibson suggested that the strategy plans for a financial year were required to be completed before the end of the preceding financial year.[68] If that were so, the Covid-19 pandemic could not have impacted the preparation of the 2020 plan. Mrs Coutts' also suggested, however, that while there may have been some misunderstanding as to which years were being referred in evidence, the absence of a plan (for 2020) may have related to Mr Eastgate's departure which, as above, occurred in March 2019.[69] She confirmed that, in her original answers to counsel's questions, she was referring to lack of a strategy plan for the year ending 30 June 2021 because of the impacts of Covid-19.[70] She could not say definitively whether there was a plan for the year ending 30 June 2020, but said that "if there was wasn't, there'd be a reason for it, which we would've understood …" [71]

[153] MNZ made formal requests for POAL's annual Health & Safety Plans for 2018, 2019 and 2020. POAL responded that it could not locate a plan for FY20 and had located two PowerPoints containing "early plans for FY21". Given that, I find that POAL had not completed strategy plans for either of those years by the time of Mr Kalati's death.[72]

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[65] Exhibit 37.
[66] Prosecution closing submissions at [205-209]; and Defence closing submissions at [696-699].
[67] NoE 2405-2406.
[68] NoE 2025-2026
[69] NoE 2356.
[70] NoE 2357-2358.
[71] NoE 2358.
[72] Exhibits 18 and 21.

[154] The prosecution submits that this demonstrates an absence of due diligence on the part of Mr Gibson as to ensuring a key document, as required by the Health and Safety Manual, was produced as required.

[155] The defence accepts that no plan was produced for the 2021 financial year but submits that this was excusable by reason of the impacts of the pandemic. In relation to the 2020 financial year, the defence acknowledged that no plan was produced in evidence. In any event, the defence submits that if there were no strategic plans created, the Safety and Wellbeing strategy document for 2018 to 2021, Exhibit 54, was the "overriding strategy" for those years.[73] The defence refers to Mrs Coutts' evidence in re-examination that Exhibit 54 contained detail similar to that which other companies had in their health and safety strategy documents at the time.[74]

[156] I do not accept the defence submission as to the import of Exhibit 54. POAL's Health and Safety Manual required that "each year, objectives and activities shall be defined to achieve POAL's health and safety strategy, and key performance indicators and targets will be proposed".[75] As above, it was Mr Gibson's responsibility, as CEO, to approve the health and safety plan. I do not accept that Exhibit 54, as a high-level general statement of goals for a three-year period, adequately substituted for the absence of specific annual plans. I am satisfied that the absence of annual strategy plans in the period leading up to Mr Kalati's death was a failure of POAL's health and safety system.

PortSafe

[157] PortSafe was a computerised reporting system for health and safety, described as a data management system.[76] PortSafe was introduced in late 2015, after the HSWA came into force, to "ensure staff follow best practice incident recording, risk assessment and risk management processes, and provide standardised documentation with enhanced auditability."[77]

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[73] Exhibit 54.
[74] NoE 2405.
[75] Exhibit 37.
[76] NoE 1404 (Kahler).
[77] Exhibit N.

[158] Stevedores could enter reports of incidents or near misses into PortSafe. Those entries would go directly to their manager. The entries were visible to the General Managers, the Ship Supervisor and the Stevedoring Manager. Additionally, OPCs, Ship Supervisors and Shift Operation Managers could upload reports of inspections or audits to PortSafe.[78]

[159] Mr Gibson and General Managers, could access an executive "dashboard" in PortSafe in order to access information such as the number of incidents on a daily, weekly, monthly or annual basis.[79] PortSafe identified where incidents were occurring on a "heatmap".[80] It also allowed managers and executives to identify who had been assigned to follow-up any incident, and would send a reminder notification if an issue was not closed off.[81]

[160] Mr Gibson points out that MNZ did not obtain access to PortSafe and the information it held. The defence invites me to infer from this, and other matters, that MNZ performed an "inadequate investigation".[82] The defence also submits that as Mr Kahler did not have an opportunity to review data contained in PortSafe, his opinions are based on an incomplete understanding of POAL's systems.

[161] I accept the evidence I heard regarding the PortSafe system, the role it performed in POAL's health and safety system, and the information that could be uploaded to it. While I acknowledge the defence submissions, I do not make any findings as to the suggested inadequacy of the MNZ investigation or intend to speculate as to what other evidence might, potentially, have been placed before me. I am required to make my findings on the evidence which has been placed before me and only on that evidence. Further, the suggestion that Mr Kahler's expert opinion evidence is 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.

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[78] NoE 747 (Tahiwi).
[79] NoE 1546-1547 (Gibson).
[80] NoE 1545-1546.
[81] NoE 1546.
[82] Defence closing submissions, at [601-609].

Audits

[162] Internal and external audits were carried out in relation to POAL's health and safety system. External audits were undertaken by the Accident Compensation Corporation (ACC) annually, to enable POAL to maintain its status as an accredited employer and in line with the Health and Safety Manual. Internal audits were carried out by external providers at the instruction of management, as approved by the Audit Committee.

ACC audits

[163] The ACC audits were required in terms of ACC's accredited employer programme, by which employers pay lower ACC levies if they manage claims and rehabilitation in-house. ACC conducted such audits in May 2017, May 2018, May 2019 and August/September 2020. On each occasion POAL obtained a 'tertiary' level rating.

[164] The defence relies on the ACC audits. It is submitted, first, that ACC is a "regulatory agency" as defined by the HSWA.[83] Second, s 264A of the Accident Compensation Act 2001 requires WorkSafe and ACC to have a workplace injury prevention plan at all times. Third, the accreditation requirement under s 185 Accident Compensation Act provides that ACC may only enter into an accreditation agreement if the employer has appropriate experience in managing occupational health and safety issues positively; has demonstrated commitment to injury prevention; and has appropriate policies and procedures in place to prevent work-related injuries. The defence submits that Mr Gibson could reasonably take some comfort as to POAL's overall health and safety systems by reason of the ACC audits.[84]

[165] The prosecution submits that the ACC audits were 'compliance audits', focussed on the existence of documentation and the paper trail of activities rather than on outcomes, and engagement with health and safety personnel.[85] The ACC audits

[83] Health and Safety at Work Act 2015, s 16.
[84] Defence closing submissions, at [545].
[85] Prosecution closing submissions, at [447]; NoE 1262 (Kahler).

were expressly limited in their scope. They could only provide POAL and its officers with limited reassurance.

[166] I accept that the ACC audits were not designed to "drill down into the organisation to determine what the systems, standards and procedures are actually translating to in terms of worker behaviours and engineering controls directed at managing risk".[86] Mr Marriott accepted that the ACC audits would have only told Mr Gibson that "on paper, the safety system, management system looked solid".[87]

[167] While the ACC audits are relevant, they did not serve the purpose of ensuring that POAL's resources and processes were appropriate in terms of its duties under the HSWA. They were limited in scope. The ACC audit reports expressly stated:[88]

> Conformance to the programme standards set out in the audit tool should not be relied on to satisfy compliance with legal and other obligations of the employer. It is the responsibility of the individual employer to be satisfied that these legal and other obligations are met.

Internal audits

[168] The scope of an internal audit and the responsibility of appointing the auditors lay with the Audit Committee, a subcommittee of the Board.

[169] In 2018 KPMG conducted an audit which assessed the progress POAL had made following previous audits in 2015 and 2016, conducted by another provider.[89]

[170] The August 2015 audit was conducted before the commencement date of HSWA.[90] Although that audit highlighted that POAL's SOPs were out of date and there was a need for health and safety documents and manuals to be updated at least every two years, MNZ does not seek to rely upon it, given its age and limited scope. The August 2016 audit was not produced in evidence.

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[86] NoE 1262 (Kahler).
[87] NoE 2099 (Marriott).
[88] Exhibits 71 to 74.
[89] Exhibit 69.
[90] Exhibit 120.

[171] The 2018 KPMG report noted that the 2015 and 2016 audits were focused on POAL's Engineering Department and Infrastructure Team (in relation to contractor management) and, therefore, did not address health and safety across all of POAL's operations. The 2018 audit was expressly stated to be focussed solely on determining whether POAL had effectively implemented the recommendations made from the moderate and high rated items identified in the 2015 and 2016 audits.[91] The audit report also noted that its scope did not constitute a full review of the effectiveness, efficiency and reliability of POAL's health and safety culture and/or management system and, further, did not include an assessment against legislative compliance, nor assessment of other elements constituting a management system.[92]

[172] Nevertheless, the 2018 audit made a number of key recommendations around three "key areas". One of those recommendations was:[93]

> To ensure health and safety is successfully embedded across all Business Units will require the Executive Leadership Team and senior management to be consistently engaged and empowered. As an initial action, it is recommended training be provided and this followed with the assignment of roles, responsibilities and accountabilities for health and safety across the Business Units.

[173] The report further stated that:[94]

> Successful embedding and integration of health and safety within POAL will initially require POAL to assign roles, responsibilities, and accountabilities to the Executive Leadership Team and senior management. The cascading of these responsibilities should follow.

[174] This finding and recommendation was assigned a "high" risk rating, by virtue of previous lack of progress. Under "Agreed Management Actions" the report noted:

> Management recognises the recommendation of developing responsibilities and accountabilities for the executive team and senior managers however further work on this is required by way of an executive workshop. The agreed outcomes of this workshop will be reported back to the December Audit Committee meeting.

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[91] Exhibit 69, at 1378.
[92] Exhibit 69, at 1398.
[93] Exhibit 69, at 1378.
[94] Exhibit 69, at 1396.

[175] Responsibility for creating a responsibility and accountability matrix was allocated to Mr Eastgate. A reference to the KPMG recommendation first appeared in the Safety and Wellbeing Report (**monthly Health & Safety Report**) dated 10 September 2018, which stated "… it was recommended that responsibilities and accountabilities need further clarification. A workshop with the Executive Team is planned to define these." [95] This notation appeared repeatedly in the monthly Health & Safety Report over the following months, with modifications.[96] In the report for 13 November 2018, it was stated that the Executive Team workshop would take place prior to the end of the year. The same statement appeared in the report of 7 December 2018. The report of 15 January 2019 noted that the workshop was to take place "in the new year". The report of 12 February stated that the workshop was to take place "in late Q3 of the financial year". By 11 March 2019, the report stated that the Executive workshop will take place "in the second quarter of the financial year". Finally, the report of 10 June 2019 stated:

> The Executive team participated in a health and safety workshop facilitate [sic] by Mike Cosman regarding accountabilities and responsibilities. It generated significant discussion and was well received, with recognition that there is still work required to achieve a Safety 2 culture. Time has been set aside as the next Executive monthly meeting to continue the discussion.

[176] Thereafter, there is no further reference to the assignment of accountabilities and responsibilities. No accountability and responsibility matrix was placed before the Court. Although Mr Gibson stated that such a matrix was created, he could not recall when the workshop which, he says, resulted in the assignment of accountabilities and responsibilities took place, what the outcomes were, or why there was slippage in the date.

[177] I am satisfied that Mr Eastgate did not complete the accountabilities and responsibilities matrix. He left POAL in March 2019, prior to the workshop taking place. Thereafter, the only reference to accountabilities and responsibilities appears in the June 2019 report, as noted above. By that time, the purpose of the Executive workshop appears to have morphed from something specific, that is, assigning accountabilities and responsibilities to the Executive Team and senior managers, to a

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[95] Exhibit 56, at 1037.
[96] Exhibit 56, at 1043,1049 and 1056; Exhibit 57, at 1062, 1068, 1074 and 1092.

more general purpose of advancing the safety culture of the organisation.[97] I therefore cannot accept Mr Gibson's evidence that POAL did adequately respond to the KPMG recommendation. At the very least, Mr Gibson and his Executive team did not properly advance or promote work on that recommendation in a timely manner.

[178] Second, the 2018 KPMG report recommended improvements to the monthly Health & Safety Performance Report. The audit report identified that the reports contained no commentary on achievement of the health and safety strategy, or the effectiveness of critical controls for critical risks.[98] KPMG recommended that lead indicators be included in the monthly Health & Safety Performance reports. The audit report recorded that management agreed to include lead indicators in the monthly Board Health & Safety Performance Report.[99] It had also been noted at the HSSC meeting of 14 May 2018 that a "lead indicator plan" was going to be worked through "with the exec".[100]

[179] I am satisfied that POAL and the Executive team did not appropriately advance the KPMG recommendation in a timely manner. The monthly Health & Safety reports from 9 February 2018 through to 10 June 2019 routinely referred to the need to develop lead indicators for Board reporting, without apparent progress.[101] When more lead indicators did begin to appear in the reports, Mr Kahler described them as being "immature" in health and safety terms.[102]

[180] I conclude that any comfort Mr Gibson took from the annual ACC and 2018 KPMG audit reports was misplaced. The audits were expressly limited in scope. And, to the extent that the KPMG report made wider recommendations, relevant to POAL's health and safety systems and reporting generally, POAL failed to action those recommendations in an appropriate and timely manner. The defence implicitly acknowledges as much. Mrs Coutts gave evidence that the Board prioritised issues around contractor management.[103]

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[97] See NoE 1630-1631.
[98] Exhibit 69, at 1387. I return to critical risks later in this judgment.
[99] Exhibit 69, at 1388.
[100] Exhibit 41, at 0852.
[101] Exhibits 56 & 57.
[102] NoE 1166-1168.
[103] NoE 2223-2224, 2228.

Other relevant health and safety measures at POAL

[181] In the course of the trial, I heard evidence relating to various other measures in place at POAL relevant to occupational health and safety. Some examples are noted in the following paragraphs.

[182] Key Performance Indicators (KPIs) linked to job descriptions, performance agreements and remuneration were used as a means to improve health and safety performance. In terms of Mr Gibson's performance agreement for the year ending June 2021, performance in health and safety was given the greatest weighting, of 30%.[104] Additionally, the Executive team had shared KPIs, meaning they had to work together on certain health and safety goals set by the Board.[105]

[183] Mr Gibson introduced a mandatory requirement that POAL leadership training included health and safety leadership. All staff members received online health and safety training.

[184] A fatigue risk management system was in place for stevedores, involving a rotation and rest system for fatigue management purposes. When a gantry crane was operating, two lashers would be resting.[106]

[185] Newly trained lashers were paired with experienced lashers and required to wear a white hard hat for a period while they gained experience. By 2017, a minimum of 160 hours experience as a "white hat" was required before new lashers "graduated" to wear a green hard hat.

[186] Hazard boards, identifying any hazards associated with working on a ship, were introduced and placed at the gangway where lashers accessed the ship. By 2019 or 2020, the hazard board would also include a reminder that lashers were to work in pairs.[107]

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[104] NoE 2334 (Coutts); Exhibit 65.
[105] NoE 1484 (Gibson).
[106] Described at [91](a) above.
[107] NoE 744-755 (Tahiwi).

[187] Members of the Executive team, including Mr Gibson, sought to engage regularly with the workforce. I accept that Mr Gibson undertook up to 30 "Have-Your-Say" workshops with staff across POAL, in which feedback was sought. Such workshops would, in part, address health and safety issues. The outcomes of the workshops and staff feedback were presented to the health and safety team and discussed by the Executive. Workplace surveys were conducted with the aim of understand organisational culture, including in relation to health and safety, with the first being carried out in 2012. Drop boxes were introduced, by which staff could make anonymous reports of matters of concern if they wished.[108]

[188] I also accept the evidence I heard at trial that, during his tenure as CEO, Mr Gibson introduced a number of measures designed to enhance staff wellness.[109] These measures included pre-employment fitness tests, instituting and regularly attending free fitness classes known as PortFit, introducing healthier food to the canteen and having diabetes awareness classes.

Summary re POAL's health and safety system

[189] The foregoing provides a general overview as to POAL's health and safety systems. As is to be expected in any large organisation with operations distributed over a number of divisions, POAL operated an expansive health and safety system which delegated roles and responsibilities from Board level to the operational level.

[190] Mr Gibson's role, as an officer and the CEO, was to lead the organisation and to ensure that POAL's systems and processes were adequate to ensure the safety of workers and compliance with the HSWA.

Mr Gibson's position, responsibilities and experience

[191] As above, Mr Gibson was employed by POAL as its CEO from February 2011 until the end of June 2021.

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[108] NoE 594 (Lander); and NoE 1573 (Gibson).
[109] NoE 1514-1516.

[192] Prior to his appointment as CEO of POAL, he had some 30 years' experience in the shipping and logistics industries, including employment in major international shipping companies.[110] He had not, however, previously worked specifically in or for a port. Mr Gibson's evidence was that, prior to taking up the position at POAL, he had little experience in managing health and safety systems.[111] It is clear, however, that by the commencement of the period reflected in the charges, Mr Gibson had acquired significant knowledge and experience of POAL's operations and systems, including the health and safety systems.

[193] As CEO he was, of course, responsible for the management of POAL and was the head of the general management team. His duties included ensuring that the company met its key objectives as set out in POAL's annual business plan, overseeing direct reports from each member of the general management team, holding directorships on subsidiary companies, and representing POAL in various industry bodies. During the Covid-19 pandemic he was also tasked with managing POAL's interactions with external organisations and agencies, including regulators.

[194] As described in POAL's Health and Safety Manual, as CEO Mr Gibson was tasked with a number of key health and safety responsibilities including authorising and approving the Health and Safety Manual, approving the annual health and safety plan, and ensuring all members of the HSSC attended meetings.[112]

[195] As previously described, a 30% weighting was given to health and safety performance in Mr Gibson's performance agreement. In terms of that agreement, he was to receive notification of all lost-time injury events from managers within 24 hours of each incident, approve any activities identified as "extreme risk" and receive monthly analysis of incident data ahead of HSSC meetings.

[196] As CEO of an organization the size of POAL, Mr Gibson had to assign responsibilities or delegate authority, but he retained responsibility for monitoring and

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[110] NoE 1445-1448.
[111] NoE 1485.
[112] Exhibit 37.

reviewing the performance of his subordinates. As Mr Gibson acknowledged, he remained ultimately responsible for health and safety at POAL.[113]

[197] The defence emphasises that Mr Gibson was considered to be a good CEO and leader. I heard evidence that Mr Gibson was "a really good person and a good manager", that he would made the effort to be seen around the working areas of the Port, that he would remain late on occasion to interact with the night shift, that he knew frontline staff by name, attended staff Christmas parties and staff funerals.

[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:[114]

(a) expansion of the health and safety team;

(b) his attendance and presentation of reports to the Board;

(c) the introduction of PortSafe;

(d) the engagement of external auditors;

(e) the introduction of health and safety KPIs for general managers and other managers;

(f) the introduction of the fatigue management system;

(g) the introduction of pre-employment fitness tests and PortFit classes, and an emphasis on personal wellness;

(h) the establishment of the HSSC;

(i) the introduction of OPCs;

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[113] NoE 1805.
[114] Defence closing submissions, at [204.1]-[204.12].

(j) the training of stevedores to an NZQA unit standard;

(k) the introduction of crane simulators for training purposes;

(l) expenditure on significant port infrastructure projects;

(m) the introduction of the Have Your Say workshops;

(n) the introduction of workplace surveys;

(o) the introduction of health and safety leadership training;

(p) the removal of consecutive eight hour shifts;

(q) the introduction of comprehensive job descriptions;

(r) the introduction of lash platforms.

[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.

[200] 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.

[201] I also conclude and accept that these features demonstrate that 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.

The Automation Initiative

[202] During the charging period, POAL was engaged in a major project directed towards significantly automating port operations. The automation initiative was led by Mrs Coutts as Chair of the Board and by Mr Gibson as CEO. This was a significant project for Mr Gibson, as evidenced by the 25% weighting given to it in his KPIs for the 2020 Financial Year. It was intended, before the Covid-19 pandemic intervened, that automation would commence in 2020.[115]

[203] Mrs Costley was engaged to assist with the implementation of the initiative. That included the introduction of a formal change management process so that POAL could understand how automation would affect POAL's existing systems and processes.

[204] The prosecution submitted that Mr Gibson's predominant focus on automation meant that his attention was diverted from his core responsibilities, and that focus also diverted Mrs Costley from maintaining momentum towards a systematised understanding of work as done. The prosecution submit that this was an unreasonable misdirection of Mr Gibson's focus, albeit one undertaken in good faith, away from his responsibilities for health and safety at POAL.

[205] The defence says that the automation initiative was part of overall health and safety at POAL. Automation was a practical way to reduce health and safety risks to workers, in addition to increasing efficiency of port operations. Embedded in the project were health and safety protocols, health and safety systems and the use of outside audits to ensure that proper standards of practice were in place.

[206] I do not consider that I need to determine whether there was an undue focus on the automation project on the part of Mr Gibson and/or Mrs Costley. Again, the issue in this case is, ultimately, whether Mr Gibson failed in his duty to ensure that POAL had and used appropriate resources and processes to eliminate or minimise health and

[115] The automation initiative was not successful. It was eventually terminated by POAL after Mr Gibson and Mrs Coutts left their positions, resulting in a $65 million write off.

safety risks and to verify the provision and use of those resources, as particularised in the charges.

Systems Leadership

[207] As I have previously noted, in any large organisation, effective systems are key to health and safety management.[116] There is no significant dispute between the parties as to the role of a CEO in relation to the operation and management of business systems.

[208] Mr Kahler's evidence was that it is the role of a CEO, at a minimum, to:[117]

(a) Introduce and improve systems so that they are in line with legislative requirements, government guidance and relevant scientific research, and achieve the policies of the Board;

(b) Verify that the business systems are achieving their purpose and the policies of the Board;

(c) Regularly report on the operation and verification of the systems to the Board.

[209] Additionally, a CEO must demonstrate, through their personal behaviour, the importance they place on safe work practices. Mr Kahler said that the work of a CEO regarding systems "is to be in a place that the information feeding up gives them assurance about what is taking place down through the organisation." [118]

[210] Mr Gibson accepted that systems were key to his role as CEO and that a CEO needs to have the systems feeding information back to them through "performance measures".[119] He accepted that he needed to obtain information about what people

[116] See above at [79] and [94-97].
[117] NoE 1031-1035, Exhibit 118 (slide 15).
[118] NoE 1007.
[119] NoE 1770-1771.

were doing on the ground and a system in place to ensure that he was looking at the right information.[120]

[211] I accept the evidence I heard as to a CEO's role in system leadership. 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".

The risks involved in stevedoring / POAL's and Mr Gibson's awareness of the risks

[212] Stevedoring is an inherently dangerous business. By comparison to other industries in New Zealand, it has the second worst rate of injuries.[121] By international standards, New Zealand ports have high rates of fatalities, with 1.8 fatalities per year over the past 10 years. In New Zealand, for every 5,000 stevedores employed full time there is one fatality per annum.[122] Statistically speaking, a company employing 600 stevedores will, therefore, experience a fatality approximately every eight years. Regulators had been drawing this data to the attention of senior port company staff from as early as 2010 or 2011.

[213] There is no dispute in the present case that Mr Gibson and POAL were aware of the risks inherent in stevedoring.

Critical risks

[214] In 2017, POAL's board committed to the identification and management of critical risks to its workers, that is, operational risks most likely to cause a fatality or serious harm. Prior to that time, POAL had identified 38 general health and safety hazards. The changed emphasis on critical risks was in line with WorkSafe's guidance to PCBUs that such risks needed to be identified and prioritised.

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[120] NoE 1771-1772.
[121] NoE 835 (Riding).
[122] NoE 1427-28 (Kahler).

[215] The seven critical risks identified by POAL were mobile equipment, working at heights, handling loads, working in isolation, dangerous goods, marine operations and pedestrian safety. The critical risk related to the handling of loads is the risk relevant to these proceedings.

[216] There is also no dispute in this case that the risks associated with falling objects and with working around cranes are generally well-known. As Mr Kahler succinctly put it, "gravity is generally [the] most common killer of people and suspended loads precedes all legislation, it's been with us for a hundred years of data recording".[123]

Controls utilised to address the critical risk

[217] POAL relied on a number of controls to manage the risk of handling overhead loads including gangway briefings, the use of the hazard board, lasher training, lash leading hand training, supervisor shift visits and walkabouts, and toolbox meetings. Most of those controls were first identified in 2016. POAL considered them to still be effective in 2018. I note, however, the absence of evidence of any "hard" or technical controls, for example, the placement of physical barriers or signage preventing access to areas where a crane was working on a ship. I consider it relevant that such additional controls were able to be put in place within a very short space of time following Mr Kalati's death.

[218] The introduction of the lash platforms was a further control addressing the critical risk of objects falling from overhead loads, particularly the risk of twist-lock mechanisms falling from suspended containers. The evidence is that the lash platform concept was developed after Mr Gibson observed lashers placing and removing twist-locks while a container was suspended over the wharf from the gantry cranes. Mr Gibson gave evidence that this "scared the living daylights" out of him.[124] It is clear that the introduction of lash platforms was a significant positive development in the management of this critical risk. It was a hard or technological control. This evidence is, however, a double-edged sword: while the introduction of the lash platforms speaks positively to Mr Gibson's desire to address risk and promote worker

[123] NoE 1411.
[124] NoE 1602 (Gibson).

safety, it is also a matter of concern that the risk only appears to have been recognised and addressed after Mr Gibson personally observed the way the work was being undertaken. There is no indication in the evidence that POAL had identified the risk and the need for the associated control in any systemic way. Further, the evidence demonstrates that Mr Gibson was personally aware of the risks to stevedores in working under suspended containers and the need, in that case, for additional controls to be put in place.

Executive & Board review of critical risks

[219] Evidence was given that the Executive would engage in what was described as a monthly "deep dive" into each one of the seven critical risks. Mr Gibson, General Managers and the Senior Manager of Health & Safety would review a critical risk and a Critical Risk Report would be produced and presented to the Board. A review of the critical risk of handling loads was carried out and a report presented to the Board at its June 2019 meeting.

[220] Two critical risk reports relating to handling loads, pre-dating the Board meeting of June 2019, were produced in evidence. The first was dated 7 May 2018.[125] The second was dated March 2019.[126] The latter report referred to the earlier and stated "all scenarios identified in the 2018 Risk Assessment continue to have effective controls, however with the implementation of Automation a number of new controls are improving this effectiveness". The 2019 report also included a table setting out numbers of incidents, near misses and non-compliance.[127] However, the report stated: "It is likely this table is not reflective of actual events occurring within POAL operational areas due to lack of overall reporting".

[221] In relation to the 2018 report, Mr Kahler said that the paper presented to the Board on this critical risk was:[128]

> …not a report that reflects current actual behaviours of lashing crews or any other crews. It is a descriptive document of how handling loads is managed in

[125] Exhibit 60.
[126] Exhibit 61.
[127] Exhibit 61, at 1234.
[128] NoE 1186.

> the business. I would have expected the document to reflect the results of audits, observations and engagement processes that would assure the CEO and the Board that handling loads was happening effectively. There are no lead indicators mentioned in the document and it is not understood why the note in the Board Report refers to lead indicators with respect to this Critical Risk Report. It is possibly referring to the 'lead indicators' of Hazard Reports and Near Miss Reports, as appear in the Monthly Steering Committee reports."

[222] In relation to the March 2019 report, Mr Kahler said:[129]

> It appears to be a guidance document. It does not describe the overall Critical Risk Owner or describe Critical Controls and the Control Owners appropriately. It has no measures with respect to verification by nominated roles of Critical Controls. This document does not allow a senior leader, such as the CEO, to gain insight as to what the actual compliances with associated controls are … It is the CEO's responsibility to ensure the Critical Risk programme develops into a robust system of sustainable Critical Controls that focus on reducing the fatality risk.

[223] Mr Kahler referred to these documents as reflecting "health and safety immaturity". He said "... what I am not seeing in any of this is how you get the confidence at the CEO and Board level that what is happening, that we've got our critical risks effectively managed." [130]

[224] I accept Mr Kahler's evidence in relation to these critical risk reports. The reports demonstrate that senior management or the Board were not gaining insight into work as done in relation to the critical risk of handling loads. Further, the March 2019 report positively alerted the reader to the fact that the data it did contain was likely not reflecting work as done in POAL's operations.

[225] Mr Kahler's evidence in relation to the reports is also consistent with what was stated in the 2018 KPMG audit report.[131] In relation to Health and Safety Performance reports, the audit report noted the lack of commentary in the reports regarding the effectiveness of critical controls for critical risks and recommended that such information be included. The audit report noted that management agreed with the recommendation and were committed to developing appropriate measures and targets

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[129] NoE 1195.
[130] NoE 1188.
[131] Exhibit 69, at 1387 and 1388.

and report on those to the Board in the monthly Health & Safety Report, including the effectiveness of critical controls for critical risks.

[226] The critical risk of handling suspended loads was not addressed again in Board minutes until after Mr Kalati's death. A Critical Risk report relating to Marine Operations was noted by the Board in the minutes for August 2019. Thereafter, there are no references to the receipt of critical risk reports.[132]

Bow-tie analysis / managing the critical risks

[227] In 2017, "bow-tie analysis" was introduced at POAL as a means of assessing and developing controls for critical risks. Bow-tie analysis is a risk management tool which centres on a hazard or potential adverse safety event. The left side of the analysis diagram represents the period of time before the event occurs and seeks to identify potential causes of the event and appropriate controls which might address or prevent the event occurring. The right side represents the period following an event, in which potential outcomes of the event and measures which might mitigate those outcomes are identified. The use of bow-tie analysis, therefore, assists in the identification of preventative and mitigating controls in relation to a hazard.

[228] Mr Gibson relies on the introduction of bow-tie analysis as evidence that resources were made available for the assessment of critical risks. He said that the bow-tie assessments were "on the wall" and people were invited to come in, comment and add their views to the assessments in an effort to make it an interactive and fun process.[133]

[229] The evidence suggests, however, that POAL's bow-tie assessments of critical risks and, in particular, the risk associated with handling overhead loads, were inadequate and not progressed in a timely manner. As above, bow-tie analysis had been introduced at POAL as early as 2017. The health and safety strategy plan for the year ending June 2019 suggested that there was to be a focus on critical risks and that bow-tie risk assessments were to be conducted on those risks.[134] However, the

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[132] Exhibit 66.
[133] NoE 1636-1637.
[134] Exhibit 51, at 925.

monthly safety and well-being reports from January to July 2019 repeatedly noted that bow-tie assessments were being developed or "in progress".[135] The August 2019 report noted that the Executive had agreed to a "more proactive approach" to bow-tie assessments[136] and the September 2019 HSSC report noted, in relation to bow-tie assessments, that workshops were to be completed to collect relevant information and that "currently, these have been done with minimal input".[137] Thereafter, there are no further references in the reports to bow-tie assessments being completed.

[230] Mr Kahler's evidence was that a competent bow-tie analysis associated with loading and unloading containers and falling objects could be completed in less than a day.[138]

[231] I accept the prosecution submission that this evidence demonstrates a lack of focus on ensuring the progression of critical risk management in a meaningful and timely way.

Lack of guidance from regulators?

[232] Mr Gibson submits that New Zealand regulators, principally WorkSafe and MNZ, did not produce relevant guidance material, standards or a code of practice relating to PCBU duties in ports or in stevedoring operations. In that respect, the regulators were not meeting International Labour Organisation obligations to publish relevant safety guidance.[139] It is submitted that the absence of such guidance is a material factor in assessing what was reasonably practicable in relation to POAL's duties[140] and, therefore, the reasonableness of Mr Gibson's actions in terms of his section 44 duty.

[233] In relation to the critical risks with which this case is concerned, that is, the handling of suspended loads and crane operations, I do not accept the defence submission. First, the evidence is clear that significant international guidance in

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[135] Exhibit 57.
[136] Exhibit 57, at 1104.
[137] Exhibit 48, at 910.
[138] NoE 1281.
[139] NoE 933.
[140] Health and Safety at Work Act 2015, s 22.

relation to port operations and stevedoring was available. Second, as noted above, the risks associated with crane operations and suspended loads are well recognised and well documented. The risks, and the need for effective control and management of those risks, are obvious. Third, POAL and Mr Gibson had recognised the critical nature of such risks.

The importance of understanding "work as done"

[234] "Work as done" is the reality of work as it is actually carried out by the workers on the shop floor. This is in contrast to "work as planned", "work as intended" or "work as imagined", that is, methods of work designed, understood or expected by management and other staff who do not actually undertake the work.

[235] There is no dispute in the present case as to the central importance of any PCBU gaining an understanding of work as done:

(a) Professor Dekker highlighted the efforts required to close gaps between work as designed versus work as done.[141]

(b) Mr Kahler explained that "you've got to understand work as done because the ultimate test of your system is what is happening".[142] He also said that "unreported experience and knowledge within work teams" is a powerful predictor of harm. Such information will not generally be deliberately withheld by workers but, for a wide variety of reasons, it may have become a cultural norm to not report incidents or experience.[143]

(c) Mr Marriott confirmed that an organisation needs to understand work as done to understand the effectiveness of its systems. Mr Marriott equated the concept of understanding work as done to "learning from normal operations".[144]

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[141] Exhibit Y, para 5.
[142] NoE 1017.
[143] NoE 993.
[144] NoE 2073 and 2157.

[236] Structured observation processes are a means by which a PCBU can acquire insight into work as done.

POAL's previous convictions: was Mr Gibson on notice of inadequate monitoring of work as done?

[237] During Mr Gibson's tenure as CEO, POAL was convicted of offences under HSWA or the previous legislation, HSEA, on four occasions (excluding POAL's convictions relating to the death of Mr Kalati). Mr Gibson accepts that, as CEO, he was made aware of each incident giving rise to the prosecutions and was involved in POAL's decisions to plead guilty in each case.

January 2014

[238] On 22 January 2014 a stevedore employed by POAL fell overboard from a vessel while attempting to dislodge a twist lock mechanism which was stuck at the top of a two-high container stack, using a lashing pole. He lost his balance and fell overboard, striking objects or structures during the fall. He suffered serious injuries.[145]

[239] A safety rail which ought to have been in place on the deck of the vessel was not in place. The stevedore had not been required to use a personnel cage to be safely lifted to the stuck twist lock. A previous Ship Supervisor's inspection had failed to address the fact that the safety rail was not in place and there was no insistence on the use of a safety cage. POAL had, some months earlier, approved and signed off on a policy or model which excluded the use of the lashing pole to remove twist locks and required that safety rails be in place.[146] Notwithstanding that, the institution of the policy did not manifest itself in a change of practice at the point of work.[147]

[240] POAL admitted that it had failed to:

(a) conduct adequate training of Ship Supervisors in relation to conducting ship inspections and, in particular, inspections of safety rails;

[145] Agreed facts, at paras 11 and 12; Exhibits 86 & 87.
[146] Exhibit 87, at para 7.
[147] Exhibit 87, at para 8.

(b) provide ongoing training to stevedores on health and safety procedures, in particular in relation to the use of safety rails;

(c) prohibit and/or effectively communicate a prohibition on the use of unlocking poles for removing twist-locks from the tops of containers; and

(d) adequately monitor employees while at work, in order to identify and prevent unsafe work practices.[148]

[241] Mr Gibson accepted in cross-examination that this incident was an example of POAL's health and safety systems not operating as intended and involved a disconnect between work as done and work as imagined.[149]

October 2014

[242] On 11 October 2014, a POAL stevedore was standing on the edge of an unprotected hatch lid on a container vessel, watching a container being unlashed, when he stepped off the hatch lid and fell onto a deck 2.78 metres below.[150] Stevedores had developed a practice, when working on that particular vessel, of walking across the hatch to access points of work rather than using inconvenient and ill-designed access ladders. POAL had a "1.4 metre rule" in place, which required employees to stay at least 1.4 metres away from fall edges. The rule was, however, inadequately communicated to workers and not referred to in relevant training manuals.[151] A shift supervisor had signed the vessel off as safe for work. He had not noted the lack of fall protection at the edge of the hatch lid, nor did he require temporary safety rails to be put in place.[152] No workers were reminded or told of the 1.4 metre rule.[153]

[243] POAL admitted that it had failed to:

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[148] Agreed facts, para 13; Exhibit 86.
[149] NoE 1791-1792.
[150] Agreed facts, paras 15-16; Exhibits 88 & 89.
[151] Exhibit 89 at paras 20–21 and 30-32.
[152] Above at para 24.
[153] At para 26.

(a) advise the owner of [the vessel] of the [difficulties with the access ladders] and/or require the ladders … to be adjusted … ;

(b) effectively prohibit stevedores from walking on unprotected hatch lid edges and/or communicate that requirement to stevedores;

(c) require safety rails to be put up on the hatch lid area of [the vessel];

(d) effectively communicate to employees a rule or requirement that they stay at least 1.4 metres from fall edges; and

(e) require employees to stay at least 1.4 metres from fall edges of less than 3 metres.[154]

[244] Again, Mr Gibson acknowledged that this incident demonstrated a gap between work as done and work as imagined or designed.[155]

April 2017 – January 2018

[245] Between 20 April 2017 and 31 January 2018, pilot boats operated by POAL exceeded 5 and 12 knot speed limits in the Waitemata harbour on somewhere between 3,465 & 4,257 separate journeys.[156] Although MNZ's investigation had commenced as the result of the death of a swimmer, the charge and facts to which POAL pleaded guilty did not allege any nexus between the offending and any injury to any person. POAL submitted that its systemic failures arose as a result of the misinterpretation of an applicable exemption to the speed limits which applied in the harbour.[157]

[246] POAL admitted that it had failed to:

(a) have or implement adequate processes to ensure its pilot boats observed applicable speed restrictions and travelled at safe speed as required by the Maritime Rules; and/or

[154] Exhibit 88.
[155] NoE 1795.
[156] Agreed facts, paras 17-19; Exhibits 90 & 91.
[157] Exhibit 91, at para 49.

(b) not operate pilot boats in breach of applicable speed restrictions or at unsafe speed.[158]

[247] While noting the issue concerning the misinterpretation of the speed restriction exemption, Mr Gibson accepted in cross-examination that the case was another example of a disconnect between work as done and what should have been done.[159]

August 2018

[248] On 27 August 2018, a nightshift straddle driver, Mr Dyer, was killed when his straddle carrier tipped over. He was not wearing a seatbelt and was using a mobile phone, in violation of policies put in place by POAL.[160] POAL was also operating a bonus scheme based on productivity which caused drivers to feel that they had to work as fast as possible. Straddle cranes were fitted with tip alarms, which would activate when the vehicle exceeded certain parameters and there was a risk of tipping. Mr Dyer had a high tip alarm activation record.[161] POAL had identified the risk of a carrier tipping and had, in 2017, dedicated significant resources to addressing that risk. There had been a high number of tip alarm activations and POAL instituted a project to reduce the number of activations, including by way of re-educating drivers. That initiative did significantly reduce tip alarm activations. However, having achieved that outcome, POAL stopped the project and ceased monitoring the alarms. By the time of Mr Dyer's death in August 2018, alarm activations were back to the levels which existed prior to the project.[162]

[249] POAL admitted that it had failed to:[163]

(a) develop, document, communicate and implement appropriate training for straddle carrier drivers in relation to:

(i) the risk of the straddle car tipping whilst turning;

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[158] Exhibit 90.
[159] NoE 1797-1798.
[160] Exhibit 93 at paras 3 and 4.
[161] Above at para 5(7).
[162] At para 12; also see NoE 1799-1801 (Gibson).
[163] Exhibit 92.

(ii) the operation and significance of the tip alarm; and

(iii) the actions to be taken if the tip alarm were activated.

(b) ensure that there was in place an effective system for monitoring and addressing critical tip alarm activations by straddle drivers;

(c) ensure that there was in place an effective system for monitoring and enforcing safety policies in relation to the wearing of seatbelts while driving and the use of handheld electronic devices in operational areas by straddle drivers; and

(d) ensure that the bonus scheme incorporated parameters that promoted safe driving practices in relation to the stability of the straddle carriers, to counter-act any incentive to achieve greater productivity at the expense of safety.

[250] Mr Gibson said in evidence that one of the trainers or OPCs had made the decision that tip alarms no longer needed to be monitored. He acknowledged that he should have been made aware of that decision.[164] I accept that, again, the facts of this fatality demonstrate a disconnect between work as done and what should have been done.

[251] I interpose that the bonus criteria were modified in March 2019, following Mr Dyer's death, as a result of a proposal made by Mr Lander, through his superiors Mr Hulme and Ms Powell, which Mr Gibson endorsed. Mr Gibson was not, however, made aware that Mr Lander had been advocating for the removal of the bonus scheme altogether.[165]

[252] Mr Gibson argues that Mr Dyer's fatality prompted "a thorough review" and that he subsequently arranged for tip alarm notifications to be sent directly to his

[164] NoE 1801.
[165] NoE 1803.

computer and devices.[166] The prosecution submits that there is no evidence that Mr Gibson acted on any such information is a systematic manner.[167]

Conclusions re POAL's previous convictions

[253] The defence acknowledges that the conviction of POAL following Mr Dyer's fatality is "the most relevant" of POAL's convictions, in relation to the prosecution allegations that Mr Gibson, as CEO, did not pause and reflect after POAL's convictions, understand the pattern of failings reflected by those events, question POAL's systems and institute appropriate audits of those systems.[168]

[254] It was put to Mr Gibson that, as a result of POAL's convictions dating back to 2014, he must have been aware that POAL had serious systemic health and safety problems. He acknowledged that there were issues but said that, on each of the occasions which resulted in prosecution, POAL addressed what were thought to be the appropriate actions in response. In response to a suggestion that steps subsequently taken were simply reactive and did not reflect a systemic response on the part of POAL, Mr Gibson did not accept systemic failure. He acknowledged that there were failures and that things could have been done better but said that there were "significant learnings from … the unfortunate tragedies that occurred at the Ports" and that he hoped that, from those tragedies, a better health and safety system and standards had been developed.[169] He accepted that it was his job, as an officer of POAL, to make sure he took those learnings and fixed the problems to the extent that he could, but added that the entire organisation has a responsibility for health and safety.[170]

[255] Mr Gibson accepted that each of the prosecutions which occurred under his leadership as CEO involved monitoring or supervisory failings on the part of POAL.[171]

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[166] NoE 2386 (Coutts) and NoE 1684 (Gibson); and Defence closing submissions, at [652].
[167] Prosecution closing submissions at [95.3].
[168] NoE 1333 (Kahler); Defence closing submissions, at [651].
[169] NoE 1803-1805.
[170] NoE 1805.
[171] NoE 1806.

[256] I am satisfied that POAL's previous convictions all reflect, to varying degrees, a failure on the part of POAL to adequately monitor health and safety systems or policies and to supervise workers. Common systemic failures on the part of POAL are reflected in the previous cases. The convictions demonstrate a consistent failure on the part of POAL to properly understand work as done, as opposed to work as designed or imagined.

[257] There is no dispute that Mr Gibson became fully aware of the circumstances giving rise to each of POAL's previous convictions. I am satisfied, therefore, that Mr Gibson was on notice, at least from late 2018 following Mr Dyer's fatality, that POAL had demonstrated ongoing difficulties in adequately monitoring work as done. 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.

The culture and work practices of the nightshift

[258] I am satisfied that, prior to Mr Kalati's death, there was a culture, particularly on the nightshift, of the stevedores engaging in unsafe practices or "cutting corners".

[259] Three of POAL's previous convictions are generally relevant to this issue, as non-compliance by stevedores was a feature of all three incidents.[172] The January 2014 offence arose as a result of non-compliance with approved policy regarding use of the unlocking pole. The October 2014 offence occurred after stevedores had developed a habit of walking across hatches as a matter of convenience and in breach of the "1.4 metre rule". The August 2018 offence involved Mr Dyer not wearing a seatbelt and using a mobile phone in breach of POAL's policies. In that case, Mr Dyer had a high tip alarm activation record but had consistently received a productivity bonus.

[260] POAL had been alert to the issue of lasher non-compliance since at least 2014.[173]

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[172] See [238]-[244] and [248]-[252] above.
[173] Exhibit L.

[261] I am satisfied on the evidence I heard that, in the period leading up to Mr Kalati's death, non-compliance was a regular feature on the nightshift.

[262] I heard evidence from a number of lashers who spoke of non-compliant practices on the nightshift. The transcripts of audio interviews with LB, KM and WM were admitted by consent and the interviews played in evidence. The defence did not require those witnesses to give oral evidence. Two lashers, MH and VH, gave oral evidence. They were not challenged under cross-examination in relation to evidence they gave about non-compliance on the night shift.

[263] On the basis of that evidence, I accept that lashers would commonly undertake unsafe and/or non-compliant practices during nightshift. By way of example, VH said:[174]

> Q. You said before that the rules were slightly different on nights. Can you help us understand what you mean by that?
>
> A. So I – the rules were the same, it was just the culture on the nights was different, yeah.
>
> Q. Sorry, what do you mean by the culture was different?
>
> A. We just wouldn't really follow the rules to get the work done faster. Yeah, and so everybody was doing it, so if you didn't, you'd sort of be the odd one out and… which didn't make you cool.
>
> Q. Why did you want to get the work done faster?
>
> A. To – to be on break faster. And because everyone was doing it, you didn't want to be the only one.
>
> Q. Now, I just want to be clear who – when you say sort of everyone was doing it, who is everyone? Just the lashers?
>
> A. Just the lashers.
>
> Q. What about the lash leading hand and the ship foreman or the ship 5 leading hand?
>
> A. (no audible answer 12:01:29).
>
> Q. Sorry, we'll start with the lash leading hand. Was the lash leading hand part of this culture as well? The lash foreman.
>
> A. Ah, would maybe turn a blind eye sometimes but he wouldn't encourage you to break rules, yeah.
>
> Q. Can you give us an example of where the lash man might turn a blind eye to something?
>
> A. So we're supposed to be, was it three containers away from the working point? We'd just be standing there with bars and then the

[174] NoE 255-256 (VH).

> container would drop down in front of us and then when it lands we could lash it up, so we weren't supposed to be necessarily right in front of it but the lash man would sort of lead us there so… yeah.

[264] In his interview, LB said:[175]

> … the night shift work a little bit faster so that was kind of, then that was in my head like okay. So entering the night shift it was, it was fast paced and it was, health and safety was a little bit um different because um there was a little bit of corners that are being cut to um sort of …
>
> … when we went to nightshift it was like whoa these guys are really fast they're lashing by themselves um, so you kind of it – it was like a thing, everyone was doing it. Um so it, there was a little bit of pressure as well so because we were new we were, um didn't really want to be the slow, the slow guys um so it was like we got to get, get the ball rolling with these guys otherwise we'll be the – the newbies that are slow.

[265] Various non-compliant practices on the night-shift practices included:

(a) Lashers would not stay the prescribed distance away from containers as they were being lowered onto the lash platform. Some lash leading hands were aware of this practice. [176]

(b) On the lash platform, lashers would press the buttons which returned control to the crane operator before they had finished removing or installing twist locks from or to the container.[177] This was done to speed up work by minimising the delay before the container could be lifted. The crane operator would therefore be able to lift the container while the lashers were outside of their huts and working on the container.

(c) Lashers would rarely work in pairs, as working alone was seen to be faster.[178] This was despite POAL's policy being clear that lashers were to work in pairs.

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[175] Exhibit 80, at 6 (LB).
[176] NoE 256 (VH).
[177] NoE 212 (MH).
[178] NoE 176 and 194 (MH); Exhibit 80, at 6 and 31-32 (LB).

(d) A practice referred to by the lashers as "load and lash" existed. Lashers would wait adjacent to a container being lowered onto a ship, so that they could lash it immediately. Some lashers would even begin attaching the lashing bars while the container was still being lowered.[179]

(e) Some lashers would use phones or listen to music while working on a vessel, despite being prohibited from doing so.[180]

[266] GB gave evidence. In 2020 he was a Shift Operations Manager. He said:[181]

> Q. Now, the reason I'm asking is because we've heard from some witnesses, just to be fair to you, that there was a difference between the dayshift and the nightshift in terms of compliance of that rule and I just wanted to ask you whether or not you were aware of that and this is before COVID and during COVID.
>
> A. Yes. Definitely we were aware of corners being cut.
>
> Q. Can you tell us how you were aware of corners being cut?
>
> A. By going out and seeing it happen, if I was out there doing an observation or going for a walkabout sort of thing.
>
> Q. Just so that we're clear, were you talking specifically about nightshift or dayshift?
>
> A. Both, both shifts it happened on, not all the time but there were incidences on both shifts, yes.
>
> …
>
> A. … so yeah, both shifts corners they had corners being cut, on occasion, yeah.
>
> Q. And so we've heard that there was a difference between dayshift and nightshift in terms of the rule of compliance, is that something that you were aware of?
>
> A. As a –
>
> Q. Just to be clear with you, that there was less compliance with that rule on nightshift?
>
> A. Correct, yes.
>
> Q. Sorry when you say –
>
> A. Ah, with yeah, there was probably more, less compliance on nightshift, yes.
>
> Q. And you've explained that you knew about that because?
>
> A. If I'd go out there doing a safety observation I'd notice it happening first hand.

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[179] NoE 192 (MH).
[180] NoE 192 (MH).
[181] NoE 779-780.

Q. And what would be your response?

A. To deal with the lashers in question and supervise and tell them not to do it.

Q. Would there be any other way that you became aware of that?

A. If someone let us know or someone told us about it.

Q. For example?

A. Say someone else was out there and they saw it happening and they called us up and let us known about it, and then we'd go and deal with it.

[267] I note GB's reference, in the preceding passage of evidence, to "we" being aware of corners being cut. GB also spoke of the safety culture changing after Mr Kalati's fatality and of Shift Operations Managers making efforts to be seen out in the working areas of the port more frequently – at least once to twice a shift.[182]

[268] It was suggested in cross-examination of Mr Kahler and in the evidence of Professor Dekker that the Court is unable to draw a conclusion as to whether there was widespread non-compliance on the nightshift by reason of the small sample size of the lashers whose evidence was presented to Court. I reject that suggestion. First, I am required to determine this case on the evidence I heard. I am not engaged upon a mathematical or statistical analysis. Second, the unchallenged evidence which I did hear, some of which I have referred to above, made clear that such practices were widespread.

[269] The existence of a culture of non-compliance on the night shift highlights the need for POAL to have had adequate systems in place to understand work as done on the night shift. It was the responsibility of POAL's officers to ensure that such systems were in place and effective.

Safety observations during the night shift

[270] Observations of workers could be undertaken by the OPCs, Ship Supervisors, Shift Operations Managers, and members of the Health & Safety Team.

[182] NoE 785-787

[271] The parties take opposing views as to who, primarily, was responsible for undertaking safety observations and the effectiveness of observations which were undertaken.

[272] Mr Gibson submits that Ship Supervisors were the persons tasked with primary responsibility for carrying out observations and were required to do so on every shift. OPCs were not solely responsible for conducting observations during shifts.[183] Health and safety compliance was always a particular focus of the Ship Supervisors' role.[184] Ship Supervisors performed at least one walkabout per shift and input their observations to PortSafe.[185]

[273] Shift Operations Managers also carried out worker observations, which continued during Covid-19, albeit less frequently. Additionally, the Health & Safety Team would undertake at least one lash walkabout per week, which was reported in the month Health & Safety reports and/or CEO reports to the board. On occasion, members of the Executive would also engage in walkabouts.

[274] Total numbers of monthly observations were reported in the monthly Health & Safety reports and, in March, June and August 2020, in the CEO's reports to the Board.[186] I note that in the monthly Health & Safety reports there was, generally, no detail provided as to the nature of the observations, the business unit involved, the time and dates of observations, who had conducted such observations or, importantly, analysis of what the observations actually revealed. The CEO's reports which were provided did provide more breakdown of the nature and timing of the observations, but no further analysis or reporting of overall compliance rates.[187] The evidence suggests that the information which was contained in the three CEO reports would have been obtained from the PortSafe dashboard application.

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[183] NoE 450; and NoE 747-748.
[184] NoE 585; Exhibit Q
[185] Exhibit U; Exhibit 60.
[186] Exhibit 57 at 1114, 1121, 1124, 1130; Exhibit 58 at 1139, 1148, 1165, 1174; Exhibits DD, EE and FF.
[187] I note that the CEO's reports, defence exhibits DD, EE & FF, were not put to any prosecution witness, including the expert witnesses called by MNZ, for comment. Nor were they produced during Mr Gibson's evidence. They were produced through Mrs Coutts. The defence advise that the documents were located by Mrs Coutts among her records on 12 May 2024, while Mr Gibson was under cross-examination.

[275] The prosecution submits that Shift Operations Managers and Ship Supervisors appear to have undertaken limited crew interactions, particularly on nightshift. The nightshift lashers who gave evidence said that they rarely interacted with or saw management while they were working on vessels.[188]

[276] The prosecution focuses on the role of OPCs as related to safety observations and submit that OPC observations were insufficient at capturing and recording work as done, particularly on the night shift. MNZ refers to Mr Landers's evidence that with the exception of Mr Lander's July 2020 initiative – to which I will return shortly – the OPC observation system was task specific and ad hoc.[189] Mr Tahiwi, one of the OPCs, said that in 2019 there was a significant focus on training rather than audits/observations.[190] Mr Gibson suggested in evidence that in mid-2020 OPC resources were diverted to training new recruits due to an acute workforce shortage and because POAL was preparing for a wider reorganisation as a result of the automation project.[191]

[277] Further, OPCs had limited ability to observe night shifts. Prior to Mr Lander's 2020 initiative, the OPCs were not required to work night shifts or weekends. Mr Tahiwi said that they were "predominantly a dayshift team".[192] Mr Lander described the OPCs as not providing 24/7 coverage: it would be "random" as to what hours between 7.00 am and 11.00 pm the OPCs worked. The OPCs chose which hours they elected to work. Mr Lander estimated that, with the exception of the July 2020 period where they were directed to work night shifts, 90% to 95% of the OPCs would work the dayshift with 5% to 10% working the nightshift. [193] MH said that he never saw OPCs on nightshift.[194] VH said that he might see OPCs at the start of the shift but not throughout.[195]

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[188] NoE 176-178 (MH); NoE 251 and 258-259 (VH).
[189] NoE 496.
[190] NoE 706.
[191] NoE 1834-1835.
[192] NoE 719.
[193] NoE 481.
[194] NoE 177
[195] NoE 259.

[278] I accept that evidence and conclude that, with the exception of the July 2020 period when OPCs were directed to work during the night shifts, OPC observations of the night shift workers was "sporadic" at best.[196] Despite 50% of the work at the Port being conducted during the night shift, OPC resources and observations were heavily weighted towards the day shift.

[279] Given the above and, in particular, the lashers' evidence of limited interactions with either OPCs or management, I do not consider it necessary to determine who had primary responsibility for conducting observations during the night shift. On any assessment, whatever observations were conducted on the night shift were inadequate. Any such observations clearly did not identify, in any adequate manner, that there was widespread non-compliance on the night shift. POAL's systems were clearly inadequate in identifying work as done.

[280] In that regard, I note that POAL pleaded guilty to a charge which particularised that it failed to 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.[197] POAL's conviction is conclusive proof of those matters.[198]

Mr Lander's restructuring proposals, the 2019 trial and the July 2020 initiative

[281] Mr Lander started at POAL in January 2019. Having identified the issues with OPCs, and driven by learnings from the 2018 straddle car fatality, in April or May 2019 he presented a restructuring proposal to his line managers, Jonathan Hulme and Angeline Powell: [199]

> A. My proposal was to put the workforce into crews, so to move the 250 stevedore workforce into crews where, in each crew, they would have a, those crews would report to a crew coach, a team leader, a person who was responsible that they had as their lead to be able to support them in their pastoral care, to be able to develop them, to deal with their issues and to have a level of support that was in place to support. So that was the reason for proposing that change at that time.
>
> Q. And that crew coach would be the OPC equivalent?

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[196] NoE 483 (Lander)
[197] See above at [11].
[198] Evidence Act 2006, s 49.
[199] NoE 478 and 562-563.

A. Correct, because they were the ideal people to undertake that role because they had great subject matter expertise, they were good people, people, and were ideally situated within the current structure to be able to apply that.

Q. And again, just for clarity, the people you made this proposal to were, the people you were speaking to in putting forward this proposal were Angeline Powell and Jonathan Hulme?

A. Correct, the proposal went to them after I'd prepared it with the assistance of people in capability business partners, so it was a formal proposal.

[282] The full restructuring proposal was declined. Mr Lander was told that "we're only doing incremental change, we're not doing wholesale change".[200] Mr Lander was unaware whether his proposal had been submitted to anyone else beyond Mr Hulme and Ms Powell.[201] He did not feel that it was appropriate within the organisational structure and hierarchy of POAL for him to approach more senior executives directly with the proposal.[202]

[283] Nevertheless, Mr Lander ran a scaled down trial of the proposal in the latter part of 2019. It involved developing the skills of a limited number of the OPCs by way of training in high-performance coaching skills, and assigning them responsibility for groups of stevedoring staff, in particular, straddle drivers.[203] This approach was referred to as "crew coaching". The OPCs who participated in the trial were still working on Monday to Friday contracts, so the trial did not operate on a 24 hours per day, 7 days per week basis.[204] Nevertheless, the trial was generally viewed positively. Mr Gibson said that he was aware of the trial and fully supported it.[205] It featured in POAL's 2019 Annual Report.[206] Mr Gibson said that the Board supported the trial and encouraged him to get on with it.[207]

[284] When it was suggested to Mr Gibson that the trial indicated what needed to be put in place by way of a structured observation programme, he initially said that the

[200] NoE 477.
[201] NoE 478.
[202] NoE 491.
[203] NoE 479-480.
[204] NoE 480-481.
[205] NoE 1831.
[206] Exhibit 128.
[207] NoE 1832.

trial "had nothing really to do with observations."[208] He later accepted, however, that the trial was a really positive initiative and was a way to clearly see work as done.[209] He said that the intention was for it to continue, but the trial was not rolled out permanently for a combination of up to four reasons: first, because it was a trial and it needed to be assessed as to whether it created value for the organisation; second, because of issues with the OPC's contracted working hours; third, because of a prospective wider organisational change as a result of the automation project; and fourth, because of the impacts of Covid-19 and POAL's planning for the pandemic in early 2020.[210]

[285] The prosecution submits that both Mr Lander's restructuring proposal and the rollout of the 2019 trial on a permanent basis, covering all shifts, would have constituted a major improvement and would have addressed the inadequacies in POAL's worker observation systems.[211]

[286] In relation to the 2019 restructuring proposal, Mr Gibson's evidence was that he was not made aware of it.[212] Mrs Coutts, similarly, said that she did not become aware of the full restructuring proposal.[213] I heard no evidence from Ms Powell, Mr Hulme or anyone else as to why the restructuring proposal was blocked. Mr Gibson submits that any "blockage" of the restructuring proposal by Ms Powell or Mr Hulme does not, therefore, reflect on him. He submits that any CEO must reasonably delegate responsibilities to responsible managers. I accept that there is no evidence upon which I could conclude that Mr Gibson was made aware of Mr Lander's 2019 restructuring proposal.

[287] It is clear, however, that Mr Gibson was fully aware of the 2019 trial and its benefits. In relation to the trial, given that Mr Lander's original restructuring proposal was made in April or May 2019 and the trial itself commenced in July 2019, the defence submits that can be considered a rapid response for a large organisation. While that may be the case, the submission misses the point that Mr Lander had

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[208] NoE 1832.
[209] NoE 1834.
[210] NoE 1833-1834.
[211] Prosecution closing submissions, at [334].
[212] NoE 1830.
[213] NoE 2389.

proposed a restructure which would have addressed the inadequacies in night shift observations. His line managers did not, apparently, advance that proposal. Instead, a scaled down trial commenced which, despite its benefits, did not and could not properly address the issue of inadequate night shift observations. That trial was discontinued in late 2019.

[288] In mid-2020, Mr Lander again formally proposed a workforce/OPC restructure. It was a very similar crew coaching proposal to that which he had advanced in 2019, but also using the results of the 2019 trial as further evidence in support.[214] Mr Lander said that, again, the proposal was declined:[215]

> It just seemed to stall in conversations between Jonathan and Angeline Powell and talking with Jonathan, pressuring him constantly: "What's happening?" It just seemed that there was a problem in decision making between him and Angeline Powell.

[289] In relation to this second restructuring proposal, Mr Gibson was equivocal as to whether he knew about it at the time. He initially said that he did not recall knowing about the second proposal. When asked if he thought that was something that should have been brought to his attention, he said: [216]

> Well, look, I don't recall it but all I can say is that it might have been delayed as a result of our work in engaging and consulting around a wider re-organisation as a result of automation.

[290] When further pressed as to whether he agreed that he should have known about the second attempt, he went on to say:[217]

> Well, possibly I do, but I can also tell you that come June, the Port was short of 60 workers, 60, six zero, so we couldn't actually man all those crane crews. So I can assure you the OPCs were very busy training lashe[r]s and straddle drivers at the time. So there was a refocus of attention, if I recall. We were 60 people short.
>
> …

[214] NoE 483-484.
[215] NoE 484.
[216] NoE 1834.
[217] NoE 1835-1838.

> Look, I may have known, but all I can say is that the resource of OPCs was redirected to training because we were 60 people short in the container terminal.
>
> …
>
> I can't remember whether I was told or not, but all I know is that there was a wider organisational redesign and we focus *[sic]* our attention on a huge recruitment drive, both from overseas and within, to actually recruit 60 people which were needed to ensure the Port could keep working in an efficient way.
>
> …
>
> Well, as I said, I couldn't remember whether I was made aware of it because we were focusing on a wider reorganisation … I mean not everything comes to me.

[291] Notwithstanding that the second proposal did not proceed, Mr Lander embarked on an observation initiative in July 2020.[218] He said that around May and June 2020 he started to see a rise in minor injuries occurring; "a statistical rise in those small events".[219] Mr Lander made a decision to require the OPCs to conduct thorough, comprehensive observations of stevedore behaviour on every vessel which arrived at the port during the month of July 2020. He directed the OPCs to work around the clock shifts to ensure observations took place on every vessel which was being worked. He said that there were "tense conversations" with the OPCs as a group to force them into those shifts.[220] The initiative could only be enforced for the month of July because of the OPCs' employment contracts. He had taken advice that the OPCs could only be directed to work outside normal hours for a specific defined period.[221] The July initiative did not, therefore, continue after that month, except on an ad hoc basis, where OPCs were willing to work other hours.[222] Mr Lander also directed the creation of a specific reporting template to be used during the July initiative.[223]

[292] It is clear on the evidence that the July structured observations occurred on Mr Lander's initiative and under his direction. He informed Mr Hulme of the actions he was taking and why.[224] Mr Lander said that he attempted to engage Mrs Costley as

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[218] NoE 481. I note that there may be an issue as to the dates over which the observation initiative took place. The exact timing is not material.
[219] NoE 482.
[220] NoE 482-483.
[221] NoE 482, 498, 578, 595-596.
[222] NoE 595-596.
[223] NoE 495-496. The reporting template did, however, continued to be used after July 2020.
[224] NoE 482.

manager of the health and safety team, but she was not interested in being a part of or resourcing the project as she saw it as an operations issue.[225]

[293] Mr Lander's restructuring proposals were implemented after Mr Kalati's death. Ms Powell left POAL and there was an organisational restructure in which Mr Lander was given the remit to implement the changes he wished to make.[226]

[294] I found Mr Lander to be an impressive witness and I accept his evidence. The prosecution acknowledges that he represented someone within POAL who was trying to do precisely the things which needed to occur.[227] The defence submits that, in that sense, Mr Lander was both a resource of POAL and an instrument for the development of POAL's processes and systems. His employment was an example, it is submitted, of Mr Gibson taking reasonable steps to provide POAL with appropriate resources and processes to minimise or eliminate risks.

[295] As to what Mr Gibson knew of Mr Lander's initiatives and the reasons why they did not continue, the prosecution submits that Mr Gibson's evidence has evolved over time:

(a) Mr Gibson attended an interview with MNZ investigators in June 2021. During that interview he presented a pre-prepared statement to the investigators. At paragraphs 25 to 27 of that statement he referred to the "crew coaches" system and said that "the system was operational during August 2020, when the container terminal accident occurred."[228]

(b) During the interview, however, Mr Gibson again referred to the "crew coaching crews" and one of the purposes was to gain an understanding of critical work behaviours (among others). He said that was "an underlying principle that we started but Covid put a stop to that unfortunately".[229]

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[225] NoE 502.
[226] NoE 484.
[227] Prosecution closing submissions, at [332].
[228] Exhibit 7, at 0170.
[229] Exhibit 6, at 0127.

(c) Further, the prosecution submits, Mr Gibson's stated reasons for the discontinuation of the 2019 trial developed in the course of his evidence. First, by way of his suggestion that Covid intervened to stop the trial.[230] Second, by reason of a combination of Covid and the fact that there was to be a full organisational redesign because of automation and the OPCs was to be part of that.[231] Third, because of difficulties in renegotiating the OPCs' contracts,[232] which the prosecution submits is contradicted by Mr Lander's evidence that the 2019 trial did not require OPCs to work nights.[233] Fourth, because the trial needed to be assessed to see whether or not it created value for the organisation and to determine what potential skill sets the OPCs would need to acquire.[234]

[296] The prosecution submits that these matters go to Mr Gibson's credibility and the weight I can place on his evidence. It says that there are three possible explanations for this suggested "evolution in [his] evidence". The first possibility is that Mr Gibson had no knowledge about Mr Lander's restructuring proposals until after Mr Kalati's death, and when learning about them misunderstood when they had been put into effect. If true, the prosecution submits this would amount to a failure of due diligence in the sense alleged by particular 1(a) of the charges. This possibility, the prosecution says, can be discounted as incredible, certainly in relation to Mr Lander's second attempt to restructure, given Mr Gibson's knowledge of the 2019 trial, the emphasis placed on it in the 2019 annual report and Mr Gibson's knowledge of its merits. It is one thing for a CEO to be unaware of an initiative the first time it has been proposed by a more junior manager, but quite another for the CEO not to be aware of a second proposal to restructure after it has been the subject of a 6-month trial.

[297] The second possibility, the prosecution submits, is that Mr Gibson knew of Mr Lander's crew coaching proposals prior to Mr Kalati's death and thought that the proposal had been permanently implemented when, in fact, this was not the case. This, it is said, would represent a failure of due diligence in the sense alleged by particular

[230] Exhibit 6, at 0127; NoE 1690 and 1832-1833.
[231] NoE 1838.
[232] NoE 1832-1833
[233] NoE 480-481.
[234] NoE 1833.

(2): a failure to take reasonable steps to verify the implementation and use of particular resources and processes. The prosecution submits that this, however, cannot be the case given Mr Gibson's unequivocal evidence that he was aware that the 2019 trial was discontinued and his stated reasons for the discontinuance.

[298] The third possibility, and that which the prosecution invites me to conclude is the only reasonable possibility, is that Mr Gibson's knew of Mr Lander's second proposal, knew that it had been rejected, knew that the crew coaching initiative was not in place at the time of Mr Kalati's death, but was woefully inexact or misleading in the information he provided to the MNZ investigators. This, it is said, goes to Mr Gibson's credibility generally.

[299] MNZ invites me to infer that Mr Lander's initiatives to restructure the stevedores and OPCs into the crew coaching model were deprioritised, likely to allow for a greater focus on automation by the OPC workforce and others who would have been involved in observations. This, the prosecution says, is a clear example of a failure by Mr Gibson to build robust systems and a missed opportunity to make meaningful improvements to POAL's safety practices. It is submitted that it was not reasonable to discontinue the crew coaching model as a means of properly understanding work as done by stevedores.

[300] I do not accept the prosecution submission that Mr Gibson's evidence as to the reasons why the 2019 trial was discontinued "evolved drastically" over time. While Mr Gibson's evidence was, at times, somewhat confused or confusing, I think the prosecution's characterisation of the evidence as evolving over time is inapt. In an early exchange with me, while he was giving evidence in chief, Mr Gibson said:[235]

> Q. But your last answer seemed to suggest that the trial wasn't continued mainly because of COVID. So was it one or the other or was it a combination of both?
>
> A. No, there was essentially three factors. So (a) that was a trial, if it needed to assessment of the trial, the second part was that we needed to change and we got legal advice on the OPCs' contract, but the third component is that we were going to make an organisational change in stevedoring, so it made sense to do it all at the same time and we were

[235] NoE 1690.

going to do that with the advent or the start of testing for automation which was to be in late February.

Q. Okay, and then COVID came along?

A. Correct, yes, yes.

Q. And buggered everything up.

A. It did.

[301] Mr Gibson appeared to be then suggesting that a combination of factors led to the discontinuance of the 2019 trial. I do not consider, therefore, that it is necessary for me to make any findings as to Mr Gibson's general credibility based on the suggested "evolution" of his evidence.

[302] It is, however, difficult to reconcile Mr Gibson's evidence at trial with his statements to the MNZ investigators that the crew coaching system was operational at the time of Mr Kalati's death. Mr Lander's restructuring did not take place until after Mr Kalati's death.

[303] I also conclude that Mr Gibson must, as CEO, have been made aware of Mr Lander's second restructuring proposal in 2020. That is consistent with the prominence that had been given to the 2019 trial, the Board, CEO and Executive acceptance and endorsements of its merits, as well as Mr Gibson's references in evidence to OPC resources being refocussed on the recruitment drive in mid-2020 as part of the reason why Mr Lander's second proposal did not proceed.

The three-container width rule: training and workers' understanding of it

[304] The three-container width rule is a behavioural control which requires workers to always be at least three-container widths (24 feet or approximately 7.3 metres) away from an operating crane. The three-container width rule is a commonly accepted minimum distance control in port operations, although some overseas ports implement a five-container width rule.[236]

[305] The evidence before me is clear, however, that POAL's training materials and documentation in relation to three-container width rule were confusing and, often,

[236] NoE 127-128.

inconsistent, and that 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 rule, particularly on the night shift.[237]

How the rule should have worked

[306] The clear purpose of the three-container width rule is to ensure that workers do not work under an operating crane or suspended load and maintain a sufficient clear distance to avoid falling objects. It is obvious that, to achieve that purpose, the rule must operate in two dimensions: if a gantry crane is working east to west on a ship, the three-container width rule must also operate in a direction north and south of the crane's operations.[238] I accept Mr Riding's evidence that, as a ship's container bays are 40 feet wide (to accommodate one 40-foot or two 20-foot containers) this means, practically, that workers must be at least a bay away, forward or aft, from the bays which are being loaded or unloaded.[239]

[307] It is also obvious that in order to achieve the purpose of the rule, workers must not be working within the "swept path area" of the crane as containers are being loaded or unloaded, that is, the path the load will take in moving to or from the wharf.[240]

[308] An issue arose in the course of some of the evidence as to whether the rule permitted workers to be in the same bays as a crane *loading* containers as long as they remained, at all times, at least three container widths away, to the seaward side, from the furthest point of the crane's operations.[241] Mr Riding, who was the only expert called with significant hands-on experience of container shipping and terminal operations, was firmly of the view that such an interpretation was unsafe: proper application of the rule meant that access should be restricted to the entire bay being worked by a crane at all times.[242] This is because cranes generally load containers tier by tier and can operate at a faster rate than the lashers which means that, at some point, the crane is likely to be moving back over lashers following behind it to start loading

[237] See above, at [259]-[263].
[238] NoE 839.
[239] NoE 839-840.
[240] NoE 124-125.
[241] NoE 841-845.
[242] NoE 845.

the next tier of containers. Further, such an interpretation of the rule would mean that the effective exclusion zone was constantly changing, depending on where the crane was presently working.[243]

[309] I note that Mr Riding's interpretation as to the proper application of the rule is consistent with the controls which were introduced by POAL following Mr Kalati's death, which operated to entirely exclude workers from any bays being worked by a crane.[244]

[310] I accept Mr Riding's evidence as to the proper and safe interpretation of the three-container width rule. On the evidence, however, it is clear that prior to Mr Kalati's death, some POAL workers understood the rule to be as described above. Even on that interpretation, however, workers were required to remain at least three-container widths to the seaward side of an operating crane.

POAL's conviction

[311] As previously noted, following Mr Kalati's death, POAL pleaded guilty to and was convicted of an offence under s 48(1) HSWA by failing to, inter alia:[245]

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

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

(c) to 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.

[243] NoE 843-846.
[244] NoE 846-847; Exhibit 76.
[245] See above, at [9] to [11].

[312] POAL's conviction constitutes conclusive proof of its failures in these respects.[246] Nevertheless, I did hear evidence as to workers' understanding of the three-container width rule and the content of POAL's documentation and training manuals relating to the rule. Mr Gibson also suggested in evidence, at least initially, that the three-container width exclusion zone was well documented and well trained.[247] Further, despite POAL's conviction, the defence urges me to exercise "some caution" around the documentation produced at trial. It is suggested that some of the documentary materials placed before me may have been updated and that some of the on-line training materials, not produced in evidence, may also have addressed the three-container width rule.[248]

[313] I do not propose to speculate as to other potential sources of evidence, nor the possible content and nature of material which is not before me.

[314] In any event, Mr Gibson eventually accepted in evidence that POAL's documentation and training materials in relation to the three-container width rule were not clear and consistent.[249] He said that his understanding of the rule, consistent with Mr Riding's interpretation, was that workers should not be in the bays which were being worked by the crane.[250]

POAL's documentation

[315] Prior to Mr Kalati's death, the three-container width rule was poorly documented by POAL. The rule was not mentioned in the Lash Training Manual.[251] It was mentioned in the Lash Assessment Manual (for those assessing lashers' training and competency), but only in in the context of containers being unlashed or discharged.[252] In that respect, the assessment manual is inconsistent with the evidence of one of the trainers, Mr Tahiwi, who said that the three-container width rule applied

[246] Evidence Act 2006, s 49.
[247] NoE 1807-1809.
[248] Defence closing submissions, at [341] and [342].
[249] NoE 1809-1816.
[250] NoE 1818.
[251] Exhibit 22.
[252] Exhibit 24, at 0456.

where containers were being loaded, as lashers should have completed all unlashing of containers and not be in any bay where containers are being unloaded.[253]

[316] The rule was mentioned in a May 2018 version of a Lash Assessor's Guide and in a July 2020 Lash Leading Hand Training Manual (but, again, only in the context of unloading a vessel) without explanation, further guidance or diagrams.[254] The rule was not mentioned in the CTOPs SOP for Ship Leading Hands as of May 2019.[255] It was not included in a list of CTOPs critical risk controls in the "Health and Safety Critical Risk Report – Handling Loads" document of May 2018, beyond general references to "keeping clear of overhead operations".[256] Nor was it mentioned as a control in the March 2019 "Handling Loads – Critical Risk" update.[257]

[317] Mr Gibson submits that, nevertheless, lashers were taught the three-container width rule as a "fundamental" part of their training which was drilled into them and the rule was reinforced by way of shift briefings.[258] The fact, however, that the workers had different understandings of the application of the rule answers the implicit proposition that a lack of adequate and consistent documentation of the rule in training materials was saved by way of actual training and briefings. I accept the prosecution submission that adequate and consistent documentation is necessary to ensure that all workers are being trained to the same standard and is a means by which compliance can be understood, assessed and measured.

[318] I therefore accept Mr Kahler's assessment that, prior to Mr Kalati's death, the three-container width exclusion zone was poorly documented by POAL. The comparison of the pre-existing documentation with that which was introduced after Mr Kalati's death is stark.[259]

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[253] NoE 725, 735-736, 753 and 756-757.
[254] Exhibit 23, at 404, 412; Exh 25, at page 19.
[255] Exhibit 30.
[256] Exhibit 60, at 1225-1226.
[257] Exhibit 61.
[258] NoE 317, 442 and 683.
[259] Exhibit 76; NoE 1075-1076 (Kahler).

The workers' understandings of the rule

[319] I heard evidence from a number of witnesses as to their understanding of the rule or rules around working under suspended loads. From that evidence, I am satisfied that the three-container width rule was, variously, not known about, not remembered or inconsistently understood. Some examples follow:

(a) In his MNZ interview, LB that lashers should not be under a container. He drew a distinction between working under a container and walking under one. When asked how far away he should be away from the container, he said "I think its something like 5 or 3, 5 containers away." He added "Yeah, you just look up if there's nothing …then go."[260]

(b) MH said that staying clear of overhead operations meant "basically, stay out of the way of the crane. That's about it." He did not remember if he was trained on how far away to stay from a crane. When asked about any container width rule, he said "Pre-accident no. Post-accident yeah." When specifically asked about a three-container width rule he said that didn't ring any bells with him. When shown a diagram and asked how far away he would work from an operating crane he said "Me personally I would probably be one container to the left."[261] In cross-examination, after being taken to parts of the Lash Training Manual[262] and in response to a leading question, he acknowledged that he had been trained to be three "boxes" away from the crane.[263]

(c) VH said that when he was trained, in 2019, "it was pretty much don't walk across the deck when there's a container coming over. As to how close he could be to a container being loaded or discharged, he said there definitely was a rule back then but that he didn't remember what it was, because the rules keep updating and changing.[264] When referred to the Lash Assessor's Guide and asked whether he remembered

[260] Exhibit 80, at 024-026.
[261] NoE 172-173.
[262] Exhibit 22.
[263] NoE 231.
[264] NoE 252.

anything about maintaining a three-container width gap from the crane spreader, he said:[265]

> Not really, no, 'cos I'd, I'd moved to the night shift not long after starting and the rules were like – well not the rules, but it was slightly different on the nights. No, I don't think I ever – I followed that.

In cross-examination, after being referred to the Lash Assessor Guide,[266] he accepted that he knew about the three-container width rule but didn't always follow it.[267]

(d) Mr Harekutu's evidence was, with respect, unclear. He initially appeared to suggest that the rule prior to Mr Kalati's fatality was that lashers were completely excluded from the walkways adjacent to the bays a crane was working.[268] He was later asked whether, pre Covid, the lashers were not permitted in the walkways at all or were permitted within three-container widths of containers being loaded on to a ship. He said that he couldn't remember.[269] He did say that there was a difference between unloading containers, where no-one needs to be near the discharging containers, and loading.[270]

(e) Mr Lander interpreted the rule as permitting lashers to be within the bay but at least three container widths away from the crane to the seaward side of the ship. He said the same rule applied to both loading and discharging containers.[271]

(f) Mr Tahiwi's understanding of the rule was consistent with Mr Lander's, insofar as he believed lashers could work three containers seaward from a crane loading containers, but not while containers were being

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[265] NoE 253
[266] Exhibit 23, at 0402.
[267] NoE 283.
[268] NoE 314.
[269] NoE 414.
[270] NoE 413.
[271] NoE 514-516.

unloaded, as the containers should have all been unlashed and lashers should not be present.[272]

(g) GB understood the three-container width rule to apply in either direction but "more towards the seaside" and to apply to both loading and unloading containers.[273]

The exploration and non-existence of hard controls prior to Mr Kalati's death

[320] I heard evidence regarding the potential availability and effectiveness of technology based hard controls as a means of establishing exclusion zones around working cranes, including GPS or laser based "geofencing" of exclusion zones.

[321] POAL had turned its mind to the potential for such technological controls as early as October 2016. A Health and Safety Hazard Report of that date relating to working under suspended loads, which referred to the three-container width rule, identified a potential control as "Install[ing] laser lighting on the boom of the crane to designate a 'safe zone' around the suspended cargo." [274] Board minutes of the same month, referring to that Hazard Report, record that:[275]

> Mr Gibson noted that new technology solutions are evolving to further de-risk this hazard, e.g. the use of GPS on hard hats. Management will continue to update the Board on new technology when these are available.

[322] No such technology-based controls were in place as at the date of Mr Kalati's death. Mr Gibson's performance agreement for the period July 2020 to June 2021 included a shared Key Performance Measure (KPI) to "Investigate and Implement technology solutions for geofencing critical work areas onboard a working vessel." Mrs Coutts said that "Mr Gibson was always enthusiastic and [a] good leader in that area, he [was] very much a promoter of technology."[276]

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[272] Above n 248.
[273] NoE 777-778.
[274] Exhibit U, Appendix 1.
[275] Exhibit U (Board Minutes, 17 October 2016).
[276] NoE 2268-2269.

[323] In his interview with MNZ investigators, Mr Gibson said that he had been driving the introduction of technology to geofence bays on a ship to ensure that alarms would go off and cranes would stop working.[277] In evidence, he said that POAL did investigate the use of GPS but there was a problem with "ghosting," that is, signals bouncing off the cranes, and the technology was not refined enough to for POAL to implement GPS geofencing.[278] When I queried why, in that case, laser geofencing wasn't put in place, Mr Gibson said that the technology was not "developed enough in terms of its application." He could not recall why the laser technology did not work and could not recall any documents which referred to any problems with laser technology.[279]

[324] Mr Gibson said that his shared KPI for the period commencing July 2020 came about because he had previously been in touch with an Australian company to further explore technological geofencing along the lines of that available in the mining industry.[280]

[325] Mrs Coutts, likewise, said that POAL had discussed technological geofencing for a number of years "but the technology wasn't available".[281] She was unable to recall the reasons why it could not be implemented.[282] When asked whether there were discussions about hard or technological controls between 2016 and 2020, she could not recall. When asked about laser technology, she said that management "had a look at cameras".[283]

[326] Mr Kahler's evidence was that technological controls could have been put in place prior to Mr Kalati's death. He said that equipment can be designed to detect the presence of people during critical activities. He provided examples of such technological controls, including pressure mats, laser beams, software controlled normal imaging cameras and thermal imaging.[284]

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[277] Exhibit 6, at 0131.
[278] NoE 1703.
[279] NoE 1703-1704.
[280] NoE 1710-1711.
[281] NoE 2268 & 2328-2329.
[282] NoE 2268.
[283] NoE 2231-2232.
[284] NoE 1197-1198.

[327] The prosecution notes that Mr Kahler was not challenged on that evidence in cross-examination and that the Health and Safety Hazard Report and Board Minutes of October 2016 (Exhibit U) was not put to prosecution witnesses. MNZ submits that, in those circumstances, I can accept Mr Kahler's evidence and should place little weight on Mr Gibson and Mrs Coutts' assertions that technological controls were not available or effective prior to August 2020. The defence submits that there was no obligation on it to put Exhibit U to prosecution witnesses or challenge Mr Kahler on the availability of technological controls.

[328] I find it difficult to accept Mr Gibson and Mrs Coutts' evidence that no technological hard controls were available to create geofenced exclusion zones around a working crane prior to August 2020. Mr Kahler's evidence was not challenged. Neither Mr Gibson nor Mrs Coutts were able to adequately explain the reasons why such technology would not work. No documentary records were produced reflecting any such enquiries or investigations into such technology carried out by POAL. Beyond Mr Kahler, no expert touched on the availability or non-availability of technological controls.

[329] I do not, however, need to determine as a matter of fact whether such technological controls were available prior to August 2020. That is not essential to the decisions I need make in this case. I conclude that the real significance of this evidence lies elsewhere. It clearly establishes that Mr Gibson was personally alert to the critical risk of workers working below suspended loads. He was personally aware of the importance of exploring hard controls, rather than POAL simply relying on behavioural controls, from at least 2016. Hard controls are not limited to novel technological controls. Hard controls include things like signage, barriers and adequate lighting. No such controls were in place in the period leading up to Mr Kalati's death. I am led to the inescapable conclusion that no-one at POAL, including Mr Gibson, turned their mind to the need for additional hard controls in the absence of technological controls.

What happened after Mr Kalati's death

[330] The ready availability of additional controls is demonstrated by what happened after Mr Kalati's death. Within a very short period of time, an unambiguous full exclusion zone, encompassing the entire bays a crane was working, was put in place.[285] Initially, cones were put at access points to prevent workers accessing the exclusion zone and, subsequently, moveable signage was introduced and placed at access points, stating "Overhead operations. Do not enter."[286] None of these controls involve novel technology.

[331] I am conscious that one must guard against hindsight bias or hindsight reasoning, that is, assessing what was reasonable or practicable with the benefit of hindsight. However, as previously stated, the risks associated with working around cranes and suspended loads have been known for many years and are very well known.[287] The need for effective exclusion zones and physical barriers to prevent access to such exclusion zones is well-known and obvious.

Covid-19 and the CTOPS Pandemic Plan

[332] It is well known that the Covid-19 pandemic created significant economic, health and social consequences in New Zealand. Stringent border controls, lockdowns and social distancing rules were put in place by the New Zealand Government.

[333] New Zealand's borders were closed to non-citizens and non-residents on 19 March 2020. On 21 March the Government announced the creation of the four-tiered alert level system and placed the country at Alert Level 2. Alert Level 3 commenced on 23 March 2020. The Government declared a state of emergency on 25 March 2020 and the country went to Alert Level 4 at 11:59 pm on that day.[288] It was a time of significant uncertainty and on-going change for the country as a whole.

[334] There is no dispute that the pandemic and the associated lockdowns, border controls and social distancing rules form part of the circumstances in which POAL

[285] NoE 216-219, 312, 316 and 417-418.
[286] NoE 218.
[287] See above, at [216].
[288] Exhibit 106.

and Mr Gibson were acting throughout 2020. Port operations were an essential service. It was critical that essential goods, food and supplies continued to enter New Zealand despite the closed borders. I accept that POAL had to rapidly respond to international developments, government directives and regulations, and changing circumstances. Covid-19 controls were, therefore, a feature of operations at POAL throughout 2020. I also accept that Mr Gibson, as CEO, undoubtedly shouldered a significant burden and an increased workload in a high-pressure environment throughout this period.

[335] POAL commenced formally planning its response to the pandemic in February 2020. The Pandemic Team (also known as the Emergency Management Team) was chaired by Alistair Kirk, General Manager of Infrastructure and Property. Other members of the Pandemic Team included: Paul Milmine, Governance and Risk Manager; Melanie Costley, Senior Manager of Health & Safety; Angelene Powell and Jonathan Hulme, CTOPs; representatives from other divisions in the organisation; and Mr Gibson.[289]

[336] POAL's business units were directed to design specific operational plans for their division. Mr Lander was directed to create a pandemic plan for the CTOPs unit (**the CTOPs Pandemic Plan**).[290] A template plan was provided by POAL, which required each business unit to identify critical processes and roles within the unit and to respond to a number of pandemic related questions relating to the various critical roles and functions, including whether the role could be performed remotely, whether activities associated with the role could be modified, and whether there was an ability to isolate or modify the workspace in which the role was performed.[291] An action plan for each critical role or process was to be created, setting out how the role or process was to be carried out under pandemic conditions. The template plan provided did not, however, require each business unit to specifically address hazards or risks associated with the critical role or process, or to undertake a risk assessment as to how proposed modifications to the role or process might impact health and safety or increase risk.[292]

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[289] NoE 1720 (Gibson).
[290] Exhibit 34.
[291] NoE 538
[292] Exhibit 34.

[337] Mr Lander put together a team within the CTOPs Unit to work on the CTOPs Pandemic Plan which included himself, two Senior Shift Managers, the Manager of Training and the Lead Workforce Planner.[293] No working stevedores or lashers were directly involved in that task, although the two Senior Shift Managers had significant experience in stevedoring.[294] The Lead Workforce planner also had significant experience at the port and came from a stevedoring family.[295] No members of POAL's health and safety team were directly involved in the creation of the plan.[296]

[338] Mr Lander's evidence was that he and the team were under time pressure to create the plan. The situation with the pandemic was moving very quickly and there was an urgent need to have a plan in place to ensure business continuity. [297] The CTOPs Pandemic Plan was, therefore, drafted one evening when the team worked around a whiteboard into the night. Mr Lander described the creation of the document as involving hours of discussion.[298] He also later clarified that there had been on-going discussions in the days preceding the actual drafting of the plan.[299]

[339] No doubt by reason of the fact that the template plan did not address such issues, the CTOPs pandemic plan did not purport to conduct, or report on, any risk assessment analysis associated with proposed modifications to methods of work. Nevertheless, Mr Lander said in evidence that there were two priorities in creating the plan, namely protecting people from Covid and conducting safe operations. He would not have recommended a pandemic plan if he did not believe it was safe for staff.[300]

[340] The plan was discussed at a CTOPs Health and Safety Committee meeting held on 18 March 2020.[301] Mr Lander and a number of workers, including crane operators, ship leading hands and straddle drivers were present at that meeting.[302] One lasher was present. No lash leading hands were present. Mr Lander's evidence was,

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[293] NoE 532.
[294] NoE 578.
[295] NoE 579.
[296] NoE 549.
[297] NoE 539.
[298] NoE 532, 535, 539, 548 and 579.
[299] NoE 582.
[300] NoE 580.
[301] Exhibit 59.
[302] NoE 581-582.

however, that all of the workers present at the meeting had experience as lashers.[303] He also gave evidence that ship leading hands could, by training, perform the duties of a lash leading hand.[304] Mr Haretuku, one of the OPCs, agreed that the attendees at the 18 March meeting were all experienced stevedores.[305]

[341] The minutes of that meeting record, under the subject heading "Pandemic Planning," that "we are currently working on the plan." The minutes also record that 13 single crane crews will be created under the plan, each set up with two crane drivers, a foreman, six straddle drivers, six lashers and supporting people.

[342] Mr Lander described briefing the heads of the unions on the plan and, also, of briefing staff of the company's intentions "as we were moving through that plan." [306] The matters discussed at the CTOPs Health and Safety Committee meeting of 18 March 2020 formed part of that briefing process.[307] Mr Lander described the briefings with stevedores as a two-way flow of information. He said that, as a group, the stevedores were not "backwards in coming forwards with their thoughts and questions."[308] Mr Lander confirmed that removal of the lash leading hand role as part of the pandemic plan was specifically discussed at the 18 March 2020 meeting.[309] No-one at that meeting raised any objection to the proposals and Mr Lander did not receive any feedback in which concerns were raised about the plan.[310]

[343] The draft plan was reviewed by POAL's Pandemic Team. Mr Lander also discussed the plan with Ms Powell and Mr Hulme but did not directly interact with the Pandemic Team. He did not know if the Pandemic Team was required to sign off on the policy and was not sure who was in that group.[311]

[344] The CTOPs Pandemic Plan was published on 19 March 2020.[312] The action plan for vessel operations described the rebuilding of the workforce into 13 single

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[303] NoE 582.
[304] NoE 546 and 603.
[305] NoE 377-378.
[306] NoE 550.
[307] NoE 583.
[308] NoE 551.
[309] NoE 599.
[310] NoE 583 and 586.
[311] NoE 548-549.
[312] Exhibit 34

crane crews, each able to operate one crane continuously for 12 hours, and each crew made up of two crane operators, one ship leading hand, six lashers and six straddle operators, with three allocated straddle cars per crew. Lash leading hands did not form part of the single crane crews. The plan provided that if one worker in a crew was infected with Covid-19, the entire crew would be required to stand down for 14 days before re-entering the workforce. If, by reason of infection, POAL was reduced to eight operational crews, crane operators and ship leading hands would be further isolated with additional labour being sourced from other stevedoring companies or the New Zealand Defence Force.[313]

[345] The plan identified ship leading hands and lashers as critical roles. Lash leading hands were not so identified. Although the plan described the role undertaken by lashers on board a vessel as working "as directed by Lash Leading Hand", that appears to have been an error in the document, as the plan identified the ship leading hand as one of the people with whom the lashers would be required to connect or report and lash leading hands were not otherwise mentioned in the plan.[314] In any event, there is no dispute in this case that the plan effectively merged the lash leading hand's role into the ship leading hand's duties.

[346] The prosecution case is that requiring the ship leading hand to assume the lash leading hand's duties in respect of the supervision of lashers meant that the communication links between working lashers and crane operations were stretched or broken. The prosecution says the CTOPs Pandemic Plan created three problems.[315]

[347] First, the additional responsibility overloaded the ship leading hand. As previously described, the ship leading hand guided the crane operator, acting as their 'eyes and ears'.[316] Cranes loading and discharging containers move fast, with the night shift averaging several container 'moves' per minute. The ship leading hand's attention was, therefore, predominantly consumed by the task of managing the crane. The merger of the roles added to these responsibilities. The additional task of

[313] Exhibit 34, at 0772.
[314] Exhibit 34, at 0767.
[315] Prosecution closing submissions at [396]-[400].
[316] See above, [92](e).

managing lashers on the ship and lash platform meant the ship leading hand had too much to do. They could not both supervise the lashers and direct crane operations.

[348] Second, the plan complicated communication links. Lash leading hands were equipped with a radio which meant they could traverse the working environment, supervise and direct lashers, and report to ship leading hands and crane operators as necessary. In contrast, a ship leading hand could not leave the area of crane operations without stopping the crane. They could only know where lashers were if lashers reported to them but, as the ship leading hand worked in close proximity to crane operations, that could place lashers in danger. Additionally, as lashers did not carry radios, if the ship leading hand was working on the vessel, they would need to communicate with lashers on the lash platform by moving to the side of the vessel and shouting instructions.

[349] Third, the evidence reveals that some ship leading hands had not previously worked as a lash leading hand, including KM, who was the ship leading hand at the time of Mr Kalati's death. The ship leading hands received no additional training or instruction as part of the CTOPs Pandemic Plan.

[350] The prosecution submits that there were a number of available alternatives which would not have given rise to the above concerns. POAL could have reduced the number of operating cranes per shift to allow each bubble to include a lash leading hand. Alternatively, POAL could have provided one of the lashers on the vessel with a radio to facilitate communications with the ship leading hand from a distance. Training a lasher to use a radio would not have been difficult, even in the pandemic environment.[317] If neither of those options were adopted, POAL might have mitigated the risks associated with the change by amending other policies or controls, for example, by expanding the three-container width rule into a wider exclusion zone to move lashers further away from the risk.

[351] The prosecution submits that Mr Gibson did nothing to assure himself as CEO that the changes made by the CTOPs Pandemic Plan did not undermine lashers' safety. It was Mr Gibson's duty as CEO to ensure that POAL had formal management of

[317] NoE 890 (Riding).

change systems in place to ensure that any change in work processes was assessed and managed to ensure safety.

[352] The defence case is that, in the extraordinary circumstances created by the pandemic, Mr Gibson could not reasonably be expected to require the CTOPs Pandemic Plan to proceed through a formal change or risk assessment process. Further, it was reasonable for POAL's management to believe that the incorporation of the lash leading hand's duty to supervise the lashers into the ship leading hand's role did not compromise safety. Prior to the CTOPs Pandemic Plan, the lash leading hand could be responsible for up to 24 lashers working on a vessel, over four separate gantry cranes.[318] Under Covid-19 restrictions it was, however, not possible for one lash leading hand to interact with lashers across crews and POAL did not have enough trained lash leading hands to assign one to each individual crane crew.[319] The rotation and rest system meant, however, that when a crane was working, two lashers would be on the lash platform and two would be resting. At most, therefore, the ship leading hand was only responsible for supervising two lashers on the vessel while the crane was operating.

[353] Further, supervision of lashers formed part of the ship leading hands' skill set.[320] A comparison of the training manuals for the respective roles supports that submission.[321] Ship leading hands' training required them to ensure that lashers were working in pairs and keeping out of the crane's working area. Their duties included directing lashers to their points of work.[322] It was a fundamental part of the training of ship leading hands to ensure that all persons, including lashers, were clear of crane operations.

POAL's conviction and the charge laid against Mr Gibson

[354] As noted previously, following Mr Kalati's death, POAL pleaded guilty to a charge which particularised systemic failures linked to the removal of the lash leading

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[318] See above, at [91](d).
[319] NoE 541 & 544.
[320] NoE 546.
[321] Exhibits 25 and 104; Defence closing submissions, at [444].
[322] NoE 425-436.

hand role in response to the Covid-19 pandemic.[323] Pursuant to particulars (d) and (e) of the charge, POAL accepted that it was reasonably practicable for it to have:

> (d) [conducted] an appropriate risk assessment relating to the removal of the lash leading hand role in response to the Covid-19 pandemic; and/or
>
> (e) [provided] effective training, instruction, and supervision to ship leading hands and crane operators when requiring them to assume the responsibilities of lash leading hands.

[355] POAL's conviction constitutes conclusive proof of those failures on its part.[324]

[356] The particulars of the charges laid against Mr Gibson in relation to this aspect of the case are, however, framed differently. He is alleged to have failed to exercise due diligence to ensure that POAL had clearly documented, effectively implemented, and appropriate processes "for ensuring coordination between lashers and crane operators" and to verify the provision and use of those processes.

[357] The prosecution case as presented at trial is, nevertheless, focussed on an alleged failure on the part of Mr Gibson to ensure that POAL had formalised management of change systems and processes in place which would have ensured that a risk assessment was carried out as part of the change created by the implementation of the CTOPs Pandemic Plan.[325]

Mr Gibson's involvement in the change

[358] The evidence at trial as to Mr Gibson's level of direct involvement in, and knowledge of, the changes brought about by the CTOPs Pandemic Plan is not particularly clear or consistent.

[359] In his MNZ interview, when asked what role he played in the drafting or implementation of the plan, Mr Gibson said:[326]

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[323] See above, at [11].
[324] Evidence Act 2006, s 49.
[325] Prosecution closing submissions, at [356]–[360].
[326] Exhibit 6, at 0124

> We had daily meetings of which I was part of but it was led by Alistair Kirk. So under our, you might say our Emergency Management Schemes is that I won't take the lead, somebody else will take the lead but I would take the Public lead. So, but I was very much part of that committee, my role was to liaise with the Ministry of Transport, District Health Boards etc to ensure that the processes and systems and the Standard Operating Procedures were common and understood across Ports and Terminals in New Zealand.

[360] He went on to describe the thinking behind the removal of the lash leading hand role:[327]

> Well the Lash Leading Hand typically has the role of if you say a ship is in and you're working three cranes, he might be working three bays on a ship and he's co-ordinating the various points of work across the ship. Now we couldn't have people working across the ship because we actually put people in bubbles. So what we did, we discontinued the Lashing Leading Hand and rolled it into what a more senior role which is the Ship Leading Hand. So they would look after a particular bay. So basically you were duplicating the role across the various but it's a more senior role. And their role was to actually look after the Lashers but also look after the operations in that particular bay and also make sure that they had knowledge of where the Lashers were, what the crane was doing and then reporting to the Ship's Operations Manager about the relationship about what needs to be done on the ship versus what needs to be done on the road.

[361] When asked if any consideration was given to leaving the lash leading hands in the bubbles, Mr Gibson said:

> Well essentially you've incorporated because you know you go Lash Leading Hand, Ship Leading Hand so, but what we have done is actually ensured that there's a Ship Leading Hand for each crane crew. See we never had a Lash Leading Hand for individual crane crews. We had Lash Leading Hand across a ship, across an operation.

[362] He went on to say in the interview that "… we firmly believe that actually it increased the amount of safety that was on board ships."[328]

[363] The prosecution submits that these statements suggest a degree of direct involvement in the decision-making process which led to the CTOPs Pandemic Plan.

[364] In evidence, Mr Gibson said that the CTOPs pandemic plan was noted by the Pandemic Team at one of its meetings and he recalled discussing it, but the removal of the lash leading hand was not discussed with him. No-one raised any concern with

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[327] Exhibit 6, at 0125.
[328] Exhibit 6, at 0134.

him about the safety of removing the role from the individual crews.[329] He later said that he could not recall whether he knew about the removal of the lash leading hand role at the time.[330]

[365] He clarified that his responses at the MNZ interview referred to his then understanding of what had occurred and why: his answers reflected the knowledge he gained after the fatality and not what he knew at the time the pandemic plan came into existence.[331]

[366] Mrs Coutts said that the pandemic plan was reviewed by Mr Gibson and Mr Thompson: "they were actively involved in what was happening".[332]

[367] I do not need to resolve the question of how much direct involvement Mr Gibson had in the creation of the CTOPs Pandemic Plan or the extent of his detailed knowledge of it. As the prosecution recognises, it is not necessary for me to do so to in order to come to my conclusions on this aspect of the prosecution case.[333] Having said that, on the state of the evidence before me I cannot discount Mr Gibson's evidence on the issue. I am not prepared to find that he had significant personal involvement in, and understanding of, the detail of the CTOPs pandemic plan and the assumption by ship leading hands of the supervision of lashers, previously undertaken by lash leading hands.

The views of management and workers

[368] Conflicting views were expressed in evidence as to the appropriateness of removing lash leading hands from the crane teams under the pandemic plan, and as to whether there were, in fact, any adverse safety consequences. While POAL's conviction provides conclusive evidence that its failures did expose workers to a risk of death or serious injury, evidence as to the views of workers and management at the time, and whether any adverse views were communicated to senior management, is

[329] NoE 1732.
[330] NoE 2045.
[331] NoE 2045-2046.
[332] NoE 2398.
[333] Prosecution closing submissions, at [381] and [387].

relevant to an assessment of the reasonableness of Mr Gibson's response to the CTOPs Pandemic Plan.

[369] Mr Gibson's evidence at trial was as previously described. He considered that the plan did not compromise lasher safety in any significant way, given the fact the ship leading hand was only supervising two lashers on a vessel at any one time.

[370] Mr Lander was of the same view. He considered that it was an improved safety situation having regard to the numbers of lashers, working across an entire vessel, who would previously have to be supervised by a single lash leading hand.[334] He also said that, pre-Covid, if a single crane was working on a vessel, it was standard procedure for the lashers to be supervised by the ship leading hand; there would be no lash leading hand on the vessel in that situation.[335] In that respect, therefore, the CTOPs Pandemic Plan was just adopting work methods which previously applied in single crane operations. As noted above, he also understood that supervision of lashers formed part of a ship leading hand's skill set and that a ship leading hand could, by training, perform the duties of a lash leading hand, but the reverse was not the case.[336]

[371] In his interview with MNZ, WM said that he wasn't sure why the lash leading hand's role was taken away because "unless … the ship foreman has had training as a lash leading hand … then you got a problem". He said: "You're there solely for the crane and keeping that crane moving, now on top of that, now you gotta deal with six guys."[337] WM also noted that as far as he knew, KM, the ship leading hand who directed Mr Kalati and LB on the night of the fatality, had never been trained as a lash leading hand. WM didn't raise the issue with his senior managers as he didn't know whether it had anything to do with him.[338]

[372] KM said, in his interview, that having to supervise the lashers meant more responsibilities. It was difficult, of itself, looking after a crane driver and the changes were a challenge for everyone.[339] The combined role placed more responsibility on

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[334] NoE 543.
[335] NoE 542.
[336] NoE 546
[337] Exhibit 85, at 182.
[338] Exhibit 85, at 186.
[339] Exhibit 81, at 066-067.

him and he was juggling quite a lot of tasks. It put extra pressure on him. He did not feel good about the extra responsibility. He did not think anyone spoke up about it and he had not been trained as a lash leading hand. He considered it was a dangerous situation.[340]

[373] MH said that the change did not make any difference to him, as he was still getting instructions from one person and, for the most part, the instructions were clear enough for him to know what he was doing.[341]

[374] VH was not worried about not having a lash leading hand because he was pretty confident he knew what he was doing.[342]

[375] Mr Harekutu, one of the OPCs, had no concerns about the change under the CTOPs Pandemic Plan because it was a move back to "the way we used to do things" where the ship leading hand controlled the lashers.[343] He understood why the lash leading hand role was removed as a result of POAL needing to ensure there was no intermingling between lash gangs.[344] He said that the ship leading hand's role included supervision of the lashers, including checking that they were working in pairs, directing them to points of work and ensuring that they were clear of crane operations.[345]

[376] PH said that "a lot of us" did not think it was a good idea to have no lash man (lash leading hand) as it was an important role and the ship leading hand had to take on another responsibility. He said that he raised the issue with one of his managers when the workers were being told about the new bubble arrangements. He was told that the ship leading hands would be looking after their own lashers and that they needed to "pick [their] game up and … look after your lashers." [346] He said that the ship and lash leading hands' roles were two separate roles and not all of the ship leading hands were trained as lash leading hands.[347]

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[340] Exhibit 83, at 149-151.
[341] NoE 207.
[342] NoE 270.
[343] NoE 399.
[344] NoE 458.
[345] NoE 425-436.
[346] NoE 661-662.
[347] NoE 668-669.

[377] Mr Tahiwi, an experienced OPC, appeared initially reluctant to express a view on whether the removal of the lash leading hand role was or was not a good thing.[348] When pressed by me, he said that, to his way of thinking, it was not a good idea as the ship leading hand already had a considerable amount of responsibility in the work area. He qualified his remarks by saying "but that doesn't mean to say that he cannot control lashers".[349] He later accepted that other persons, experienced in port operations, could have reasonably held the view that it was not necessary to maintain the lash leading hand's role within individual crew cranes under the pandemic plan, adding that the skills of the two roles are "almost identical". Both roles involve being in charge of people, they both understand the area they are operating in, and they both have the authority to use workers in a controlled environment.[350]

[378] GB, one of the Shift Operations Managers, said that he disagreed with the decision as the lash leading hand's role was an important one in terms of co-ordinating with the lashers and getting things completed on the vessel. They were a focal point for the Shift Operations Managers to communicate with to see how everything was going with the lashing and unlashing of containers. He said that he believed he raised his concerns with one of his managers but did not know what the response was. He could not remember having any concerns expressed to him by any workers.[351] GB was previously a ship leading hand. In cross-examination, he accepted that his training in that role had included responsibility for ensuring that lashing and unlashing had been undertaken, directing lashers to points of work and ensuring that the crane did not operate overhead of any worker.[352]

[379] No evidence was placed before me suggesting that any concerns which may have been expressed by workers were passed up the chain to senior management. The prosecution accepts there was a "modest degree" of consultation on the CTOPs Pandemic Plan, but submits it was not sufficient to address the issues created by the plan.

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[348] NoE 736.
[349] NoE 737.
[350] NoE 755.
[351] NoE 782 – 783.
[352] NoE 793-794.

Return of the Lash Leading Hand

[380] The lash leading hand's role was not removed for the entirety of the period between the commencement of the level 4 lockdown on 25 March 2020 and the date of Mr Kalati's fatality. Lash leading hands were active at Alert Level 1 and, possibly, during periods when Auckland was at Alert Level 2.[353] Auckland returned to Alert Level 3 on 12 August 2020. At this level, the ship leading hand again assumed responsibility for supervision of the lashers within single crane crews. This was the state of affairs at the time of Mr Kalati's death.

[381] The prosecution submits that, in the period between March and August 2020, there was an opportunity for POAL to have instituted further training of ship leading hands to clarify roles and responsibilities and to have enabled those who had not previously worked as lash leading hands to be upskilled as necessary. Further, the prosecution submits that risk assessment processes could have been carried out in the intervening period to ascertain whether there were, in fact, safety consequences arising from the change instituted in terms of the pandemic plan.

[382] The defence submits that those who initiated the CTOPs Pandemic Plan did not consider that it constituted any significant change, for the reasons identified by Mr Lander: the plan simply meant that the method of work which already existed in single vessel, single crane operations was instituted across all operations. Further, by reason of the evidence addressed above, the ship leading hands were trained to, and did, supervise lashers as part of their duties.

The charges - Particulars 1(a) and 2

Prosecution submissions

[383] The prosecution case is that a reasonable CEO in Mr Gibson's position, in the circumstances of POAL's business, would have ensured that POAL had in place an effective and appropriate system for risk management in relation to the critical risk of handling loads.[354] Mr Gibson's role as CEO required him to ensure that such a system

[353] NoE 596-597 and 785; Exhibit 33, at 0693.
[354] Prosecution closing submissions, at [250].

- containing relevant resources and processes - was developed, available for use, and was actually used by POAL.[355]

[384] Whether POAL was using such a system, and whether it was effective, could have been determined by performance measures and a proper review process. Lead indicators are a means of measuring the effectiveness of critical controls against critical risks as such performance measures. A process which allowed management to understand 'work as done' was crucial to the effectiveness of such a system. Such insight could have been obtained in a number of ways, including by a review of critical risk standard operating procedures, by structured observations and as a component of management of change processes.

[385] Any review and observations relating to the critical risk required critical controls to be sufficiently and clearly documented in order to provide a 'yardstick' against which compliance with the SOPs and controls for handling loads could be measured. POAL's documentation of the three-container width rule was not coherent, resulting in uncertainty and making compliance observations more difficult. The prosecution says that, had the system been working the way it should have been, non-compliant nightshift behaviours would have been identified. In a properly functioning system, this should have prompted review and amendment of the SOPs and controls around handling loads. Such controls may have included implementation of a full exclusion zone or other technological/engineering controls.

[386] Mr Gibson did not ensure that a system containing these components was in place, or that these components had been implemented, despite him knowing that such components were not in place. His failure meant that the shortcomings in POAL's procedures and controls, in particular the three-container width rule, was not identified.

[387] The prosecution submits that the lack of an effective and appropriate system for management of the critical risk in relation to the handling of loads is evidenced by:

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[355] Prosecution closing submission, at [251].

(a) The inadequate state of POAL's exclusion zones and rules for operating around cranes (as proven by POAL's conviction relating to Mr Kalati's death).

(b) The poor state of the documentation relating to exclusion zones, and of other SOPs for lashers working around cranes (other than for the ship leading hands). Such documentation was rapidly put in place after the incident.

(c) The inadequate monitoring of 'work as done' by structured observations and other means, which demonstrates the absence of any systematic efforts by senior management to obtain insight into work as done.

(d) The absence of any earnest effort by POAL to introduce a critical risk management system including those components, in line with management's commitments to the Board in response to audit recommendations. By the date of Mr Kalati's death, POAL had only just commenced this process.

[388] POAL's conviction provides conclusive proof of POAL's failures in these respects over the same period as reflected in the present charges against Mr Gibson.

[389] POAL's proven failures are linked to Mr Gibson's failure to exercise the due diligence required of a reasonable CEO. Mr Gibson should have taken steps to ensure that POAL had in place an effective and appropriate system for critical risk management in relation to handling loads, and to ensure that POAL was utilising such a system. Such steps should have been taken by Mr Gibson given his knowledge of relevant circumstances, including the previous injuries and death evidencing a disconnect between work as done and work as designed or imagined. This does not mean Mr Gibson needed to be across every single operational process or resource at POAL or the actions of every single nightshift worker.

[390] It is submitted that Mr Gibson either knew, or ought to have known, that the components of the system were not in place. The effectiveness of POAL's systems could have been determined by the use of performance measures (such as leading indicators, measuring the effectiveness of critical controls against critical risks) and systemic review processes. To the extent that such information was not available to Mr Gibson due to the state of POAL's systems and reporting processes, he failed to exercise due diligence to ensure that he received adequate information. He failed to identify and address the relevant systems failures.

[391] Mr Gibson ought to have ensured that a system was in place to ensure that POAL's stevedoring resources (including SOPs) were regularly reviewed and updated, by reference to international best practice and guidance documents. MNZ submits that POAL was slow to review procedures even when there was a clear imperative to do so. The evidence demonstrates that POAL had no structured SOP review process, despite this being a recommendation in the 2015 EY report. A proper review of SOPs needed to be informed by risk assessments, which in turn needed to be informed by an understanding of work as done. POAL's risk assessments failed to take account of actual events. Regular reviews of SOPs should have been required by the Health and Safety Manual, which would have provided Mr Gibson with assurance that there was system in place by which the review of critical SOPs and training manuals took place. It was Mr Gibson's responsibility and a critical part of his role as CEO to ensure that business systems were subject to review and audit to ensure they were achieving their intended purpose.

[392] POAL's workplace observations, particularly over the night shift, were not effective and structured. MNZ submits that, as CEO, Mr Gibson did not take reasonable steps to ensure POAL was obtaining insight into work as done.

[393] The prosecution submits that Mr Gibson had a duty and the power to make meaningful improvements to POAL's systems. A reasonable CEO would have done so in the circumstances. It was incumbent upon Mr Gibson to be aware of the issues with workplace observations at POAL and to have "robust conversations" with his subordinates to insist on a strategic and systematic response to the issues.

[394] Mr Lander's proposals were an opportunity to take a reasonable step to improve observations at POAL. They were only implemented after Mr Kalati's death, as a result of a management restructure by which Mr Lander was authorised to put them in place. MNZ submits that the failure to advance Mr Lander's proposals earlier is a clear example of Mr Gibson's failure to build robust systems, resulting in a missed opportunity to make meaningful improvements to POAL's safety practices. This was an opportunity to gain insight into 'work as done' which was deprioritised, in spite of a statistical rise in lasher incidents in early 2020.

[395] The prosecution submits that Mr Gibson, as CEO, was required to make it his business to ensure that POAL's health and safety management system was such that "fit for purpose" resources and processes were in place to eliminate or minimise the risk of stevedores being struck by falling loads: "the buck stopped with him".

Defence submissions

[396] The defence submits that Mr Gibson's duty was to take reasonable steps to ensure POAL had resources and processes available to it to eliminate or minimise risks to health and safety. It has not been proven beyond reasonable doubt that Mr Gibson failed to take the reasonable steps that a reasonable CEO would have taken, in the same circumstances, to ensure POAL had available for use and used resources and processes to eliminate or minimise the health and safety risk of handling loads, specifically exclusion zones.

[397] The defence admits POAL's failures in relation to the exclusion zones but deny those failures should be linked to a failure of due diligence on the part of Mr Gibson. Mr Gibson did not have and ought not to have had a direct role in the documentation and implementation of exclusion zones or a personal responsibility to analyse the content of exclusion zone rules.

[398] The defence rely on Mr Marriott's witness statement in which he set out the means by which an officer of a PCBU can exercise due diligence, by:

(a) Reviewing the organisation's H&S strategy and plan and ensuring that the necessary resources and processes are included.

(b) Enquiring about performance shortfalls and understanding whether causal factors relate to resources and processes.

(c) Ensuring H&S is separately budgeted with a clear allocation of resources to align with both strategy and obligations.

(d) Asking about H&S implications for business cases requiring approval for new activities or operations.

(e) Seeking views directly from workers or their representatives on what is needed to better manage H&S risks.

[399] The defence submits that officers may rely on the expertise of others, so long as that reliance is reasonable. It is said that Mr Gibson relied on specialist expertise as to the design of controls, and that such reliance has not been proven beyond reasonable doubt to be unreasonable.

[400] In terms of POAL's critical risk management system, the defence say that POAL had identified seven critical risks despite little guidance being provided from WorkSafe or MNZ. The categorisation of the critical risks and the adoption of bow-tie analysis was identified through reference to what other ports were doing. Mr Gibson introduced hazard risk reports. The Health & Safety team provided advice on critical risk controls and management. The Health & Safety team's systems and processes included bow-tie assessments, risk management plans, a critical risk review schedule, reports to the Board and Mr Gibson in each Safety & Wellbeing Report on critical risk management work, "safety scrum" workshops, and monthly hazard reporting to the Board broken down into risk category. The Health & Safety team also had access to operational expertise through OPCs who were available to help them understand operational matters relating to the container terminal.

[401] In managing the critical risk of handling loads, the defence submits that POAL relied on a range of controls by 2020, representing a combination of resources and processes.

[402] The defence acknowledges that the evidence suggests that there did not appear to be a clear understanding of the three-container width rule as it applied in August 2020, but say that there was consensus throughout the evidence that working under a crane or in close proximity to it was prohibited. The rules were taught to stevedores in training and reinforced by way of toolbox meetings. The ship leading hand was required to enforce the rules and be proactive in not permitting workers to be within three-container widths of a working crane. Additionally, crane drivers were required to stop immediately if anyone entered the three-container width zone.

[403] The defence submits that the enquiry must focus on the reasonableness of Mr Gibson's reliance on the advice he received around the three-container width rule being an effective control, that it was being taught in training, and that the controls identified were appropriate. It is submitted that the three-container exclusion zone was industry standard during the charging period and had been in place for a long time at POAL.

[404] POAL had established SOPs, training materials and assessment guides for operating near cranes. OPCs drafted such procedures and materials by conferring with relevant operational staff and external experts if necessary. The documents were reviewed by seniors. The lash assessment guide and lasher training had been reviewed when the HSWA was introduced. The three-container width rule had been considered to still be appropriate.

[405] It was reasonable for Mr Gibson to rely on the expertise of the OPCs because they received considerable training and were variously qualified. The OPCs were sent to conferences and had direct contact with WorkSafe. POAL's OPC programme was industry leading by 2019. The OPCs developed safety initiatives such as pedestrian crossing safety and special grid lighting for lashing at night. They were trained with a standardised NZQA-based unit standard. They developed questions for trainees to answer through an online training system and, by March 2020, it was a requirement of the OPC role to regularly review training programmes and procedures. Additionally, senior managers within the CTOPs unit were highly experienced, with detailed knowledge of operations.

[406] Mr Gibson knew that controls had, over time, been created and supplemented at POAL. As at October 2014, such controls included the ship hazard notification board, the lash leading hand check sheet, the OPC lash check sheet and the video recording of shift briefings. By 2017, there was an increase in lasher training from 40 to 80 hours, and 160 hours minimum experience required as a "white hat". By August 2019, lash platforms were introduced and operational. Mr Tahiwi gave evidence that, by 2019 to 2020, there had been a review of the lash training manual by a contractor and the introduction of a hazard board which reminded lashers to work in pairs.[356] Health and Safety shift briefings were in place before Mr Kalati's death.[357]

[407] Mr Gibson and the Executive undertook monthly "deep dives" into critical risks, which the Senior Manager of the Health & Safety team attended. The defence submits this demonstrates that Mr Gibson actively participated in interrogating critical risks. He also attended Board meetings at which critical risks were reviewed.

[408] The defence submits that Mr Gibson's exploration of potential further technological controls, such as geo-fencing, constitutes evidence of him exercising due diligence.

[409] The defence also submits that, to the extent POAL's systems around critical risk management might be considered to have not developed "enough", that was reflective of, and consistent with, the immature state of critical risk management in New Zealand during the period reflected in the charges and, accordingly, does not establish a failure of due diligence.

[410] In summary, the defence submits that the evidence establishes that Mr Gibson exercised due diligence in a number of respects, and that he took reasonable steps to ensure POAL had available for use resources and processes to eliminate or minimize risks. The defence also suggests that the evidence establishes that the reliance Mr Gibson placed on others, in ensuring that POAL had available and utilised appropriate resources and processes, was reasonable when considered in the context of the circumstances at the time, the training and expertise of the staff to whom such roles

[356] NoE 712 and 744-745.
[357] NoE 442-443.

were delegated, and industry standards. Further, Mr Gibson took personal steps to ensure that POAL was utilising appropriate resources and processes.

Analysis

[411] The starting point is that POAL failed in its primary duty of care to ensure, so far as reasonably practicable, the health and safety of its workers. The company's conviction provides conclusive proof of its failures in respect of:

(a) The development and documentation of adequate and effective exclusion zones around operating cranes;

(b) Its training of, and instruction to, workers in relation to safely working around operating cranes, and

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

[412] I have concluded that, prior to Mr Kalati's death, there was a practice, particularly on the night shift, of stevedores engaging in unsafe practices or cutting corners.[358] Non-compliance was a regular feature on the night shift. Lashers would regularly not work in pairs as required and would breach the three container-width rule, including by adopting the "load and lash" practice. Some would use phones or listen to music while working on a vessel. Some lash leading hands and managers were aware of corners being cut.

[413] POAL had been alert to issues regarding lasher non-compliance since at least 2014.[359] It was the responsibility of POAL's officers, including Mr Gibson, to ensure that POAL had adequate systems in place to monitor compliance and to understand work as actually carried out by all workers but particularly, in this context, workers on the night shift. I have concluded that POAL's systems were clearly inadequate in identifying work as done and reporting on it to senior management and the

[358] See above, at [258]-[269].
[359] See above, at [260].

Executive.[360] The need for effective systems in this respect was clearly critical in the context of port operations, where approximately 40% of POAL's employees were stevedores, engaged in the work of loading and unloading vessels.

[414] POAL's training materials and documentation in relation to the three container-width rule were confusing and, often inconsistent. Different workers had different understandings of how the rule was to apply.[361]

[415] POAL and Mr Gibson were fully aware of the critical risk of handling suspended loads. The risks of working in close proximity to an operational crane are well established and generally well-recognised. The risks have been known, certainly within any industry which undertakes crane operations, for many years.[362]

[416] Mr Gibson was, ultimately, responsible for health and safety at POAL. He was tasked with a number of key health and safety responsibilities. He retained responsibility for monitoring and reviewing the performance of his subordinates and POAL's systems.[363] He was a "hands on" CEO in relation to port operations and health and safety issues in many practical ways.[364]

[417] I have concluded that there was a lack of progress on the part of POAL in creating clearly assigned responsibilities and accountability for the Executive team and senior managers, which had been recommended in the 2018 KPMG audit report.[365] That report had also recommended improvements to the monthly Health and Safety Performance report and the inclusion of lead indicators in the reports. POAL's management had accepted the recommendations and, as early as May 2018, committed to the inclusion of lead indicators in the monthly reports. Nevertheless, POAL's Executive team did not advance the KPMG recommendations in a timely manner.[366] Mr Gibson was aware of the KPMG recommendations and of the lack of timely response by reason of the monthly Health & Safety reports he received. I have

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[360] Above, at [279].
[361] Above, at [305], [314]-[319].
[362] Above, at [212]-[216].
[363] Above, at [194]-[196]
[364] Above, at [201].
[365] Above, at [133] and [168]-[180].
[366] Above, at [177] and [179].

not accepted Mr Gibson's evidence that POAL adequately responded to KPMG's recommendations.[367]

[418] It was Mr Gibson's duty, as CEO and the interface between POAL's Executive team and the Board, to ensure that POAL did progress these matters in a timely fashion. He failed to do so.

[419] I have also concluded that any comfort Mr Gibson may have taken from the 2018 KPMG audit and the annual ACC audits was misplaced.[368]

[420] I accept the evidence I heard, particularly from Mr Kahler, that the Health and Safety Steering Committee was not fulfilling its role of providing a high-level forum in relation to the review and improvements of POAL's health and safety policy.[369] The HSSC was not operating as a strategic oversight committee and was not adequately monitoring POAL's performance against its policies and procedures. Mr Gibson did not attend HSSC meetings from 14 November 2019 to 21 July 2020. There appears to have been only one HSSC meeting held in the period reflected in the charges. I accept that 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.

[421] I have found that POAL had not completed annual Health and Safety Strategy plans for the financial years ending 30 June 2020 and 2021.[370] I have rejected the defence submission that the Safety and Wellbeing strategy document for 2018 to 2021, Exhibit 54, addressed the absence of the annual strategy plans.[371] This was a failure of POAL's health and safety system. It was Mr Gibson's responsibility to approve the annual plans and to ensure that POAL was not failing in that regard.

[422] In relation to the critical risk relevant here, relating to the handling of loads and working in close proximity to cranes, Mr Gibson was aware, by reason of the March 2019 Critical Risk Report, that the number of incidents, near misses and non-

[367] Above, at [177].
[368] Above, at [180].
[369] Above, at [135]-[145].
[370] Above, at [153].
[371] Above, at [155]-[156].

compliance recorded in the report were "likely … not reflective of actual events occurring within POAL operational areas due to lack of overall reporting".[372] I have accepted Mr Kahler's evidence in relation to the adequacy of the critical risk reports.[373] Mr Gibson was also aware of the lack of commentary in the reports regarding the effectiveness of critical risks for critical controls by reason of the 2018 KPMG audit. He and POAL's management had agreed with the recommendation that such information be included in the reports.[374]

[423] I have also concluded that POAL's bow-tie assessments of critical risks, including the risk associated with handling overhead loads, were inadequate and not progressed in a timely manner.[375] There was a lack of focus on ensuring the progression of critical risk management in a meaningful and timely way. Mr Gibson, as CEO, was aware of this or ought to have been aware of this, by reason of the monthly safety and wellbeing reports.

[424] By virtue of POAL's previous convictions, Mr Gibson was on notice, at least from late 2018, following Mr Dyer's fatality, that POAL had demonstrated on-going difficulties in adequately monitoring work as done on the wharves.[376] It was his responsibility, as CEO, to ensure that appropriate systems and processes were put in place to address POAL's failures in that respect.

[425] In the context of the monitoring of work as done, Mr Gibson was aware of Mr Lander's 2019 crew coaching trial.[377] He was aware of its benefits. He recognised it was a way in which management could see work as done.[378] I have also concluded that Mr Gibson must have been aware of Mr Lander's second restructuring proposal in 2020.[379] While there may have been a number of reasons why that proposal did not proceed, it is clear that Mr Gibson must have been aware, by reason of the trial and

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[372] Above, at [220].
[373] Above, at [224].
[374] Above, at [225].
[375] Above, at [229]-[231].
[376] Above, at [257].
[377] Above, at [283] and [287].
[378] Above, at [284].
[379] Above, at [303].

the 2020 proposal, that POAL's systems and processes for monitoring work as done, particularly on the night shift, needed improvement.

[426] In relation to controls relating to the three container-width rule or exclusion zones around cranes, POAL had turned its mind to technological controls, including GPS or laser based geo-fencing, as early as October 2016.[380] The introduction of the lash platforms was an example of a hard or technological control having being introduced. That positive health and safety development only came about, however, because Mr Gibson personally observed something which "scared the living daylights" out of him.[381] By virtue of that experience, a reasonable CEO would have paused to reflect on why no-one in the organisation had identified or raised the need for such a control before then.

[427] Mr Gibson was personally alert to the critical risk of workers working below suspended loads and of the importance of exploring hard controls rather than simply relying on behavioural controls.[382] On his evidence, he was actively engaged in exploring the availability of technological controls to prevent lashers entering crane exclusion zones. He did not, however, turn his mind to the need for any additional, non-technological, hard controls which might be put in place in the meantime.[383] Such additional controls were available at the time and were able to be put in place in short order after Mr Kalati's death. I conclude that a reasonable CEO, with Mr Gibson's knowledge and experience and in his circumstances, would have recognised the shortfalls in POAL's management of exclusion zones around cranes working over ships and would have ensured that POAL utilised appropriate resources and resources to address those shortfalls.

[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

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[380] Above, at [321].
[381] Above, at [218].
[382] Above, at [329].
[383] Above, at [218].

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.

The charges - Particulars 1(b) and 2

Prosecution submissions

[432] These particulars concern the changes to the lash leading hand and ship leading hand duties pursuant to the CTOPs Pandemic Plan. The prosecution submits that had Mr Gibson exercised due diligence to ensure that POAL had a formalised management of change system in place, encompassing a structured change management process, then a risk assessment would have been undertaken as part of the introduction of the plan. A reasonable CEO in Mr Gibson' position, in the circumstances of POAL's business, would have ensured that there was a system in place by which POAL could

assure itself that any change made to work processes was safe. Resources and processes which might have been applied include appropriate risk assessment tools and procedural changes to the communication links between lashers, the ship leading hand and crane operators.

[433] Despite knowledge of the critical risk of handling loads, this was not done. The prosecution says that Mr Gibson did nothing to assure himself that changes under the CTOPs Pandemic Plan could be implemented safely in relation to that critical risk.

[434] A clearly documented management of change process, with risk assessment procedures, should have been in place well in advance of the Covid-19 pandemic. Such a process would have allowed management to have understood 'work as done' in assessing the proposed changes to work.

[435] The prosecution submits that a risk assessment was either not performed or not performed in a sufficiently robust manner to identify the safety implications of the plan, because Mr Gibson failed to ensure the relevant process was a component of POAL's systems.

[436] MNZ says that Covid-19 was not an impediment to effective change management. First, because a structured change management process could – and should – have been in place long before the pandemic as a critical part of POAL's health and safety system. Such a process could and should have been undertaken by the Pandemic Team and Mr Gibson should have been ensured it was that team which introduced the change. Second, in the period following the initial Level 4 lockdown, there was a period of relative calm and periods where the lash leading hand was reintroduced to operations. In those periods, a risk assessment or an informed review could have been undertaken.

[437] The prosecution submits that it was not appropriate for a trade-off to be made between managing Covid-19 related risks and other, pre-existing (and critical) risks such as working under cranes, even recognising the Port's essential role during the pandemic. The prosecution points out that the automation project continued during this period, and that project consumed the lion's share of health and safety resources.

The defence suggestion that the automation project was designed to enhance safety could not have extended to the safety of lasher working on vessels. The prosecution submits that Covid-19 can be put aside in assessing the reasonableness of Mr Gibson's actions or inaction.

[438] Mr Gibson had a duty to ensure POAL had available for use, and used, a change management system that provided an opportunity to identify work as done and ensure that changes made to workers' roles, specifically those involved in coordinating high risk work, did not undermine behavioural or other controls. Such a change management system should have been clearly documented, established the essential components of the system, defined changes which would trigger the application of the system, provided guidance and encouraged the use of specialised expertise to inform the change management process.

[439] The prosecution relies on the evidence of Mr Kahler that, following a review of POAL's documents, no evidence indicating such a document or formalised system was in place.[384] The prosecution say that POAL understood the importance of having such a system in place; POAL's safety plans for the 2018 and 2019 financial years briefly referred to change management,[385] and a high-level comment regarding the importance of risk analysis when processes change was included in the Health and Safety Manual.[386]

[440] The prosecution does not submit that Mr Gibson ought to have actively participated in or interrogated the fine details of a change management process in relation to the removal of the lash leading hand. Rather, the duty of a reasonable CEO arose at a prior stage in terms of systems leadership; Mr Gibson was required to ensure that POAL had systems in place to ensure that any change made to work was safe.

[441] The prosecution submits that Mr Gibson did nothing at all to assure himself that any changes would made be made in a manner which avoided undermining POAL's behavioural controls in respect of the critical risk of handling loads.

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[384] NoE 1322.
[385] Exhibits 50 and 51.
[386] Exhibit 37, at 0813.

[442] The change introduced by the CTOPs Pandemic Plan was one which required the application of a change management process, regardless of the pandemic. Effective documentation was necessary to ensure that this took place. MNZ refers to the circumstances around the creation of the CTOPs Pandemic Plan, POAL's admitted failings, and the lack of effective consultation on the plan. These circumstances were inconsistent with a change management process providing insight into work as done by way of a risk assessment. A risk assessment was either not undertaken or was insufficient to enable insight into work as done and the safety implications of the role change. It is submitted that the later return of the lash leading hand role represents an organisational acceptance that its removal was a mistake resulting from a defective process.

[443] Mr Gibson was only required to exercise due diligence when he was presented with the CTOPs Pandemic Plan by asking whether proper regard had been made to ensuring that the proposed change to work with safe. In failing to do so, he failed to exercise due diligence. He could have satisfied himself that an appropriate change management process would take place anytime between March and August 2020.

[444] A reasonable CEO ought to have ensured that a clearly documented management of change process with risk assessment was in place, ahead of the pandemic. Mr Gibson's failure to ensure that such a system was in place meant that a risk assessment was either not performed or not performed in a sufficiently robust manner.

[445] The prosecution emphasises that the CTOPs Pandemic Plan related to one of the highest risk work area at the port. The merger of the lash leading hand and ship leading hand roles should have been one of, if not the most, scrutinised changes made during the pandemic. More attention needed to be paid by management to the existing critical risks, in addition to the management of the new, pandemic related, risks.

[446] Mr Gibson had "set himself up to fail" by neglecting earlier systems leadership. He failed to rectify that neglect at the time the pandemic plan was introduced, despite the obviousness of the existing risks.

Defence submissions

[447] The defence submit that Mr Gibson took a range of steps which were reasonable in the circumstances.

[448] In terms of those circumstances, the defence refers to the unprecedented nature of the challenges posed by the pandemic generally but, in particular, on the port as an essential service and a critical point of entry for essential supplies into New Zealand. The mandatory 14-day isolation period for those infected and for those in the same bubble created significant health risks and strategic difficulties if Covid-19 was to spread through the Port. This provides essential context in assessing the steps taken by POAL to reorganise the stevedoring crews and Mr Gibson's conduct in relation to that reorganisation. The defence refer to Professor Dekker's evidence regarding corporate decision-making during the pandemic.[387] The defence also refer to the then existing legal requirements relating to Covid-19 and the impact of the elimination strategy. All of these matters impacted on corporate governance.

[449] The defence emphasise POAL's foresight and preparedness in relation to the pandemic, which permitted the port to continue functioning as soon as the Level 4 lockdown commenced.

[450] The defence emphasise that the lash leading hand was not assigned to each team under the CTOPs Pandemic plan for two reasons. First, the role had traditionally worked across lasher crews and under the pandemic it was not possible for one staff member to interact with multiple crews or bubbles.[388] Second, POAL did not have enough trained lash leading hands to include one in each crew.[389] The defence acknowledge that the lash leading hand role was not removed for the entirety of the period between 25 March and 30 August, but also note the lash leading hand manual was reviewed in July 2020.

[451] The defence also acknowledge that there were witnesses who did not agree with the decision to remove the lash leading hand role but emphasise that some

[387] Exhibit Y, at paras 23 to 25.
[388] NoE 541.
[389] NoE 544.

workers thought it was appropriate. Mr Lander also considered that it was appropriate and did not compromise safety.

[452] The resources and processes which Mr Gibson made available to POAL to ensure safe operational changes were made under pandemic conditions included: creating the Pandemic Team with a membership who had appropriate skills; directing it to design safe working practices; having appropriately experienced staff employed in operational management roles; the existing training of staff in six-sigma analysis and change management; directing the Pandemic Team that safety was not to be compromised; and having processes in place by which staff could provide feedback.

[453] The defence submit that it was reasonable for Mr Gibson to rely on the expertise of the Pandemic Team and operational staff. Mr Lander, whom the defence characterises as a human resource, had taken advice from highly experienced staff including two Senior Shift Managers and the Manager of Training and Performance.[390] He had a series of discussions in relation to the plan, including discussions with Mr Hulme and Ms Powell.[391] The plan was also the subject of discussions at the CTOPs Health and Safety Committee Meeting on 18 March 2020, which contained a cross-section of "on the ground" operational staff with working knowledge of stevedoring operations.[392] The plan had then been elevated to the Pandemic Team. There was further consultation with workers.

[454] The defence submits that there are two key features regarding the removal of the lash leading hand role. First, it is submitted that Mr Gibson did not necessarily need to be aware of this change. Second, the evidence of Mr Lander was that he did not regard the removal of the role as a significant change.[393] Advice from the Manager of Training was that the supervision of lashers formed a part of the ship leading hand's skill set, and involved a higher level of skills training than that undertaken by a lash leading hand.[394] A comparison of the training manuals relating to lash leading hands

[390] NoE 578 and 579.
[391] NoE 549.
[392] Exhibit 59.
[393] NoE 541.
[394] NoE 546.

and ship leading hand support this view.[395] The defence refers to the evidence of Mr Tahiwi, GB and Mr Haretuku as to the responsibilities of the ship leading hand.[396]

[455] The defence submits that, in any event, POAL was utilising change management processes before March 2020. These processes included six-sigma analysis, change management processes associated with the introduction of the lash platforms in 2019 and a formal change management plan in relation to the automation project. It was, therefore, reasonable for Mr Gibson to assume these skills would be drawn upon if change was occurring. The defence acknowledges that change management processes were not, however, formally documented in the way in which the prosecution submits they should have been.

[456] POAL's staff were able to provide feedback through a number of avenues, including weekly company meetings, Microsoft Teams meetings, anonymous feedback and reporting boxes, by being able to telephone the shift manager or contact anyone as necessary.[397] The defence also notes that Mr Gibson was at the port every day during the first lockdown, and attended all shift changes to personally check on staff (while wearing personal protective equipment).

[457] Mr Gibson had the full support of the Board in operating the port under pandemic conditions. His workload at the time was immense but, notwithstanding that, he spent a significant amount of personal time at the port (rather than working remotely). The Board considered that he was "fit for purpose" at that time of emergency.

[458] The defence submit that it has not been proven beyond reasonable doubt that Mr Gibson failed to take the reasonable steps that another CEO would have in the same circumstances, in the context of the global Covid-19 pandemic and an unprecedented time of challenge for POAL and the country.

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[395] Exhibits 25 and 104.
[396] NoE 737 and 755; 793; and 425-436.
[397] NoE 594.

Analysis

[459] Again, as the starting point in assessing whether Mr Gibson exercised due diligence, I return to the identified failures of POAL, as proven by its conviction. POAL failed to:

> (d) conduct an appropriate risk assessment relating to the removal of the lash leading hand role in response to the pandemic; and/or
>
> (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.

[460] I have addressed the particulars of the charges laid against Mr Gibson above.[398]

[461] Mr Gibson's alleged failures are to be assessed in terms of the time period reflected in the charges, that is, from 31 May 2019 to 31 August 2020. While events prior to that period may, of course, be relevant to the assessment of whether Mr Gibson failed in his duty within the period of the charge, the defined charging period is particularly relevant in the context of the allegations relating to the CTOPs Pandemic Plan. The requirement that the ship leading hand assume the supervisory duties previously undertaken by the lash leading hand took place as a result of the implementation of the plan, and as a direct consequence of the Covid-19 pandemic. I conclude that my principal focus, therefore, must be on the reasonableness or otherwise of Mr Gibson's actions in relation to the CTOPs Pandemic Plan, from early 2020 to 31 August of that year.

[462] The circumstances in which Mr Gibson was acting include the pandemic and the associated nation-wide state of emergency, lockdowns and social distancing rules. I accept that this was an unprecedented time in modern New Zealand history. While I accept that, potentially, a pre-existing failure of systems leadership by Mr Gibson may have continued into and through the charging period, I cannot accept the prosecution

[398] See above, at [14], [356] and [357].

submission that I should put to one side the circumstances of the pandemic in assessing the reasonableness of Mr Gibson's actions in relation to POAL's failures.

[463] I must assess Mr Gibson's alleged failure as against the care, diligence and skill that a reasonable CEO would have exercised in those same circumstances.

[464] In that respect, Professor Dekker referred to research conducted into organisational decision making during the Covid-19 pandemic.[399] The research indicates that:

(a) Organisational decision making during the pandemic was demonstrably and consistently different from non-pandemic decision making, across all kinds of industrial, logistical and service sectors;

(b) New Zealand's elimination strategy placed extraordinary demands on New Zealand business leaders compared to what occurred in other countries;

(c) Decision makers experienced a higher pace of organisational decision making in a more dynamic, uncertain, politicised and polarised environment. Decision makers reporting being barely able to keep up with events;

(d) Decision makers experienced acute concern about the contagion/health impacts of the pandemic;

(e) Organisations typically reshaped their systems, structures and processes towards assuring the organisation's mission. Role mergers were common;

(f) Fast decision making was prioritised over confident decision making;

[399] Exhibit Y, at paras 23 to 25.

(g) Decision makers had to learn to be uncomfortable and recognise that no protocol or structure was going to be exhaustively tested or risk assessed, nor was it going to be permanent;

(h) The setting up of auxiliary or subsidiary decision-making bodies below the CEO and senior officers was highly typical;

(i) Delegation and decentralisation became the rule;

(j) Authority to change, test and explore new ways of working was pushed to the "front line" to assure operational delivery in highly dynamic circumstances;

(k) Decision makers could not comprehensively incorporate all feedback from constituents, employees or other stakeholders, as they would have during, for example, a management of change process in "normal" circumstances.

[465] Professor Dekker stated that the research shows these features of organisational decision making became the "new normal" during the pandemic and concludes that normal management of change processes were not, and would not have been, up to the task. They would have been too deliberative, non-creative and slow to work in the pandemic environment.[400]

[466] There is no suggestion in the present case that the decision to establish the Pandemic or Emergency Response Team was not reasonable. To the contrary, it was a sensible response to an approaching emergency. Similarly, POAL's actions in requiring each business unit to draft a pandemic plan was appropriate and reasonable. This work, necessarily, had to be conducted in an extremely compressed time frame. Notwithstanding that, I accept Mr Lander's evidence that there was some consultation with workers and with those experienced in stevedoring, albeit that the consultation process may not have been as extensive as might have been the case in the absence of

[400] Exhibit Y, at [27].

emergency. Removal of the lash leading hand from the individual crews was specifically considered and discussed.

[467] I also accept Mr Lander's evidence that his priority was to both keep people safe from Covid-19 and maintain safe operations. No part of the decision-making process was intended to involve a trade-off of safe work practices against the need to manage Covid-19.

[468] While some workers were concerned about the removal of the lash leading hand from the individual crane crews, no safety concerns regarding the proposal were received by Mr Lander and there is no evidence that any such concerns were received by more senior management or officers.

[469] POAL's conviction provides conclusive proof that its failure to conduct an appropriate risk assessment, and to provide effective training, instruction and supervision to ship leading hands and crane operators, did expose workers to a risk of serious death or injury. In assessing the reasonableness of Mr Gibson's actions, however, it is relevant that many of those involved in the CTOPs unit at an operational level did not consider there were negative safety implications in the removal of the lash leading hand when individual crane crews were established.

[470] Similarly, it is relevant that staff within the CTOPs unit, including Mr Lander, did not consider that the plan involved a significant change of work processes, by reason of the fact that, pre-pandemic, in a one crane - one vessel situation, the ship leading hand already had responsibility for the lashers working on the vessel.

[471] In those respects, I note Mr Marriott's evidence that a CEO would typically only be required to sign off on change which is involves a certain level or threshold of risk. It would be overly onerous and create an enormous organisational bottleneck to require a CEO to sign off on all change. If no risk assessment was done, or if the change was not assessed as high risk, such change may not, generally, be elevated to a CEO.[401]

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[401] Exhibit AA, at para 139.

[472] I also accept the evidence which I heard as to the significant additional burden placed upon Mr Gibson, as CEO, by reason of the pandemic and, notwithstanding that, the significant efforts he went to make himself seen and available to workers at the port.

[473] There may be some merit in the prosecution's submission that POAL should have had a formalised change management process in place at an earlier stage, which might have responded to the pandemic emergency and the proposed changes to work processes. I accept that Mr Gibson, as CEO, was responsible for systems leadership. However, on the state of the evidence before me, it is not clear that in the period leading up to and including the time frame of the charges, POAL was significantly out of step with industry generally in having no formalised and documented management of change process, as opposed to managing change and undertaking risk assessments as and when necessary. Mr Kahler 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 involving risk assessments.[402]

[474] In that respect, I note that POAL was not convicted on the basis that it failed to have a formalised and documented management of change process in place; it was convicted in relation to its failure to carry out an appropriate and specific risk assessment relating to the removal of the lash leading hand from the individual crane crews.

[475] I remind myself of the burden of proof. On the state of the evidence before me and in the circumstances in which he was acting, I cannot be 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. I cannot be sure that Mr Gibson failed in his duty under s 44 HSWA in the manner described in particular 1(b) of the charges.

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[402] NoE 1355-1356

Did Mr Gibson's failure expose stevedores to a risk of death or serious injury?

What does the prosecution need to prove?

[476] I have concluded that Mr Gibson failed to comply with his duty under s 44 HSWA in the terms of particulars 1(a) and 2 of the charging documents.

[477] I have previously addressed the elements of the offences.[403] To be found guilty of the offence under s 48(1) HSWA, the prosecution must, additionally, prove that Mr Gibson's failure exposed 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.

[478] The prosecution submits that, because POAL has been convicted of breaching its primary duty of care in a manner exposing Mr Kalati and LB to the risk of death or serious injury, and because POAL's conviction constitutes conclusive proof of that fact, a finding that Mr Gibson failed to comply with his duty under s 44 to ensure that POAL complied with its primary duty of care necessarily means that the offence against s 48 has been proved as against Mr Gibson. Nothing further is needed.

[479] In the alternative, the prosecution submits that if it is necessary to go on in these proceedings and prove the final element of the offence as against Mr Gibson, all that the prosecution is required is to establish is a nexus between his breach of duty and the existence of the relevant risk of death or serious injury. That is, the prosecution must prove that the officer's breach made it *materially more likely* that the PCBU would breach its duty of care in a manner giving rise to the risk of death or serious harm.

[480] The prosecution submits that proof of the s 48 offence does not require the prosecution to prove that:

(a) the officer's breach was the sole or exclusive cause of the risk of death or serious injury;

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[403] See above, at [43].

(b) that the officer's breach in fact resulted in death or serious harm; or

(c) that the officer's breach *directly* contributed to the existence of the risk of death or serious harm.

[481] The prosecution submits that any further causal analysis, as to the extent to which the officer's breach can be said to be an operative cause of serious harm or death, is a question which goes to culpability and sentencing, not liability.

[482] The defence submits that proof of causation under s 48 requires the prosecution to prove a particular connection between the officer's failure of due diligence and the exposure of workers to the risk of death or serious harm. In the context of this case, the defence say that proof of causation requires the Court to "trace" Mr Gibson's failure to exercise due diligence in the way(s) specified in the charging document to an exposure of the stevedores to a risk of serious injury or death, by way of being struck by falling objects, between 31 May 2019 and 31 August 2020.

[483] For present purposes, the defence submits that the prosecution must prove that whatever Mr Gibson did or did not do at a due diligence level *caused* POAL to not have clearly documented, effectively implemented and appropriate exclusion zones in place.

[484] I consider that, in most cases where a PCBU has breached its primary duty of care in a way which exposes workers to a risk of death or serious injury, proof of a failure on the part of the PCBU's officer to exercise the s 44 duty to ensure the PCBU complied with its duty is likely to lead to a conclusion that the officer's breach also exposed workers to that risk. That is because, depending on the facts and the specific allegations, it is likely that the officer's breach will take the form of failures which are linked to the PCBU's breach of its duty.

[485] It cannot be the case, however, that proof of an officer's breach under s 44, coupled with proof of the PCBU's breach of s 48, automatically leads to a conclusion that the officer has also breached s 48. The prosecution must prove, as an element of

the s 48 offence, that the officer's breach exposed workers to the risk of death or serious injury.

[486] Having regard to the purpose and scheme of the legislation, however, I accept the submission that proof of causation means that the prosecution is required to establish that the officer's breach made it materially more likely that the PCBU would breach its duty of care in a manner giving rise to the risk of death or serious harm.

Prosecution submissions

[487] The prosecution accepts that Mr Gibson's failures were not the only cause of the exposure to risk. Causation is almost universally multi-factorial. There may be multiple people who could have intervened to prevent a risk arising.

[488] Mr Gibson's failure of due diligence represented, however, missed opportunities to reduce or eliminate the extent to which POAL was breaching its primary duty of care, and thereby exposing its lashers to the risk of being struck by falling objects.

[489] In relation to particular 1(a), the prosecution submits the evidence demonstrates the way in which the three container-width rule was understood and enforced on night shift between 31 May 2019 and 31 August 2020 clearly exposed stevedores to a risk of death or serious injuries. Lashers were frequently in close proximity to working cranes carrying containers and were therefore vulnerable to being struck by twist lock mechanisms, lashing bars or other debris falling from containers or, indeed, by a falling container.

[490] There is, it is submitted, a clear nexus between the failures of Mr Gibson to exercise due diligence in respect of the exclusion zones and the three container-width rule and the exposure of stevedores to the risk of death or serious injury.

[491] It is submitted that the Court can readily infer that practices on the night shift would have changed in a world where Mr Gibson had exercised due diligence to ensure that POAL had a system that afforded management insight into work as done, made identification of the culture of non-compliance more likely, and prompted a

review of the relevant behavioural controls and inadequate documentation. Such a system would have significantly reduced the exposure of lashers to the risk of being struck by falling objects.

[492] Mr Gibson's failure to undertake verification of work as done further decreased the likelihood of these matters being identified and rectified.

Defence submissions

[493] The defence submits that there is no causal nexus between any failure on the part of Mr Gibson and POAL's deficient processes and documentation in respect of the exclusion zones.

[494] The documentation, implementation and appropriateness of the three container-width rule, exclusion zones and the monitoring of work as done was the domain of subject matters experts. Those experts worked within a planning, review and modification system established by the Health & Safety Team. Oversight was undertaken by the Health & Safety Team, the HSSC, Senior Management and the Board.

[495] The defence argue that there is no evidence that Mr Gibson played any direct role in causing POAL not to have clear documents or appropriate processes in place. To the extent that there were deficiencies, that was a "systems" issue.

[496] The defence submits it is too much of a stretch to say that Mr Gibson was a significant and substantial cause of alleged deficiencies in documentation and discrete working practices in the absence of evidence tying him directly to the documentation and practices.

Analysis

[497] I largely accept the prosecution submissions.

[498] Mr Gibson's failure(s) in relation to the exclusion zones particular are matters of omission rather than commission. It is not, in my view necessary for the prosecution to establish that he was directly responsible for, or had a direct role in, POAL's failure to have adequate documentation, monitoring or procedures in place.

[499] I have, however, concluded that:

(a) Mr Gibson was fully aware of the critical risk of handling suspended loads;[404]

(b) He was, ultimately, responsible for health and safety and was tasked with a number of key health and safety responsibilities;[405]

(c) He was responsible for monitoring and reviewing the performance of his subordinates and POAL's systems. He was required to exercise systems leadership;[406]

(d) He was "hands on" in relation to health and safety issues;[407]

(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;[408]

(f) He was aware, or ought to have been aware, of the lack of timely progression of bow-tie analysis of critical risks;[409]

(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;[410]

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[404] See above, at [415].
[405] Above, at [416].
[406] Above, at [416] and [429].
[407] Above, at [416].
[408] See above, at [417] and [422].
[409] Above, at [423].
[410] Above, at [424] and [425].

(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;[411]

[500] I conclude that a reasonable CEO would have recognised the shortfalls in POAL's management of exclusion zones and would have ensured POAL utilised appropriate resources and processes to address those shortfalls. Mr Gibson did not so so. In these circumstances, I am 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.

Conclusion and Verdict

[501] For the reasons set out in this judgment, I find Mr Gibson **guilty** on the charge laid under s 48(1) HSWA in terms of particulars 1(a) and 2 of the charge.[412] I was not satisfied, beyond reasonable doubt, of his guilt in relation to particular 1(b) of the charge.

[502] As the charge alleging an offence under section 49(1) HSWA is laid in the alternative, I return no verdict on that charge. The charge will be dismissed in open court in due course.

Non-publication orders

[503] Permanent orders have previously been made preventing the publication of the names or identifying details of the persons referred to in this judgment as LB, KM, WM, MH, VH, GB and other persons identified in my Minute dated 21 May 2024.

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[411] Above, at [426] & [427].
[412] CRN 21004501680.

[504] At the request of the parties, I order that there be no publication of the above verdict or details of my reasons in any media report until 10 am on 27 November 2024.

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Judge S J Bonnar KC
District Court Judge | Kaiwhakawā o te Kōti ā-Rohe
Date of authentication | Rā motuhēhēnga: 26/11/2024