Key Messages Relating to the Tony Gibson Prosecution and Officer Obligations

[Developed by: The Business Leaders Health and Safety Forum, Institute of Directors, General Manager Health and Safety Forum, Maritime NZ and WorkSafe]

- The facts are specific to the case. In particular, in this case as outlined in the Court judgement Mr Gibson:
    - managed the port company for more than a decade, during which the Port was convicted of several offences under health and safety legislation that had led to fatalities and injuries.
    - was aware of relevant risks and the controls that were or were not in place to address the risks
    - knew of the lack of timely response by POAL to recommended improvements to health and safety matters
    - was focused on additional technological controls, but had failed to turn his mind to other, non-technological controls
    - had the knowledge, resources, influence and opportunity to address the safety risks but did not do so in a timely and effective way.

- The key take-outs from the case are:
    - Officer due diligence failings that the regulators focus on will often occur in circumstances where a PCBU's safety gaps have been present over time, or across a range of incidents or issues and insufficient action has been undertaken to address them.
    - While Mr Gibson's case is fact-specific it has three general cautionary lessons for Officers, in particular that CEOs:
        - deal with specific risks promptly
        - if an incident or issue occurs, seek to understand the cause and what actions are being taken
        - seek assurance any actions and recommendations are progressed in a timely way, and explore all types of controls.
    - The Court noted that Mr Gibson had taken many positive steps towards health and safety but still failed in his duty in other respects. An officer can take positive steps in some areas but still breach their duty if critical risks are not managed. In this case Mr Gibson was focused on future technological controls but failed to ensure that other hard controls were put in place to address safety risks in the interim.

- Effective systems are crucial to health and safety management for larger companies. A Chief Executive Officer plays a significant role in systems leadership in an organisation. Chief Executive Officers do not need to be involved in day-to-day operations but they cannot rely simply on what they are told by those who report to them in their management chains. They must make their own assessments, and this includes being proactive in verifying and interrogating the information they receive and seeking assurance from a number of sources.

- There is a need for effective reporting lines, ensuring that necessary health and safety information flows to officers consistent with their respective management and governance roles, and a review of processes. This is more than noting the reported actions taken by others. Evidence should exist showing the Chief Executive Officer has interrogated the information, particularly where issues are raised showing some action needs to be taken in a timely way.

- Officers, particularly board members can find useful guidance in the *Institute of Directors and WorkSafe NZ: "Health and Safety Governance: A Good Practice Guide"*.

- The case re-enforces this guidance.

- Extending beyond this guidance, the case provides more insights for a Chief Executive Officer on what their due diligence role as an officer is, and shows how the management and governance roles play out differently in practice given what a Chief Executive can influence and control, compared to a Director.

- The Business Leaders Health and Safety Forum, Institute of Directors, and General Manager Health and Safety Forum, working together with Maritime NZ and WorkSafe NZ, are looking to provide additional guidance to Chief Executives of large companies around their due diligence obligations.

- This will complement the current IOD/WorkSafe guidance and while it will focus on the work of the Chief Executive it will also look at how this role works with Directors and Senior leaders to deliver the due diligence obligation.

- This work will be useful guidance regardless of the Gibson case and whether there is an appeal or not.

- In the interim the Forum's Actionable Insights document and the IOD Good Practice health and safety Governance Self- Assessment on health and safety are useful resources for Chief Executives and other Officers to consider. IoD Health and Safety Governance Board Pack can also help.

- The case offers useful reminders for Officers**:**
    - Ensure you are clear of your business's critical hazards, risks and controls and that the hierarchy of controls has been applied (i.e. if you have soft controls in place be clear about why they are being used and why other controls cannot be implemented, and document this).
    - Maintain sufficient knowledge of work as done versus work as imagined through testing, and receiving assurance, that the H&S system and critical risk controls are in place and working effectively.
    - Ensure that your sources of assurance are diverse, reliable and competent (for example, data and insights from health and safety teams, senior management, workers, contractors, and external experts eg SafePlus).
    - Where you do have internal and external recommendations from audits, reviews and investigations either assure yourself these are actioned in a timely way or if the organisation has not accepted them be clear why not.
    - Make sure there are clear accountabilities and responsibilities around health and safety and seek assurance around how these are being met.
    - Ask for, and receive, reviews of how critical risk and controls are working, regularly, after incidents, and also when **context changes.** Focus not only on improvements but what worked, and why, and can be repeated.
    - For Officers that are taking these steps already it will affirm their current approach.