national research centre for
OHS regulation

RegNet

**Working Paper 91**

# ACT WorkCover and the Failed 1997 Implosion: A Case Study of the Role of the Inspectorate

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**September 2015**

Australian National University

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## Author's Acknowledgements

This study is for all the OH&S inspectors who recognize the dilemma at the heart of their role but nevertheless persevere to make workplaces safer.

*"Inspectors fulfil their role according to principles which already structure the laws, most prominently according to the costs and risks associated with compliance. These are matters which pervade regulation and which, of necessity, are part of the regulatory inspector's world view. Resolving the tensions between costs and risks are both a broad rationale for the inspector's job and a point upon which the regulatory agency and officials can become the fall-guys of a system which fails to specify how stringently compliance should be defined"*[1]

My thanks to those at ACT WorkCover who provided me with information and trusted me with their thoughts and their stories. Thanks also to Professor Andrew Hopkins whose scholarship and insights have been invaluable. None of them are in any way responsible for anything written here - the views expressed and the analysis made are mine alone.

**Patricia Healy, September 2015**

[1] Bridget Hutter (1997) *Compliance: Regulation and Environment* Clarendon Press Oxford.

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# 1. INTRODUCTION

The failed implosion of the old Canberra Hospital buildings on Sunday 13 July 1997 resulted in an explosion which blasted masonry and steel debris beyond the 200 metre exclusion zone to where thousands of spectators stood watching on the shore of Lake Burley Griffin. A young spectator, Katie Bender, was killed instantly when struck by a fragment of that debris.

At the Bender Inquest the Coroner, Mr Shane Madden, described the implosion project as having failed systemically. He attributed the failure to:

- the Project Manager's and contractors' lack of appropriate competencies;
- the absence of input from independent engineers and explosives experts;
- inappropriate action by the ACT Chief Minister's Office and Department in promoting the implosion as a public event; and
- failure of the regulatory agencies to properly discharge their functions.

The Coroner documented a litany of failures and inadequacies on the part of all the contractors and government bodies involved. Key decisions were poorly informed and inappropriate. Necessary actions were omitted or poorly implemented. Established safety procedures were followed inadequately, incorrectly or not at all.

It is clear, in retrospect, that the wholesale underestimation of the risk to public safety was a significant factor in this litany of failures. The public safety risk inherent in the implosion project as it was implemented, was unrecognized, discounted or underestimated by all the parties involved at all stages of the project.

This study, with the great benefit of hindsight, examines why this occurred and how it affected the role of ACT WorkCover and those inspectors directly involved. Specifically it examines how the particular circumstances of the implosion project combined with the situation and practice of WorkCover to influence the inspectors' assessment of the inherent risks and the exercise of their regulatory enforcement powers.

The Coroner's Report clearly acknowledged that primary responsibility for the safe conduct of the implosion project rested with the demolition contractors and those who employed and supervised them. However, he also criticized the roles and actions of all the ACT government bodies involved in the project. He was particularly critical of ACT WorkCover inspectors directly involved in the project. While acknowledging that they

had not *"contributed to or had any direct connection with the death of Katie Bender*,"[2] he concluded that they had "*failed to meet the standards that could be reasonably expected of a competent WorkCover inspector*." The inspectors argued, to the contrary, that their decisions and actions were in accord with both statutory requirements and the established policies and practice of WorkCover. That is, they were acting as they were required and expected to do and as they normally did.

The disparity between the Coroner's findings and the contentions of WorkCover staff reflects, in part, a difference in the scope and intent of their analyses. However, it primarily reflects differing perspectives on the role of the OHS inspectorate. Some of the inspectors' actions criticized by the Coroner as failing to "*meet the standards that could be reasonably expected of a competent WC inspector*,"[3] were standard practice for all Australian OHS inspectors at the time and an established part of their dual role as both advisor and enforcement agent. The inspectors were justified in arguing that they were acting in accordance with statutory requirements and long established policies and practice. However, in this case they were doing so in unprecedented and very unusual circumstances, many of which were unknown to them. They failed to fully appreciate how those circumstances compromised their role and invalidated their risk judgements, with major implications for the outcome of their legitimate actions.

## Methodology

This study draws on the relatively small body of empirical research regarding how regulatory bodies assess risk in the process of determining how to exercise their regulatory enforcement powers; particularly in the context of the non-adversarial approaches taken by Australian, and other, OHS regulatory agencies. It also draws on documentary material concerning the implosion project, including:

- the documents and transcripts of evidence presented to the Coronial Inquest into the death of Katie Bender and the final Coroner's Report;
- transcripts of evidence presented to subsequent ACT Public Service Disciplinary Inquiries into the actions of two WorkCover inspectors, and the Reports of those Inquiries;
- the Reports of two ACT government reviews of ACT WorkCover; and
- media reports of the implosion and its aftermath and of the subsequent Coronial Inquest, Public Service Inquiries and related court cases.

[2] Shane Madden (1999) *The Bender Coronial Decision. INQUEST FINDINGS, COMMENTS & RECOMMENDATIONS into the death of Katie Bender on Sunday 13th July 1997 on the Demolition of the Royal Canberra Hospital Acton Peninsula*, ACT. ACT Magistrates Court, p 292.
[3] Ibid, p 291.

This documentary material is supplemented by:

- confidential in-depth interviews conducted by the author in 2001-2003 with inspectors and others employed at ACT WorkCover prior to or at the time of the implosion, and

- access to their private papers, including transcripts of interviews with the Australian Federal Police.

**Structure of the Report**

Chapter 2 outlines the key failures and inadequacies identified by the Coroner and associated actions that contributed to a breakdown of established systems to ensure the safety of construction work in the ACT in the mid-1990s.

Chapter 3 discusses how the circumstances of the project impacted on the work of ACT WorkCover. It includes consideration of the Coroner's findings and conclusions, and the contrary views and interpretations presented by WorkCover staff.

Chapter 4 discusses the failure of all involved in the implosion project to appreciate the level of public safety risk inherent in the project as it was implemented, and the consequent implications for WorkCover staff.

Chapter 5 provides concluding remarks about the implications of the project for ACT WorkCover and its inspectors, including in the aftermath of the Inquest.

## 2. IMPLOSION PROJECT – SYSTEMIC FAILURE

At the Inquest following the death of Katie Bender, the Coroner, Mr Shane Madden, described the implosion project as having failed systemically and documented a litany of failures and inadequacies on the part of all the government bodies and principals involved. He identified the contractors' methodology as directly contributing to Katie Bender's death[4] and clearly acknowledged that the primary responsibility for safe conduct of the project rested with the contractors and those who engaged and supervised them. However, he also explicitly criticized the actions and omissions of all the ACT government bodies involved in the project, for contributing to its fatal failure, including:

- ACT Cabinet's choice of implosion as the method of demolition for two of the buildings, without informed consideration as to the feasibility and safety issues included in commissioned reports;[5]

- the failure of the ACT government to consult and involve the relevant regulatory authorities;

- ACT Chief Minister's Office (ACT CMO) and Chief Minister's Department (ACT CMD) for unwarranted promotion of the implosion as a public event that resulted in the presence of thousands of spectators in a high risk situation;

- ACT Department of Urban Services (ACT DUS) and Totalcare Industries Ltd (TCL), the Project Director,[6] for appointing Project Coordination Australia Pty Ltd (PCAPL) as Project Manager, despite the company's lack of appropriate credentials and relevant experience;

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[4] Specifically, incorrect use of explosives and site preparation, inadequate protective measures and testing, and failure to obtain appropriate expert advice. He found that four of the project contractors contributed to Katie Bender's death and recommended that two be committed to trial for manslaughter. Explosives sub-contractor Rod McCracken was charged with manslaughter and demolition contractor Tony Fenwick with being knowingly concerned with the same offence. All charges were later dropped after the Director of Public Prosecutions found there was not enough evidence to support them. Rod McCracken was subsequently fined $15,000 for an offence under the *ACT OH&S* Act.

[5] The reports were prepared by Richard Glenn and Associates (RGA) a project management company specializing in planning and management of largely health related projects. The company prepared 3 commissioned reports for the ACT Department of Services (ACT DUS) concerning the demolition of the hospital buildings. A feasibility report was prepared in July 1995, with an addendum in September 1995. An extra study in February 1996 addressed the impact of the demolition on the Hospice. The initial feasibility study was conducted with the assistance of PCAPL (alternative methods of demolition) and WT Partnership (costings).

[6] Totalcare Ltd (TCL) was incorporated in December 1991 as an unlisted public company wholly owned by the ACT government. Some of the ACT DUS engineering and technical business units (capital works delivery, civil engineering and building maintenance, surveying and property management) were transferred to TCL from 1/1/97. TCL assumed responsibility for the old Canberra Hospital demolition project from 1/1/97.

- the failure of the tender process undertaken by TCL (Project Director) and PCAPL (Project Manager), which culminated in the inappropriate appointment of the demolition contractor, Tony Fenwick of City and Country Demolitions (Australia) PL (CCD), and his explosives sub-contractor, Rod McCracken of Controlled Blasting Services (CBS);

- the failure of TCL, as Project Director and agent of the ACT government, to ensure that contractual requirements were met and the project was conducted safely;

- ACT WorkCover[7] (ACT WC) and ACT Dangerous Goods Unit (ACT DGU)[8] for their failure to "*properly discharge their functions*."[9]

This chapter outlines the key 'failures and inadequacies' identified by the Coroner which, singly and combined, resulted in a breakdown of the established systems for ensuring the safety of construction work:

- the choice of implosion to demolish the two tallest buildings;

- the decision to stage the implosion as a public event;

- the appointment and inadequate supervision of inappropriate contractors;

- the contractors' failure to follow appropriate procedures to ensure that the implosion was conducted safely; and

- lack of appropriate involvement and action taken by the regulatory agencies.

## Choice of Demolition by Implosion

In August 1995 the ACT Cabinet gave in-principle approval for demolition of the old Royal Canberra Hospital buildings on Acton Peninsula pending a landswap with the Commonwealth to allow construction of the National Museum on the lakeside site. The approval included the implosion of the two tallest buildings on site, Sylvia Curley House and the Main Tower Building.[10]

The Cabinet decision was informed by a submission from ACT DUS on the feasibility and options for demolition. The submission misrepresented the findings and recommendations of the commissioned feasibility studies completed in 1995 by Richard

[7] Located in the Department of Business, Arts, Sport and Tourism (BASAT)
[8] Located in the ACT Emergency Services Bureau (ACT ESB)
[9] Shane Madden, above n 2, p 197 para 11.
[10] The plan was to demolish the majority of the large on-site structures, including the old A&E, main foyer of the hospital and internals of Sylvia Curley House, by conventional mechanical demolition.

Glenn & Associates (RGA). The RGA studies recommended that demolition by implosion was feasible for the two taller buildings but also recommended caution and further investigation. They noted the need for careful attention to be paid to:

- issues of publicity, safety and pollution control;
- the impact of implosion on the remaining buildings in the area; and
- the need to obtain a building permit and other statutory approvals.

The RGA reports proposed that tenders be called for both implosion and more traditional methods of demolition to allow more time for the Project Director or Project Manager to further investigate the use of implosion. Additionally, although not included in the Report, the RGA Director verbally advised the Chair of the ACT DUS Acton Steering Committee on the need for consultation with overseas experts regarding implosions.

The ACT DUS submission to Cabinet ignored the recommendations of the RGA reports. It recommended demolition of the two taller buildings by implosion without any mention of RGA's recommended precautions. It claimed that implosion would be just as safe as other methods of demolition – a claim not included in or supported by the RGA reports. This claim was not challenged before the submission went to the Cabinet for decision as none of the DUS staff with appropriate technical knowledge or expertise compared the submission with the recommendations in the RGA reports.[11] The Acting Director of ACT DUS Works and Commercial Services, who was responsible for clearing the submission, did not read it before he signed off on it. As a result, the Cabinet in-principle approval of implosion was based on an incorrect and misleading submission that was, in the Coroner's words:

*" ... fundamentally defective to the extent that vitally important advice was not included concerning the following areas:-*
*(a)There is no mention of an overseas expert,*
*(b)The cautions and safety issues and matters requiring further investigation raised by the RGA Report are not mentioned, and*
*(c)The comment and advice that the implosion was just as safe as conventional methods was not substantiated by reliable evidence.*
*... The Cabinet was being asked to make a decision on incomplete and inadequate information."*[12]

A subsequent commissioned report prepared by RGA in February 1996, concerning the potential impact of the implosion on the activities of the nearby hospice, was also

[11] Preparation of the submission was coordinated by the Chair of the ACT DUS Acton Steering Committee, Mike Sullivan, who had no technical experience in engineering, construction or demolition. It was circulated within ACT DUS & other agencies for comment.
[12] Shane Madden, above n 2, p 110 para 34.

ignored. The Coroner noted that it was *"not read or considered by the people at the critical levels of responsibility for the project until the project had advanced some way to completion or until it was too late to apply solutions to the problems*."[13]

Following agreement on the landswap, ACT Cabinet gave an immediate go-ahead for the demolition in early December 1996. PCAPL was appointed as Project Manager - without a tender process - to start work on fencing and securing the site. At that stage there was no further consideration of the RGA reports. Nor was there any further assessment – then or subsequently - of the suitability of the implosion option and the precautions recommended by the RGA reports. Indeed the Coroner concluded that after August 1995 and throughout subsequent developments *"the RGA Reports were either ignored or simply became a forgotten chapter in the project."*[14]

Consequently, the Cabinet choice of demolition by implosion, based on inadequate and misleading information, became and remained the preferred option for the two tallest buildings on site. It was regarded throughout the project as both appropriate and without significant risk for promotion as a public spectacle. Work proceeded accordingly.

## Decision to Stage the Implosion as a Public Event

In early 1997 the ACT Cabinet approved the decision to stage the implosion of Sylvia Curley House and the Main Tower Building as a public event. Control of the project was transferred from ACT DUS, normally responsible for major public works, to staff in the Chief Minister's Office and Department, who treated it as a major public relations exercise.[15] By the time that work started in late April 1997, the implosion-as-public-event was a fait accompli, and staff in the Chief Minister's Office were already consulting with the local media about how to promote it as a 'Celebration of Change'. A large and inherently high risk explosive demolition was quickly transformed into a well-publicized spectator event with little consideration given to the public safety risks or the potential repercussions for the regulatory agencies.

On Saturday 4 January 1997 the Canberra Times reported that ACT Chief Minister, Kate Carnell, was seeking suggestions about how to bring down the buildings in an appropriate way and that it would be a major public event. This was an understandable move given the high level of interest and nostalgia among Canberra residents. Many had been born or been cared for in the old hospital and thus were ambivalent or opposed to its loss. A few days later a media strategy for a demolition by implosion was agreed upon. Mr Dawson, Kate Carnell's Media Advisor, would handle the political aspects and the Project Director TCL would be responsible for the technical aspects. In mid-April, with Ms Carnell's

[13] Shane Madden, above n 2, p 393 para 21.
[14] Ibid, p 132 para 68.
[15] The head of TCL, the Project Director, reported to the Chief Minister's Department, not to the Minister for Urban Services, Mr Kaine, for this project. In the Coroners' words: "*The client for this demolition project was the Chief Minister's Department"* ... the Minister for Urban Services, Mr Trevor Kaine had "*no input or involvement in the project."*

authorization, a formal proposal was received from Rohan Chabaud, of local radio station MIX106.3, for media promotion of the implosion as a large scale public event – a Celebration of Change.

Subsequently an officer in the Chief Minister's Department was appointed to liaise with MIX106.3, TCL, PCAPL, the Australian Federal Police and others to coordinate arrangements for the public event and ensure full consultation with various interest groups. The consultation group did not include representatives from the government regulatory agencies responsible for public safety (WorkCover, Dangerous Goods Unit) or the demolition contractors – none of whom had been advised or consulted before approval was given for the Celebration of Change.[16]

Undoubtedly the initial ACT Cabinet decisions that resulted in the implosion-as-public-event, were made with no awareness that it could pose significant risks to public safety. Presumably the senior CMO and CMD staff subsequently responsible for the project, were also initially unaware that by-passing the regulatory safeguards had public safety implications. However, their initial failure to give appropriate consideration to public safety continued throughout the planning and promoting of the event. Their main focus throughout was on ensuring that the major public spectacle occurred on time and on budget. Although it was soon obvious that large crowds of spectators were likely to watch from the lake shore, they failed to consider the public safety implications.[17] Only the potential impact on the nearby Hospice was duly considered.

Although Warwick Lavers, TCL Project Director, was consulted in early 1997, there was no other prior consultation about public safety with the contractors or government regulatory agencies. From the commissioning of the final RGA report (February 1996) to the time of the blast (13 July 1997), protection of the nearby Hospice remained the major concern. There was little, if any, consideration of the possibility that spectators on the lake shore could be hit by flying debris if the explosions did not go according to plan and the buildings did not fall in (or close to) their own footprint as proposed. In the Coroner's words:

"*The question of public safety in mid April 1997 was simply not a realistic consideration for the project operators. One is left with the impression that save for the welfare of the Hospice and its patients and possible traffic congestion, any forward planning was absolutely non-existent in the terms of concern for general public safety. This aspect of the project simply meandered along in a very casual manner. The possibility of debris flying across the Lake in the direction where the public were later being encouraged, by the public promotion, to congregate was simply not considered*."[18]

[16] The possibility of the implosion becoming a public event had not been previously mentioned in the project tender advertisements and documents.
[17] Shane Madden, above n 2, pp 375-499.
[18] Shane Madden, above n 2, p 416 para 59.

It is difficult to determine when, and to what extent, political expediency became a factor in ACT government support for the implosion-as-public-event. However, evidence to the Inquest indicated that, over the course of the project, some major decisions about organization and timing were not made for technical reasons. They were made by senior staff of the Chief Minister's Office and Department, functioning in areas outside their usual areas of responsibility and capacity. Failing any appreciation of the potential public safety risks, promotion of the public spectacle became the primary driving force for the implosion project. The implosion became a major public relations exercise for the government. In the process it created a climate of hostility to any interventions likely to cause delays or cost increases. This subsequently included dismissal of legitimate safety concerns and attempted interference with the WorkCover inspectors' role.

In late June, when the local Health Services Union, raised legitimate safety concerns but the Union was fobbed off with false claims of ongoing risk assessments to ensure public safety. In early July there were improper attempts made (unsuccessfuly) by a senior public servant to have WorkCover inspectors removed from the site.

The Coroner concluded that the government's wish to present the demolition in the best possible light was understandable, given its significant role in the history of Canberra and the lives of its people. However, he criticized the extent of involvement by staff of the Chief Minister's Office and Department as "*far exceed*(ing*) what was reasonably necessary by public officials."*[19] He further suggested that this involvement resulted in "a *subtle pressure particularly on* (Project Director, TCL) *in setting and then meeting a specific deadline for the demolition so that in the long term the concept of a public event would crystallize from an idea in January 1997 to a reality by July 1997."* [20]

The media promotion of the implosion, inviting all of Canberra to attend the gala event, aroused huge public interest. It resulted in thousands of spectators gathering in the well publicised lakeside viewing areas. However, the initial blast protection measures were not appropriately calculated to ensure spectator safety if the implosion failed. There was reassessment of the initial arrangements following reconfiguration of the blast towards the lake (away from the Hospice), although the contractor was by then aware that the steel columns could shatter and result in flying debris. The containment barriers on the lake side of the blast site (sandbagging, mesh curtains, bund walls – common measures in explosive demolitions) were less than proposed and proved to be inadequate given the force and direction of the explosion. When the implosion failed, debris blasted well over 200 metres, showering the spectators on and beside the lake with high velocity fragments of steel and masonry. As the Coroner noted, the planning failures seem in retrospect to be almost incomprehensible.

[19] Ibid, p 427 para 76.
[20] Ibid, p 428 para 79.

## Inappropriate Appointments

The Coroner's Report describes the contracting, tender and selection processes which lead to the appointments of the Project Manager PCAPL and contractors, CCD and CBS, as *"a chain of procedural deficiencies"* [21] The failure to follow established procedures resulted in the appointment of a Project Manager and contractors without appropriate expertise and without the experience or capacity to identify and manage the project's public safety risks.

### Appointment of Project Manager - PCAPL

PCAPL was initially appointed as Project Manager to manage the fencing and securing of the site and the removal of hazardous waste prior to demolition. But, according to the CEO of ACT DUS, this was done on the *"... assumption that that would evolve into a full project."*[22] Because PCAPL had been involved in the 1995 RGA feasibility study,[23] it was presumed to be knowledgeable about the site and able to make the immediate start necessary to meet the August 1997 deadline set by the Chief Minister. The Coroner, while expressing some concerns about the appointment process, noted that the initial single selection and appointment of PCAPL for a limited role in December 1996 was *"reasonable, practical and appropriate"* – but not so its continuation.

The initial appointment of PCAPL was continued without any steps being taken to either confirm its capacity to manage the whole demolition project or to consider the merits of other potential candidates. This decision was criticised by the Coroner as, *"the continuation of this appointment as Project Manager without any form of review is unsatisfactory as PCAPL did not have any relevant experience in implosion demolition".*[24] The Coroner concluded that PCAPL "*were being given full recognition of their status long before the projects had been let and no serious consideration was given as to whether their qualifications were suitable to manage a demolition of this nature*."[25] He noted, without further questioning the probity of the process, that "*PCAPL on any objective view of the evidence would appear to have been in some favoured position for its appointment."*[26]

### Advertisements and tenders

PCAPL's lack of expertise was subsequently instrumental in the appointment of inappropriate contractors. Specifically in:

- the failure to properly advertise the project tenders;

[21] Shane Madden, above n 2, p 181 para 153.
[22] ROI 10/6/98 p 15.
[23] In relation to the mechanical demolition of other parts of the site, not the implosion.
[24] Shane Madden, above n 2, p 121 para 51.
[25] Ibid, p 130 para 66.
[26] Ibid, p 126 para 60.

- the failure to provide all the necessary technical specifications; and

- the failure to critically examine the suitability of each contractor's experience and methods at the tender stage.

The conduct of the tender process undertaken by PCAPL (as Project Manager) and TCL (as Project Director)[27], was described by the Coroner as *"nothing less than appalling."*[28]

Advertisements calling for tenders for the demolition were published only once in the Canberra Times and the Australian newspapers of Saturday 25 January 1997 (the Australia Day long weekend) and contained no reference to implosion as an option – although the ACT government's preferred use of implosion was by then widely acknowledged.[29] The restricted advertising, and the limited information it provided, resulted in relatively few responses from mainly locally based firms. Despite receiving such a limited response, the tender was not re-advertised more widely.

The advertising deficiencies continued into the information package, issued on Wednesday 5 March to prospective tenderers at an on-site briefing, which:

- failed to mention the use of implosion as an option;

- gave incomplete and incorrect specifications for the buildings;

- failed to indicate the size and quantity of steel in the support columns of the two tallest buildings to be demolished; and

- omitted expertise in implosion from the selection criteria.

Structural drawings of Sylvia Curley House indicating the presence of structural steel, were not provided until Thursday 13 March, allowing only one working day before tenders closed on Tuesday 18 March.[30] As the Coroner noted, this was clearly inadequate time for tenderers to inspect the site and adjust pricing in light of the new information. The tenders for Stage 4 opened on Tuesday 18 March and closed on Thursday 27 March.[31] Again, as the Coroner noted, this was a very short period of time to assess the site and prepare and submit a tender.

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[27] The contracts for the demolition project (between the ACT and the contractors PCAPL, CCD, and CBS) were prepared and issued by the Contracts section of ACT DUS but TCL acted as the Project Agent or Director, after it took over the relevant functions 1 January 1997.
[28] Shane Madden, above n 2, p 175 para 139.
[29] The only indication of the preferred use of implosion was through news reports in the local Canberra media.
[30] Monday 17 March, Canberra Day, was a public holiday in ACT.
[31] The day before the Easter break.

### Appointment of contractors - CCD and CBS

The tenders and quotes were assessed by Cameron Dwyer, PCAPL Project Manager. After consultation with Gary Hotham, the TCL site representative, Mr Dwyer recommended acceptance of the non-conforming CCD bid for Stages 1 and 4. His report was presented to TCL for perusal and approval on Friday 11 April.

Mike Sullivan, Director of TCL, testified that TCL staff had the necessary expertise in project delivery and engineering to ensure that there were no non-conformities in the tender documents and that the PCAPL recommendations were fair and reasonable. He further testified that he had assumed that this would be done by the TCL staff. However, by the time of the tender approval on 11 April, and despite interviewing Mr Fenwick of CCD, Mr Sullivan's expectations had not been realised. TCL staff did not identify the non-conformities in the CCD bid. They approved PCAPL's recommendations without any further questioning of whether they were fair and reasonable.

The non-conforming CCD bid, recommended by PCAPL and approved by TCL, failed to meet the basic tender requirements. It did not give details of the sub-contractors and did not provide detailed method statements. The established tender procedures required that non-conforming bids be excluded and given no further consideration. However, the CCD bid was approved on the basis that it was *"the lowest conforming suitable contract. Best value for money for the ACT Government."*[32] The decision to approve it on 11 April was made without appropriate consideration of other bids, without thorough examination of the reasons for disparities in the various quotes given, and although the initial deficiencies of the non-conforming CCD bid had not been addressed.

Such comprehensive failure of the tender selection process may be partly explained by Mr Hotham's admission that, although consulted by Mr Dwyer, he did not read any bids, other than the CCD one, in any detail. His actions were allegedly based on the then departmental policy of accepting the lowest suitable quote. However, there is little credible explanation of why the CCD bid was regarded as suitable when it so clearly failed to comply with the tender requirements. The explanation given by both Mr Hotham and Mr Dwyer for accepting it, despite lack of a work method statement, further lacks credibility in light of their subsequent behaviour. Both claimed to have relied on a contract provision that, alternatively, a workplan could be provided within seven days of the letting of the contract. But neither subsequently required CCD to comply with this provision once the contract was let and work had started.[33] In the Coroner's words, *"These steps were done in blatant disregard for the contractual provisions. There is no excuse for such conduct."*[34]

[32] Shane Madden, above n 2, p 178 para 147.
[33] A workplan was not prepared until WorkCover issued a Prohibition Notice requiring one some four weeks after work had commenced.
[34] Shane Madden, above n 2, p 169 para 127.

The Coroner also documented a breakdown in the normal 'arms length' procedures to ensure the integrity of the tender process, which *"... should have been conducted in a more responsible manner in terms of its independence from the Government."*[35] Communication between TCL staff and the Chief Minister's Office about the preferred tenders and prices, was characterised by the Coroner as *"inappropriate involvement."*[36] He further noted that the involvement of Mr Dawson (Ms Carnell's Media Advisor) "*compromised the independence of the Chief Minister in a government tender process in respect of which he had no right to be engaged, let alone as her Media Advisor and thereby caused her to become involved, albeit indirectly*."[37] Mr Madden did not suggest any direct or improper involvement by the Chief Minister.

In short, the flawed tender process undertaken by TCL (as the Project Director) and PCAPL (as the Project Manager), resulted in the ACT government accepting a non-conforming tender bid that failed to provide either the required information about sub-contractors or an adequate work method statement. It did so despite failing to elicit any clear indication of how the contractors intended to demolish the buildings and without any independent verification of the contractors' capacity to safely complete the project. The Coroner concluded that this flawed tender process was connected to the fatal outcome of the failed implosion:

*"The actions of Mr McCracken and Mr Fenwick on site contributed to the death of Katie Bender. The process by which those persons were appointed, was connected to that death. If proper efforts had been made to check that these* people (Mr Fenwick and Mr McCracken) *were qualified, they would never have been given the job ... Although there are varying degrees of responsibility, the inescapable conclusion is that these poor work practices of PCAPL and TCL in the appointment process permitted two persons to be assigned to the demolition project who were entirely unqualified for the task*." [38]

## Contractors' Failure to Follow Appropriate Procedures

The Coroner found that both the contractor, Anthony Fenwick, and sub-contractor, Rod McCracken, contributed to the death of Katie Bender through incorrect use of explosives and site preparation, inadequate protective measures and testing, and failure to obtain appropriate expert advice. He committed them to trial for manslaughter by gross negligence.[39]

The Coroner was also critical of Cameron Dwyer, the PCAPL Project Director. But despite listing numerous deficiencies, failures and inadequacies, he found that there were not sufficient grounds to support "*beyond reasonable doubt that Mr Dwyer has*

[35] Ibid, p 434 para 84.
[36] Ibid, p 434 para 85.
[37] Ibid, p 435 para 88.
[38] Ibid, p182 para 154.
[39] McCracken for the indictable offence of manslaughter by gross negligence and Fenwick for being knowingly concerned in the commission of that offence.

*committed an indictable offence of being knowingly concerned in the offence of manslaughter."*[40] He did however recommend further action against Mr Dwyer for breaches of the *ACT OH&S Act 1989*.

PCAPL, as the Project Manager, was responsible for implementing the approved strategy in accordance with the contractual arrangements and quality assurance (QA) procedures. It was responsible for coordinating and supervising the contractors' work and monitoring their compliance with the contractual and regulatory requirements. It failed to do so. Despite its clear contractual responsibilities, PCAPL did not effectively supervise the contractors' work. Nor did it require them to provide regular and appropriately detailed reports about the planned use of explosives and associated safety measures.

The Project Director, TCL, as the agent for the ACT Government (the project Principal), was required to monitor the project and act as the interface between the ACT government and the Project Manager, PCAPL. It failed to do either adequately. In the Coroner's words, *"One is left with the impression that (*TCL*) was simply ignored and bluffed by contractor and sub-contractor."*[41]

The provisions of the contracts between the ACT government and PCAPL and CCD, clearly required their compliance with the *ACT Demolition Code of Practice.* However they did not comply with the Code as required. They failed to comply with the pre-commencement provisions of the Code to consult with the regulatory authorities.[42] Once CCD and CBS were appointed and work began, they again failed to comply with their contractual and regulatory obligations, including development of a workplan. Their failures that directly contributed to the death of Katie Bender were summarized by the Coroner as follows:

- *Detonating explosive charges imploding the Main Tower Block of Canberra Hospital cutting a fragment of steel of a high velocity.*
- *Employing an incorrect methodology, viz:-*
- *The use of an excessive amount of explosives.*
- *The use of the wrong type of explosives,*
- *The use of a steel backing plate rather than a soft backing cover such as rubber,*

[40] Shane Madden, above n 2, p 653 para 25.
[41] Shane Madden (1999a) *Executive Summary. Inquest into the death of Katie Bender on 13th July 1997.* ACT Magistrates Court. Manuscript copy, p 189 para 168.
[42] The contractors failed to comply with Section 6.17, the pre-commencement provisions of the Code, and Section 4.6, which required the development of a detailed work plan in consultation with the site health and safety representative.

- *Incorrect cuts made to the columns,*

- *Failure to use cutting charges together with kick charges to correctly pre-weaken the steel columns,*

- *A failure to retain, on a continuing basis, for advice a structural engineer experienced in the implosion process of demolition,*

- *A failure to retain for consultation or advice again on a continuing basis an independent explosives expert having knowledge of the implosion method of demolition,*

- *Placing the explosives on the incorrect side of the steel columns so that the blast was directed at the spectators on the other side of the lake,*

- *Inadequate protection measures,*

- *Inadequate testing.* [43]

The contractors failed to determine and provide adequate protection measures (sandbagging, mesh, bund walls and appropriate exclusion zone) on the lake side of the implosion site. The initial 200 metre exclusion zone *("determined by means of a rough opinion rather than a specific calculation*"[44]) appeared to meet the relevant standards but was not appropriately calculated to ensure spectator safety if the implosion failed. It was not reassessed following reconfiguration of the blast away from the Hospice and towards the lake despite the 's knowledge

## Regulatory Agencies' Lack of Appropriate Action

In 1997 there were a number of regulatory mechanisms in place in the ACT to ensure – directly and indirectly - that construction and demolition work was carried out safely and without undue risk to the general public. Taken together, they provided a reasonable level of assurance that major projects would be conducted appropriately by suitably qualified and competent contractors who could identify and manage the safety risks involved.

None of the regulatory agencies usually involved were consulted during the planning phase, the preparation and letting of the tenders, or prior to work commencing. Nor were any of the usual pre-commencement approvals for demolition work sought from the appropriate ACT regulatory agencies, ACT Building Commission, WorkCover and

[43] Shane Madden, above n 2, Executive Summary p 4.
[44] Ibid, p 506 para 12(g).

Dangerous Goods Unit. It is unlikely that the implosion project as implemented would have survived this multiple scrutiny of the proposed work methods and contractors.

### Role of ACT Building Commission

By-passing of the usual regulatory procedures allegedly followed from the assumption that ACT Building Commission (ACT BC) had no jurisdiction because the demolition, although an ACT government project, was being conducted on Commonwealth land.[45] The National Capital Authority (NCA) was initially approached for approval to demolish the buildings on the Acton site, but this only concerned the erection of temporary structures, including fencing of the site. There was no further request for NCA or ACT BC to undertake any formal examination of the proposed demolition. Nor did any of those involved in the project expect them to do so at any stage.

However, regardless of any jurisdictional ambiguities, the various contracts between the ACT government and PCAPL and CCD, explicitly required compliance with the *ACT Demolition Code of Practice*. The Code is quite clear on the need for a workplan to be prepared and documented prior to any demolition work commencing.

- Section 4.1 specifies that no demolition should commence until a workplan is completed.

- Section 6.17 specifies that *buildings should not be demolished by explosives without the express permission of the ACT Building Control and the ACT Dangerous Goods Unit.*[46]

- Section 4.6 specifies how this is to done: *An application for approval of plans for building work involving the removal or demolition of an existing building (see Appendix 2) is required to be submitted to the ACT Building Control. Section 34(1) of the Building Act 1972 requires that this application be accompanied by detailed plans relating to the demolition proposal.*[47]

Section 4.6 goes on to specify that the workplan is to be developed in consultation with the site health and safety representative and lists the minimum documentation to be included.

- Section 6.6.4 (Permission to Demolish) further states that, in the case of demolition by means of explosives, WorkCover be notified, that work not be carried without that notification and that it should be in accordance with any conditions imposed:

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[45] The Demolition License Agreement specified that Acton Peninsula was Commonwealth land and that the ACT was permitted to occupy it for the purpose of having the buildings demolished.

[46] ACT Occupational Health and Safety Office, *Demolition ACT Code of Practice* (Second Revised Edition, May 1993) s 6.17, p 44.

[47] ACT Occupational Health and Safety Office, *Demolition ACT Code of Practice* (Second Revised Edition, May 1993) s 4.6, p 12.

*The demolition of a building … by means of explosives …. .*

- *this Code of Practice recommends notifying the Chief Inspector of the OH&S Office,*[48] *who may attach conditions to any system of work, and*

- *not be carried out without that notification and in accordance with any conditions required.*[49]

Despite their contractual requirements, neither the Project Director or Manager nor the contractors complied with these clear provisions of the Code. There was no pre-commencement consultation with ACT Building Commission, no application was made for approval of a workplan and neither WorkCover nor the Dangerous Goods Unit were notified.

It is difficult to understand these significant failures on the part of all involved. All should have been aware of their clear obligations under the provisions of the contracts they signed. All had construction industry experience requiring familiarity with the regulatory framework. Staff of TCL were, until that time, part of the Works & Commercial Services section of the ACT DUS. As such they were likely to be very familiar with the provisions of the *ACT Building Act 1972* and related regulations. The Project Manager was familiar enough with the requirements of the Code to have (incorrectly) advised CCD on 21 April that compliance was not required.[50] It is also inconceivable that the experienced contractors, CBS and CCD, were unfamiliar with the provisions of a Code that was similar to those in other jurisdictions where they had worked.

One can only assume that such comprehensive failure to comply with the clear regulatory and contractual requirements was due to incompetence, ignorance of the potential safety risks or by concern to avoid any delays to the project – or perhaps all three. The effect of by-passing the usual procedures allowed the required rapid start on the demolition and limited regulatory intervention that may have delayed it. However, it also significantly undermined the safety of the project from the very start.

Only two of the usual regulatory agencies subsequently had a direct role in the implosion project – Dangerous Goods Unit and WorkCover. Their roles and the nature of their participation in the project are outlined below.

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[48] Which became WorkCover in 1994.

[49] ACT Occupational Health and Safety Office, *Demolition ACT Code of Practice* (Second Revised Edition, May 1993) s 6.6.4, p 34.

[50] I Nash (1999) *Inquest into the death of Katie Bender during the failed implosion of Royal Canberra Hospital.* Submissions of Counsel assisting the Coroner (with Solicitor Assisting. S Whybrow). Unpublished manuscript, p 83.

### Role of ACT Dangerous Goods Unit

In 1997, the Dangerous Goods Unit, located within the ACT Emergency Services Bureau (ACT EBS), was responsible for the regulation of dangerous goods, including explosives, under the provisions of the *Dangerous Goods Act (ACT) 1984* and some provisions of the *ACT Demolition Code of Practice*.

Although it was required under the *Code of Practice*, the Dangerous Goods Unit was not advised of, or consulted about, the proposed use of explosives in the demolition nor requested to give permission for such use. Indeed, the Unit staff did not even know about the demolition until the public announcement that a demolition contractor had been appointed to implode two of the buildings. Tony Smith, then Acting Chief Inspector of the Dangerous Goods Unit, alerted his senior management to the proposed use of explosives in the demolition *"without prior consultation of all sections of government which may have legislative involvement*," including the Unit, ACT Building Commission and WorkCover.[51] He noted specifically that the successful tenderer could not carry out the proposed work because he did not have the appropriate licence and permit to import explosives and use them in the ACT. He advised that Unit authorization would have to be obtained to meet the regulatory requirements.

Unit staff met with the project principals on 16 April. Subsequently the explosives sub-contractor, Mr McCracken, applied for and was issued a licence to import and keep explosives and a Shotfirers Permit to use them, both valid for 12 months. The Unit did not make any independent checks of the information supplied by Mr McCracken before determining, in accordance with the *Dangerous Goods Regulations* and on the basis of his NSW and Queensland certification,[52] that he was sufficiently competent in the use of explosives to be granted an ACT Shotfirers Permit. The issued licence was not limited to any specific purpose or project, nor did it limit the amount of explosives to be imported or used. Nevertheless Mr McCracken indicated in his application that he would probably not need more than 250kg of explosives. He did not give, nor was he required to give, any specification of his proposed methodology.[53]

On Wednesday 7 May 1997 Mr Smith convened a site meeting of the contractors and regulatory agencies (including WorkCover and the ACT environment protection agency) to discuss the regulatory requirements. Following the meeting Mr Smith sent a memo to the Project Manager, Mr Cameron Dwyer, advising that he address the following in order to satisfy the requirements of the ACT Dangerous Goods legislation:

- Master workplan to meet the approval of ACT WorkCover, and

[51] ESB minute 16/5/97.
[52] NSW WorkCover and Queensland Powdermans licences. State permits and licences were granted on the basis of mutual recognition of credentials without any further assessment of competency.
[53] Shane Madden, above n 2, p 223 para 42.

- Workplan for explosives phase to be submitted to the Dangerous Goods Unit.[54]

Mr Dwyer provided neither. After this meeting the Dangerous Goods Unit played no further role in the implosion project and did not expect that it should do so.

At the time there was considerable confusion over the respective roles of WorkCover and the Dangerous Goods Unit in relation to the use of explosives on construction worksites. There was very little communication and liaison between them as they were located as sections in different departments and earlier attempts to resolve demarcation issues had stalled in late 1994.[55] The role confusion may also have been due in part to some misalignment of the legislative and institutional requirements relating to responsibility for dangerous goods. Although the ACT adopted the NSW Dangerous Goods legislation in 1984, it did not have the same institutional arrangements as NSW for its administration. Whilst the NSW DGU was part of NSW WorkCover, the Dangerous Goods Unit had been transferred to the ACT ESB some years prior. No formal agreement had been developed at the time or subsequently about the boundaries of the respective responsibilities of the Dangerous Goods Unit and WorkCover or for management of their interface

At the Inquest, the Unit staff claimed to be unaware that they had any role or responsibilities under the Demolition Code of Practice. The Unit Director, Bill McTernan, claimed to be unaware that the Code required pre-commencement notification to the Dangerous Goods Unit or the Unit's approval for the use of explosives for demolition. Mr Smith, then Acting Director, claimed to be aware of the Code provisions but equated them with the need for contractors to obtain the necessary licences and permits from the Unit. Both were of the view that use of explosives on building sites was the responsibility of WorkCover. None of the Unit staff had any expertise in the use of explosives for demolition and overall the Unit did very little work involving non-

[54] Mr Smith had no statutory power to require such submission to the Dangerous Goods Unit and requested it as a matter of personal interest. See Madden 1999 p 221-222

[55] For some years, there had been discussion between the Dangerous Goods Unit and WorkCover about their respective roles in relation to the use of explosives on worksites. Correspondence from the ACT Chief Inspector of DGs (in DG Unit in DUS) to the Director, ACT OH&S Office (later WorkCover) in August 1993, suggests that formal ratification of the 1990 "verbal agreement that neither … will give advice or comment on any matter which is the responsibility of the other," noting that it had resulted in a "very good working arrangement." The demarcation of responsibility, according to the Chief Inspector of DGs was "... clearly established on the principal (sic) that once a dangerous good leaves storage, is not being transported or in the public domain, and enters the work environment it is considered to be "in immediate use" and therefore not subject to the Dangerous Goods Legislation." Further correspondence from Mr Southwell to the WorkCover Chief Inspector Kevin Purse, some 16 months later in December 1994, noted that there had been no reply to his letter and requested a meeting "to get some resolve to this even if it is only between you and I." This had not happened by April 1997. Demarcation and role clarification remained unresolved and liaison continued to be limited by the location of the two agencies as sections in different departments. There had also been longstanding ill feeling between senior managers of the two units.

fireworks explosives. ACT WorkCover staff were unclear about the appropriate role of the Unit under the provisions of the Code.

### Role of ACT WorkCover

WorkCover was not advised or consulted about the implosion project prior to commencement and none of the relevant Code of Practice provisions had been met when WorkCover inspectors visited the site on Wednesday 7 May – two weeks after work commenced. WorkCover Inspector Peter Hopner, visited the site to make initial contact with the site management. He was accompanied on a site tour by the CFMEU OHS site representative & the PCAPL OHS Officer. Chief Inspector Kevin Purse attended a site meeting initiated by the Dangerous Goods Unit to discuss the regulatory requirements with the contractors.

The next day (Thursday 8 May) after a further site inspection, Mr Purse issued a Prohibition Notice to the PCAPL Project Manager, prohibiting any further work until;

- an appropriate work plan was provided, and
- engineering certification was provided concerning the use of bobcats on the suspended floors.

On receipt of the engineering certification, work was allowed to continue pending receipt of the work plan by Friday 16 May. The provided work plan was examined by Chief Inspector Purse and Inspector Hopner, who deemed that it met the performance requirements of the Demolition Code of Practice and revoked the Prohibition Notice. This action was in accord with the OHS inspectorates' general approach to managing safety by seeking compliance and assurance from duty holders through evidence that they had safety management systems in place. Subsequently, on Monday 2 and Tuesday 3 June, Mr McCracken phoned Chief Inspector Purse about use of explosives in preparatory work and was advised to provide an engineer's report, which he did, and to liaise with the Dangerous Goods Unit.

WorkCover had no further direct involvement with the project until some five weeks later on Wednesday 25 June, when the local Health Services Union (HSUA) contacted them to raise concerns about the safety of the patients and staff remaining in the nearby Hospice during the implosion. WorkCover Inspector Margaret Kennedy contacted the PCAPL Project Manager and Chief Inspector Purse about the HSUA concerns. The following day she initiated phone enquiries to obtain further information about the competencies and previous work of the explosives sub-contractor, Rod McCracken. As a result of these enquiries WorkCover obtained information that one of his previous demolitions had caused minor damage to a Queensland police station. They also became aware of Appendix K of Australian Standard (AS) 2187.2 (Explosives – Storage, Transport and Use – Use of Explosives), concerning use of explosives in demolition. At about the same

time Inspector Hopner obtained a copy of a 1984 UK HSE Guidance Note on demolition techniques, which contained information about setting exclusion zones.

Two days later, on Friday 27 June, Inspectors Kennedy and Hopner visited the Acton site to arrange a site meeting about the potential impact of the implosion on the Hospice. In discussion, Mr Fenwick and Mr McCracken advised them that the proposed method of demolition would drop the buildings within their own footprints, that there would be no fly-rock, only dust, with debris flying no more than 10 metres, and that there would be no pyrotechnics. Inspector Hopner noted that both men appeared to be under a lot of stress but that, in his experience, this was not uncommon for site managers.[56]

The site meeting, held on Wednesday 2 July, was attended by Chief Inspector Purse and Inspector Kennedy and the contractors. It focused on the safety of the Hospice during the demolition. Mr McCracken advised on the amount & type of explosives to be used proposed sandbagging of the site and that an exclusion zone of 200 metres would be established. He also tabled a risk assessment. Chief Inspector Purse gave some consideration to issuing an Improvement Notice but agreed to delay it pending receipt of a full risk assessment and written indication of compliance with AS2187.2 Appendix K.

On Monday 7 July, PCAPL submitted a written risk assessment and response to the provisions of Appendix K and Chief Inspector Purse agreed to not issue an Improvement Notice. The contractors subsequently met with WorkCover to discuss the submitted risk assessment report on Tuesday 8 July. On Wednesday 9 July Chief Inspector Purse wrote to Mr Dwyer, PCAPL Project Manager, to confirm the proposed three metre height of bund walls. Mr Dwyer replied on 10 July confirming that bund walls of 2.5 – 3 metres would be built around some parts of the buildings.

Inspector Kennedy also visited the site on 10 July and took some photographs, not to make a formal inspection but as a matter of personal interest. The photographs were not developed before the implosion as Inspector Kennedy did not regard them as having any immediate relevance. They were subsequently used in evidence of the failure of some of the proposed safety measures.

Also on 10 July, Moiya Ford,[57] Acting CEO, BASAT, approached Ms Plovits (then Manager of Organisational Development, BASAT)[58] and *" ... directed her "at the high end of her vehemence" to "get the inspectors off the site" adding words to the effect that "John (Walker) is pretty angry and it's your job."*[59] Ms Plovits indicated to the Inquest, that she took this direction "*very seriously and felt under pressure by it"* as it came from her Acting Department Head (Ms Ford) and referenced John Walker, CEO of the Chief

[56] Inspector Hopner went on leave the next day and had no further role in the project.
[57] Ms Ford had previous involvement with the implosion project as a senior officer in the Chief Minister's Department with direct access to the Chief Minister.
[58] WorkCover was situated as a section in the ACT Department of Business, Sport, Arts & Tourism (BASAT).
[59] Shane Madden, above n 2, p 466 para 13. Contains direct quotes from Ms Plovits.

Minister's Department. Ms Plovits knew that the inspectors were not subject to direction in the exercise of their statutory powers. She therefore asked WorkCover Manager, Greg Ash, to check that *"the inspectors' processes were OK."*[60] Chief Inspector Purse had that day received the Appendix K response and decided not to issue any Notices so, Ms Plovits testified, she assured Ms Ford that the inspectors would not be a problem, without any further action on her direction.[61] On the following Thursday (10 July), at a meeting of senior staff, Ms Ford made further *"derogatory remarks about WorkCover inspectors only causing delays on the project site to get free tickets to the implosion."*[62] Ms Plovits discussed the issue with BASAT CEO, Ms Annabelle Pegrum, indicating that "*there had been some tension in discussions about what the WorkCover inspectors had thought would be necessary to do in relation to safety for the implosion around the Hospice*."[63] No further action was reported.

Ms Ford was, as the Coroner noted, in a position to exercise some influence over WorkCover and thereby interfere with their statutory responsibilities. Her action in seeking the removal of inspectors from the site failed. However, had it had succeeded "*there would have been a direct causal link to the death of Katie Bender in so far as safety checks would not have been undertaken. Nonetheless this conduct reflects an intrusion, interference and involvement of CMD individuals that was unwarranted …it was intermeddling to a significant degree that was wholly unnecessary as it impacted on public safety issues."*[64]

Ms Plovits did not explicitly inform WorkCover inspectors of Ms Ford's intervention. However, it became known to staff that Mr Ash had been requested by senior departmental staff to check on their actions. They were already aware, from previous experience, that their presence on government related jobs was not always welcome.[65] Consequently, there was generally seen to be an unspoken but clear implication, increasing as the implosion deadline approached, that any intervention by WorkCover would be carefully scrutinized by senior public servants up to and including the Chief Minister. Moreover, it would likely have major repercussions for the individual inspector unless its necessity could be fully and irrefutably justified.

A final inspection of the site was made by Chief Inspector Purse and Inspector Phil Adams on the morning of Sunday 13 July prior to the implosion at 1.30 pm. Mr Purse subsequently noted[66] that his inspection indicated that some of the safety measures did not appear to comply with the work method statement received on 10 July. At the time,

[60] Ibid, p 466 para 133.
[61] Ibid, p 466-467 para 133.
[62] Ibid, p 468 para 136.
[63] Ibid, p 468 para 137.
[64] Ibid, p 473-474 para150.
[65] In 1995 a political adviser to an ACT government minister was involved in an attempt to intimidate a WorkCover inspector in relation to an asbestos related investigation and prosecution. This was reported in the local media. See Canberra Times 2 July 1999.
[66] ROI 2 August 1997.

he queried this with Mr McCracken who explained that it was because changes had been made to the blasting configuration. Mr McCracken responded to Chief Inspector Purse's further queries about the safety implications, by assuring him that the work would be done safely. Mr Purse accepted Mr McCracken's assurances and the implosion proceeded at approximately 1.30pm but failed to successfully demolish the two buildings.

## 3. WORKCOVER AND THE IMPLOSION PROJECT

The Coroner was critical of all the regulatory agencies that were involved in the implementation of the implosion project, most particularly of WorkCover and the individual inspectors directly involved. His report concluded that "*the WorkCover inspectors .... failed to meet the standards that could reasonably be expected of a competent WorkCover inspector"*[67] that there were "*significant failings by the inspectors*"[68] and that their actions "*warrant the gravest degree of censure in the way the project was approached having regard to the information provided to them".*[69] In support he cited:

- WorkCover's lack of efficiency,
- failure to adequately examine and assess whether the contractors' workplan complied with the *ACT Demolition Code of Practice,* and
- failure to properly supervise the use of explosives and liaise with the Dangerous Goods Unit.

He also cited the actions of the WorkCover inspectors directly involved in the project:

- failure to issue Prohibition Notices on some occasions,
- failure to seek information and advice from an independent expert, rather than relying on that of the contractors, and
- failure to appreciate the implications of their lack of knowledge and experience.

This chapter will examine these claims and how the circumstances of the implosion project impacted on the cited actions of WorkCover generally and on the inspectors directly involved. Particular consideration is given to:

- the impact of the chronic under-resourcing and organisational instability of WorkCover;
- the very unusual circumstances created when the usual regulatory procedures and safeguards failed or were by-passed;
- the failure of other government bodies to effectively exercise their statutory responsibilities to ensure probity and good governance;

[67] Shane Madden, above n 2, p 290 para 181.
[68] Ibid, p 291 para 182.
[69] Ibid, p 291 para 183.

- the failure of the Project Director and Project Manager and the demolition contractors to properly discharge their regulatory and contractual obligations; and

- the transformation of the demolition, a major construction project, into a public spectacle.

It is argued that the inspectors' actions cited critically by the Coroner, were in accordance with the standards and practice of all Australian OHS regulatory agencies. As such, they were not the *'significant failures'* claimed. They were an essential and central part of the inspectorate's long established dual role of negotiating regulatory compliance in the non-adversarial approach adopted by the regulatory agencies. In this case, the inspectors were doing what they had long been required and expected to do. However, they were acting in unusual circumstances that were unprecedented and, in some cases unknown, and which had significant consequences for the outcomes of their actions.

## ACT WorkCover - An Organisation in Distress[70]

In the 1980s sweeping new legislation was introduced into all Australian OHS jurisdictions bringing a shift from prescriptive standards to a more self-regulatory style of process based regulation. It had significant implications for the work of all the OHS regulators. The ACT adopted the *ACT Occupational Health and Safety Act 1989* to cover the private sector and extended it in 1994 to cover the public sector. ACT WorkCover was established to replace the Occupational Health and Safety Office.

At the time of the implosion project in 1997, WorkCover was still adjusting its policies and practice to meet the requirements of the new OHS legislative paradigm after years of institutional change. However, its transition was hindered by inadequate resourcing, under-funding and insufficient staff. The practical difficulties this created were further compounded by the institutional instability arising from the many organisational restructures and department relocations over the previous years. They were exacerbated by the lack of permanent senior management with a good understanding of strategic implementation of OHS in the regulatory environment. The Inquest gave little consideration to the resulting impact on the capacity of staff to effectively discharge their regulatory responsibilities.

The resourcing and staffing of WorkCover and training for its inspectors in 1997 remained largely as criticised by the1995 national Inquiry into OHS.[71] The 1995 Inquiry found that the ACT compared poorly to other state/territory jurisdictions on various measures. It was the least well staffed and resourced of the jurisdictions – with only 10 inspectors and no specialist expert staff (unchanged in 1997). It had the lowest outlay, at $7.00 per employed person, of any OHS authority. The ratio of inspections to workplaces

[70] Description by a former member of WorkCover in confidential personal communication.
[71] Industry Commission (1995) *Work, Health & Safety. Inquiry into OH&S.* Industry Commission Report 47. Industry Commission Canberra Sept 1995.

(1:9.8) and the proportion of proactive inspections (at 15%), were significantly worse than the national average.[72] Little had changed in 1997. Nonetheless, the Coroner explicitly rejected evidence from WorkCover staff that their work was detrimentally affected by a chronic lack of resources, under-funding and under-staffing.[73]

Although he noted that the *" ... the administration, management and organisation of the ACT WorkCover unit in 1997 was most unsatisfactory,"*[74] the Coroner forcefully rejected a senior inspector's criticism of its funding and administration - "*It was embarrassing to hear such sweeping assertions. It is doubtful whether the ACT Government would permit such a circumstance to exist."*[75] He further suggested that inspectors' claims that funding constraints precluded them from seeking funding for independent expert advice, were an attempt to, "*minimise their own inadequacies and failures."*[76]

In rejecting the inspectors' claims of difficulties in obtaining funding for independent expert advice, the Coroner relied on the hypothetical assurances of Ms Jocelyn Plovits, then Manager of Organisational Development in BASAT. She testified that she would have approved such funding had she been asked. *"I am not satisfied about the lack of resources issue. There is no direct evidence of a funding problem. I prefer the evidence of Ms Plovits, the General Manager of ACT WorkCover on this issue."*[77] However, Ms Plovits was not the Manager of WorkCover at the time of the implosion project and was therefore not in a position to either directly receive such requests or approve such funding. The Coroner gave no reason for his reliance on her hypothetical assurances. Nor did he explain his extrapolated confidence that WorkCover management would have been similarly responsive to such requests. On the evidence of previous experience it seems reasonable to assume, as the inspectors did, that it was unlikely.[78]

Chief Inspector Purse provided supporting details of the limited funding in referring to the impact of budget constraints on obtaining independent expert advice. He noted that with an operating budget of approximately $140,000 - $160,000[79] there was little money available to pay for it and he knew of only one instance of doing so. That was in the context of a prosecution and was greatly influenced by the probability of reimbursement. In the event, Mr Purse did not request funding for independent expert advice since he

[72] Industry Commission, above n 71, p 431.
[73] It should be noted that many of the WorkCover inspectors' criticisms were addressed in the subsequent findings and recommendations of a government review to change the structures and operations of WorkCover. This included merging WorkCover and Dangerous Goods Unit, improving staff training and recruitment and contracting a panel of experts to provide independent technical advice.
[74] Shane Madden, above n 41, p 18.
[75] Shane Madden, above n 2, p 195-6 para 10.
[76] Ibid, p 246 para 90.
[77] Ibid, p 248 para 90.
[78] Ms Plovits' did not become Manager of WorkCover until after the implosion.
[79] From an initial budget allocation of $1.1 m, approximately $960,000 was allocated to salaries and salary related costs. The remaining operating budget covered items such as vehicle (approximately $40,000) and computing and other running costs. Any funding for independent expert opinion had to come from this operating budget.

expected that, given the lack of precedents and the significant budget constraints, it would not be approved. He commented about the setting of budgets, *"We thought we were doing well if we could stave off cuts".*[80]

The Coroner's comments also made it clear that he regarded the 'inefficiencies' of WorkCover staff, rather than inadequate resourcing, as the main problem: *"There is no doubt in 1997 that the ACT WorkCover office was an inefficiently run organisation insofar it was fragmented and disjointed in terms of its administration. At the time of the tragedy ACT WorkCover resources were inefficiently used by the inspectors. The practices of the WorkCover office at the time contributed to the inadequate way the inspectors responded to the problems that arose on the project."*[81]

There was no attempt to locate the cited 'inefficiencies' in the broader context of the organisational limitations and system failures that adversely affected the capacity of staff to function effectively in discharging their regulatory responsibilities. These included:[82]

- Organisational instability. Since its inception WorkCover had functioned as a section within a government department rather than an independent statutory authority, as in other jurisdictions.[83] In the several years prior to 1997 WorkCover was caught up in six re-organizations, including a review and restructure ongoing at the time of the implosion project. Each involved transfers within or between departments, some with little apparent relevance to OHS, and resulting changes of senior departmental management. This instability was exacerbated by the failure to appoint a permanent WorkCover Manager from 1994 until 1997.

Limited resourcing including little funding for professional training. In 1997 $10,000 was budgeted for the professional training of WorkCover's 22 staff (ie less than $500 per staff member). Analysis of staff skill requirements and training needs did not occur. Training and skills needs were not identified and not aligned to the requirements of industries in the jursdiction. Training, when it did occur, was irregular and infrequent, usually done informally by members of WorkCover, not formally recorded or evaluated and was often of poor quality. A critical failure recognized:

- Poor access to departmental administrative support, notably in the lack of timely access to accurate financial information and the projections required to plan and prepare budgets. This was doubtless exacerbated by the frequent restructures and moves. It is likely that these changes also contributed to the failure, over some years, to establish an effective filing system.

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[80] Evidence to the Inquest provided by Kevin Purse 8/7/1998.
[81] Shane Madden, above n 2, p 238.
[82] Personal confidential communication with members of WorkCover staff.
[83] The Coroner's Findings recommended that "*WorkCover should be established as an independent statutory authority removed from any departmental or governmental control, appropriately funded so that it can exercise its statutory functioning independently*." Shane Madden, above n 2, p 496-7 para 185(i).

- Strategic organisational planning was limited to ensuring focus and alignment with the frequently changing parent department's business planning. Individual, team and sub-unit planning did not occur.

- Major difficulties in getting legislation drafted and incorporated into the parliamentary agenda and timetable. For example, it took over 3 years for repeal of some the old regulations required by adoption of the 1989 Act. These delays had direct impacts on the work of inspectors who were responsible for the practical implementation of the regulations. In some cases the legislation awaiting repeal was so out-dated that its implementation would have created unsafe systems of work (eg *Scaffolding and Lifts Act 1959*).

- There was little in the way of strategic direction, support or advocacy from the tri-partite Occupational Health and Safety Council.

Despite the Coroner's rejection, there can be little doubt that these practical obstacles to efficient functioning resulted from the combined effects of organisational instability, lack of effective leadership, chronic under-funding and inadequate resourcing and staffing. The situation was described by one WorkCover staff member as *"... a siege mentality and a view that all that could be done was to get on with the job as best one could."*[84] A more balanced assessment of the failures and inefficiencies cited by the Coroner, would regard them as indicative – at least in large part – of system failures and signs of organisational breakdown.

There can be little doubt that these system failures and organisational breakdowns had a detrimental impact on the day-to-day work of the WorkCover inspectors directly involved in the implosion project. For instance, as acknowledged by the Coroner, the poor filing system reduced the efficient allocation of staff resources. Most significantly, the lack of adequate funding had both a direct and an indirect impact. The inadequate funding of professional training left the inspectors poorly informed overall and the lack of funds prevented access to independent expert advice.

## Failure and By-Passing of Regulatory Procedures

The implosion project was, from its inception, remarkably free of the usual scrutiny given to large construction projects in the ACT in the mid-1990s. The failure or by-passing of the usual regulatory procedures and safeguards resulted in WorkCover becoming the only regulatory agency with an independent role in monitoring the project. It was ill-prepared and poorly equipped for this role. The circumstances also deprived WorkCover of access to the independent expert advice previously available from other government departments concerned with safe construction. Given their inability to fund access to independent expert advice, WorkCover inspectors had little option but to rely on the advice of the Project Manager (PCAPL) and the contractors, CCD and CBS. And reliance on their

[84] Confidential personal communication with WorkCover staff.

advice did not appear to be inappropriate given that Mr McCracken's expertise was acknowledged by other statutory authorities and vouched for by the government appointed Project Director.

Regardless, the Coroner strongly criticised the inspectors for relying on the information and advice of the contractors and failing to seek other independent advice. He acknowledged that it was "*not unreasonable"* in the circumstances to them do so, but he nevertheless persisted in describing it as *"unsatisfactory"* practice by the inspectors without canvassing alternatives.

*"WorkCover assumed the demolition contractors were properly qualified and experienced in such a way as to be sufficiently able to identify potential hazards. WorkCover assumed that PCAPL as the Project Manager would have had some competence in the area otherwise they would not have been appointed. Nothing could have been further from the truth. Although such expectations of expertise were not unreasonable it left WorkCover having to accept the word of those on site. It was acknowledged by WorkCover that safety is not always accorded the priority it ought to be on a work site. WorkCover, being cognisant of that fact it was unsatisfactory for WorkCover then to simply accept the assurances of those on site that the job was being done safely."*[85]

### Loss of usual sources of independent advice

Ordinarily WorkCover inspectors in the mid-1990s, functioned within the network of regulatory agencies with overlapping responsibilities for the assessment, approval and inspection of construction projects and contractors. This network provided reliable advice and information based on independent expert assessment. This gave them assurance that a project as approved was basically sound. That is the work method and scheduling had been scrutinized by the appropriate technical experts and approved as appropriate and compliant with relevant standards, regulations and Codes of Practice. This assisted inspectors to identify hazards and alerted them to potential risks and appropriate and justifiable risk mitigation strategies. Given the absence of this information and support network, and lacking the funding to pay for independent expert advice, the WorkCover inspectors involved in the implosion project had to function beyond their limited areas of technical expertise and without support in a novel and complex industrial situation.

Particularly crucial was the non-involvement of the ACT Building Commission.[86] Under the provisions of the *ACT Demolition Code of Practice 1993*, no demolition work was to proceed before a workplan was submitted to and approved by the Commission. In this case there was no workplan submitted for the Commission's usual critical scrutiny or approval. This lack of an approved workplan deprived WorkCover of a reliable

[85] Shane Madden, above n 2, p 255 para 103.
[86] In his final report, the Coroner recommended that, in the interests of safety, failure to involve ACT Building Commission in approval of construction projects should not be allowed to happen again.

comparator against which the contractors' work could be assessed and acceptable levels of regulatory compliance determined.

A non-approved workplan was eventually provided to WorkCover by the contractors on 17 May, two weeks after work commenced and in response to a Prohibition Notice. It was not an adequate substitute. It required WorkCover to determine whether the non-approved workplan complied with the requirements of the *ACT Demolition Code of Practice* to include detailed plans and other documentation. WorkCover did not have the statutory power to approve the workplan or any detailed plans accompanying it.[87] Such approval was the statutory responsibility of the Building Commission under Section 34(1) of the *ACT Building Act 1972*.

Secondly, the transfer of responsibility for the project, away from DUS to the Chief Minister's Office and Department, by-passed the usual ongoing scrutiny by DUS staff with relevant industry experience and technical expertise. The CMD and CMO staff who undertook responsibility for steering the project had neither. As the Coroner noted; *"There was simply no logical basis for personnel in the CMD or the CMO to become involved in the technical aspects of the project. It was an unwarranted interference."*[88] As well as lacking expertise, the CMD and CMO staff appeared to lack any understanding of its relevance and failed to include the contractors or WorkCover in the consultation group subsequently established. Their focus was on the implosion as a public spectacle not as a major construction project. This reduced the usual lines of industry communication, lead to inappropriate pressure on the contractors to meet deadlines and created a climate inimical to the on-site participation of WorkCover inspectors.

Thirdly, the Dangerous Goods Unit's lack of active involvement in the project also had significant implications for the WorkCover inspectors.[89] Firstly the Unit's absence deprived inspectors of ready access to a potential source of independent advice about the adequacy of the explosives workplan and the contractors' qualifications and competence.[90] This was particularly important given the inspectors' lack of knowledge about the use of explosives generally and specifically in a form of demolition not previously done in the ACT.

Further, the DGU's non-involvement exacerbated the already poor communication between the two agencies in circumstances where it was of great importance. The

[87] Appendix 2 of the ACT Occupational Health and Safety Office, *Demolition ACT Code of Practice* (Second Revised Edition, May 1993) lists, under Requirements for Approval of Demolition, the following information – site plans, details of work methods, public safety measures and cost estimates. Details of the documentation required are also listed in part in S.4.6.
[88] Shane Madden, above n 2, p 393.
[89] The role of Dangerous Goods Unit and its relationship with WorkCover is discussed more fully in Chapter 2.
[90] Whilst the Dangerous Goods Unit lacked staff with relevant expertise in-house, it did have access to information through its relationship with DGUs in other jurisdictions.

WorkCover inspectors incorrectly assumed that the Dangerous Goods Unit was responsible for monitoring the method of work and use of explosives in the implosion. The Unit assumed that WorkCover was responsible. The result was that neither closely monitored the use of explosives. The Coroner found that the incorrect use of explosives contributed directly to the failure of the implosion and the resulting death of Katie Bender.[91]

### Reliance on contractors

The WorkCover inspectors directly involved in the implosion project were aware that they lacked technical knowledge and experience relevant to demolition by implosion – and acknowledged this in their evidence to the Inquest. They agreed that their lack of expertise and lack of access to independent expert advice were factors that limited their capacity to assess the potential public safety risks of the implosion. They also acknowledged their reliance on the contractors' information and veracity. They contended that, in the circumstances, there was little alternative – there was no indication that the contractors were anything other than appropriate and reliable sources, and such reliance was not uncommon.

There appeared to be no reasonable grounds for the inspectors to assume that PCAPL, CCD or CBS were incompetent or to doubt the veracity of their assurances – quite the contrary. Their appointment resulted from established government selection and tender procedures designed to ensure that only appropriately qualified and competent contractors were awarded government contracts. The explosives sub-contractor, Mr McCracken, had been duly certificated as a competent person to use explosives in demolition work, by both ACT and other state jurisdictions. The Project Manager PCAPL, an experienced firm selected by DUS, was responsible for ensuring the contractors complied with the contractual requirements. This included compliance with OHS legislation and the ACT Demolition Code of Practice. And Mr Hotham, the Project Director's site representative, was located on site to oversee the project and had ready access to expert advice from other TCL technical staff. Given this context, it was unremarkable, and far from unreasonable, for the inspectors to rely on the competence of the Project Director, Project Manager and contractors', and to assume that they were able and willing to comply with the clear regulatory and contractual requirements.

Moreover, such reliance was a long established practice for all OHS inspectorates.[92] In the context of negotiated compliance within a self-regulatory regime, OHS inspectors' are heavily reliant on a company's cooperation in providing accurate information and on their capacity and readiness to comply with regulatory requirements. This is particularly so when, as in this case;

[91] In his final report the Coroner recommended that WorkCover and Dangerous Goods Unit be amalgamated.

[92] See Appendix 2 of this report for further discussion of the standard operating procedures of the inspectorates.

- the work is unfamiliar and significant risk factors are largely invisible to the inspectors, and they have limited access to relevant expertise and resources, and

- the contractors are deemed to be appropriately qualified and competent and able and liable to comply with the regulatory requirements.

However, in this case the inspectors' established strategy of negotiated regulatory compliance [93] was substantially undermined. Contrary to all reasonable expectations, the contractors were unable or unwilling to comply with safety requirements. The Project Manager and Project Director in turn failed to take appropriate measures to ensure that they did so. This created significant hidden risk factors that were largely invisible to the inspectors and significantly undermined the validity of their assessment of the public safety risk. The implications of this under estimation, by all those involved in the project, is further discussed in Chapter 4.

## Issuing Notices

The *ACT Occupational Health and Safety Act 1989* authorised an inspector to issue Prohibition Notices to prohibit specified activity if they " ... *believes on reasonable grounds that an activity carried on at a workplace involves a risk of imminent and serious injury to a person at or near the workplace".*[94] In the course of the implosion project, WorkCover inspectors issued one Prohibition Notice. Consideration was given to issuing an Improvement Notice [95] during a site meeting on 2 July but delayed pending the outcomes of recommended action – a common practice for inspectors concerned with ensuring compliance whilst minimising disruption.

The Coroner criticised the inspectors for failure to issue Notices on some occasions. He specifically cited concerns about the failure to issue a Notice during the 2 July site meeting and during inspection of the demolition site prior to the implosion on the morning of 13 July.

### Issue of Prohibition Notice on 8 May

WorkCover inspectors' first direct involvement in the implosion project, was a site visit and participation in a meeting on Wednesday 7 May, some two weeks after work had commenced. A further site inspection the next day (Thursday 8 May) resulted in the issue of a Prohibition Notice in response to specific *ACT Demolition Code of Practice 1993.* There was no workplan and bobcats were in use on suspended floors without engineering

[93] Further discussed in Appendix 2 of this report.
[94] *Occupational Health & Safety Act 1989* (ACT) s 77(1).
[95] An inspector may issue an Improvement Notice if he/she believes on reasonable grounds that a person is contravening or likely to contravene a provision of the Act or regulations. The Improvement Notice may specify action that is to be taken within a specified time.

certification to determine the floors' maximum safe working load.[96] Work was suspended pending provision of an appropriate workplan and the required engineering certification. On receipt of the engineering certification, work was allowed to continue pending receipt of the workplan by Friday 16 May. The workplan was submitted as required and the Prohibition Notice was then revoked.

The workplan was examined by WorkCover and deemed to meet the performance requirements of Section 4.6 of the *Demolition Code of Practice*.[97] Chief Inspector Purse testified that the workplan included the relevant documentation and indicated that hazard identification had been undertaken and control measures determined by the expert explosives sub-contractor, Mr McCracken. Mr Purse was questioned about WorkCover's failure to seek independent expert advice about the proposed methodology at this stage – a so-called 'second opinion'. He replied that this was the regulatory and contractual responsibility of the Project Manager, PCAPL. They were responsible for ensuring that work was conducted safely and in accordance with the relevant regulations. Mr Purse noted that whilst he could have insisted that PCAPL obtain an independent 'second opinion – at some cost – he had no grounds for doing so. Given that he had no reason for doubting Mr McCracken's experience, which was well documented, or the adequacy of his proposed explosives plan, any such requirement would have been successfully appealed.

Mr McCracken phoned Chief Inspector Purse on 2 and 3 June about the use of explosives in preparatory work. He was advised to provide an engineer's report approving it and to liaise with Dangerous Goods Unit. An engineer's report was subsequently provided.

Chief Inspector Purse was queried about the lack of on-site involvement, over the 46 days between 13 May and 27 June, despite the earlier issue of a Prohibition Notice. He reiterated that WorkCover had been provided with a workplan that appeared to comply with the requirements of the Code and it was the Project Manager's responsibility to ensure compliance with it. No problems about the project had been brought to WorkCover's attention[98] and, compared to many other workplaces, there were already multiple levels of responsible supervision, "*…in this particular project you had at least two levels of supervision, or three levels. You had the blaster* (CBS), *you had City and Country (*CCD), *you then had Project Coordination* (PCAPL), *you then had the*

[96] Section 6.9 of the Code also required that permission for all forms of mechanical demolition should be sought from the Chief Inspector no less than 2 weeks prior to work commencing, the application to include a work method statement, details of proposed plant use, a structural engineer's report and a completed copy of the Guidelines Proforma for Use of Earthmoving Machinery on Suspended Floors (s 6.9).

[97] This approach was based on advice previously obtained from the ACT Government Solicitor in relation to application of Codes of Practice and standards under the OH&S Act. The contractor Tony Fenwick certified the statement as a competent person under the provisions of the Code.

[98] Various witnesses' evidence to the Inquest indicated that critical consulting engineers' reports and the contractors' mid-project change of consultant engineers was not brought to WorkCover notice, as it should have been, by PCAPL, the responsible Project Manager.

*government through Totalcare* (TCL). *I mean it seems to me that quite a lot of resource was already being put into that area."*[99]

### HSUA concerns about safety of Hospice

WorkCover had no further direct involvement with the project until 25 June, when it was contacted by the local Health Services Union (HSUA) with concerns about the safety of patients and staff remaining in the nearby Hospice during the implosion. The Union also wrote similarly to the Chief Minister requesting a full risk assessment be carried out on the potential dangers to those in the Hospice. This request was dismissed by the CEO of the Chief Minister's Department, Mr Walker, as a *"political stunt"* and the response was drafted accordingly, after consultation with the Project Director, Mr Lavers. The response falsely claimed that an ongoing process of risk assessment was being conducted and that the government *"has been undertaking since February 1997 to ensure full consideration of all factors."*[100] As the Coroner noted, the HSUA letter *"... raised legitimate genuine matters of safety concerns."*[101] and presented a *"golden opportunity „. to engage in a full consultative process with the relevant experienced personnel engaged on the project*."[102] With the government's dismissive response, that opportunity was lost.

As a result of the contact from HSUA, WorkCover initiated a search for standards and guidelines relating to the use of explosives in demolition used in other jurisdictions. It also made enquiries about the record and reputation of the explosives sub-contractor, Rod McCracken. This resulted in WorkCover obtaining relevant material – a 1984 UK HSE Guidance Note on demolition techniques, containing information about the setting of exclusion zones, and Appendix K of Australian Standard 2187, concerning the use of explosives in demolition. Enquiries about Mr McCracken indicated that he had a good reputation as a competent operator with the NSW and Queensland authorities ("*… you won't have any problems. He's one of the best in Australia, one of the top three. I would highly recommend him too."*[103]*).* Additionally, his previous demolition of a silo in Queensland many years ago had caused damage to the windows of a nearby police station. When queried about this, Mr McCracken explained that the circumstances were quite different from the current project, the damage (broken windows) was minor and nothing similar had occurred again.

Following a short site visit by Inspector Hopner and Inspector Kennedy on Friday 27 June, an on-site meeting with the contractors was arranged to discuss the safety of the Hospice the following week. Inspectors Hopner and Kennedy asked Mr Fenwick and Mr McCracken what safety systems had been put in place for the people remaining in the Hospice and how the implosion would affect the building. Mr Fenwick assured them that there would be no problems for the Hospice but that *"... they hadn't specifically written a*

[99] Kevin Purse evidence 13/7/98 p5145 para 1034.
[100] Shane Madden, above n 2, p 457 para 120.
[101] Shane Madden, p 458 para 121.
[102] Shane Madden, p 464 para 129.
[103] Quoting Mr Hess from NSW WorkCover. Kennedy Inquest evidence 13/7/98 p5659 para 170.

*safe system of work for the people in the Hospice.*"[104] Inspector Kennedy also took some photos of the buildings and was given a brief description of the proposed method of implosion. A meeting was arranged for the following week.

### Site meeting on 2 July

The site meeting on Wednesday 2 July was attended by Inspectors Purse, Kennedy and Adams, Cameron Dwyer, Warwick Lavers, Mr Fenwick, Mr McCracken, Sister Bernice Stubbs from the Hospice and Mr Stone from Calvary Hospital. It focused on the safety of the staff and patients at the Hospice, situated 78 metres from the implosion target buildings. Chief Inspector Purse requested information from all about what arrangements they had made for the safety of the people in the Hospice during the implosion. Assurances of safety were given by Mr Dwyer and Mr Lavers, who referred to 'a risk assessment done some time ago' – ie the RGA Report. They used enlarged photos from the report of the St Vincent's Hospital implosion, to show that adjacent buildings had not been damaged. Mr McCracken gave various assurances that the buildings would drop in their footprint plus a few metres to each side. He advised that he had added extra sandbagging to ensure a higher level of safety, although he thought it unnecessary. He also advised that he might change the configuration of the charges to ensure that the Sylvia Curley building would fall away from the Hospice. There was also some discussion of security arrangements to prevent spectators getting on site, and about the type of explosives to be used, the estimated noise levels, the possibility of problems with air blasts and dust and the arrangements to minimise the impact on the Hospice.

Following discussion, Chief Inspector Purse asked for preparation of a new risk assessment plan addressing all the issues included in Appendix K of Australian Standard 2187.2 and including details of contingency arrangements in case of the planned implosion failed. Mr Lavers, Cameron, Fenwick and McCracken queried the necessity of this but Chief Inspector Purse, after conferring with Inspectors Adams and Kennedy, insisted. He advised that if he did not receive the requested risk assessment by the following Friday (4 July) he would issue an Improvement Notice requiring it. Mr Dwyer agreed to draft the required risk assessment and the requested material was lodged with WorkCover as instructed. The plan included actions to minimise noise and fly from the implosion, including covering all concrete walls that required firing with carpet and chain wire mesh, and use of heavier explosive charges on the lower ground floor. The plan also included information that the demolition was cleared by an engineer consulting to CBS (Gordon Ashley), and an outline of a contingency plan. Subsequently, in evidence to the Inquest, Mr Dwyer advised that he had not read any of the material contained in the document he had prepared and that it was merely a glue-and-paste exercise.

There were more discussions on Tuesday 8 July when further concerns were raised about the impact on the Hospice and the adequacy of the contingency plan. On Wednesday 9 July, Chief Inspector Purse wrote to PCAPL confirming the outcomes of the meeting and

[104] Kennedy Evidence to Inquest 13/7/98 p 5664 para 230.

that the bund walls on the Hospice side would be at least three metres high. On Thursday 10 July, PCAPL provided the requested details and confirmed that the bunding on the north (Hospice) side would be 2.5 - 3 metres where required. They advised that the bunding would not be required along the full length of the building and would be formed where necessary to eliminate fly and reduce noise. They further asserted that the implosion of Sylvia Curley House would not adversely affect the structural integrity of the Hospice.

During the Inquest the WorkCover inspectors, the contractors and the project principals were frequently questioned about their emphasis on the safety of the Hospice and the lack of consideration given to the safety of spectators on the opposite lake shore. There were Coronial references to this 'preoccupation'[105] occurring on several occasions, including at the meeting on 2 July when Mr McCracken advised that he might reconfigure the blast away from the Hospice. It appeared that his comment did not trigger any concern among those present that such reconfiguration could create higher risk for the spectators on the opposite lake shore.

Various explanations were offered. They were based first on confidence in the expert contractor's assurances that there would be little fly because the imploded buildings would fall in, or near, their own footprints. Second, there was confidence in the adequacy of the 200 metre exclusion zone. Several noted the difference in the distances involved - the 200 metre exclusion zone was considerably more than the 78 metres to the Hospice. As Chief Inspector Purse noted In his evidence, *" the view was that if we could take care of the people at the hospice that indicated pretty well that other people's safety would be addressed as well."*[106] The proposed 200 metres was also more extensive than that suggested by the guidance material otherwise referenced (ie twice the 78 metre height of the tallest building). Chief Inspector Purse again noted, "*We'd seen the exclusion zone of 200 metres. We checked that ourselves to establish whether it was a realistic estimate. And ... the UK document we found was saying if you've got a radius which is twice the height of the building, then as a general proposition that was the way to go."*[107] Although the emphasis throughout was on ensuring the safety of the Hospice, there seemed to be no reason to also question the safety of spectators who would be well beyond the 200 metre exclusion zone.

### Morning of 13 July

On the morning of 13 July, a final inspection of the demolition site was made by Inspectors Purse, Adams and Kennedy prior to the implosion scheduled for 1.30 pm. Mr Purse testified that his inspection indicated that the placement of carpeting and chain mesh screening and the height and positioning of the bunding did not fully comply with the agreed arrangements. At about 12.15 pm he queried this with Mr Dwyer, who contacted Mr McCracken via 2-way radio for an explanation.

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[105] Inspector Hopner on one occasion in his evidence referred to it as "*tunnel vision in this respect".*
[106] Purse Evidence to Inquest 14/7/1998 p 5116 para 699.
[107] Purse Evidence to Inquest 14/7/1998 p 5153 para 1122.

Mr McCracken explained that changes had been made to the blasting configuration and the bunding and screening in place were appropriate and sufficient in relation to those changes. Inspector Purse had not been previously informed about these late changes to the blasting configuration and he queried whether the implosion would still be done safely. He was assured that it would and accepted Mr McCracken's assurances. Inspectors Purse and Kennedy continued their site inspection and filmed part of the site. They then went to their allocated viewing position on another building.

The implosion proceeded but failed to successfully demolish the two buildings. The Main Tower Block did not fully collapse and Sylvia Curley House failed to implode. Chief Inspector Purse issued instructions that no further work was to be done until a revised workplan was prepared in conjunction with a structural engineer and that there was to be no unauthorised entry to the site.

## In Hindsight

Although the Coroner criticised the inspectors' failure to issue notices on some occasions, their actions were clearly in accord with the statutory requirements and consistent with the standard practice of WorkCover. On 8 May Inspector Purse issued a Prohibition Notice in response to clear, unambiguous breaches of the regulatory requirements. On 2 July he gave some consideration to the issue of an Improvement Notice requiring provision of further information in the form of an updated risk assessment. He agreed to delay in light of the Project Manager's previous cooperation and his agreement to provide the updated risk assessment within two days. However he warned that a Notice would be issued if the documentation were not provided as agreed. This was consistent with the usual practice of inspectors concerned with ensuring compliance whilst minimising disruption.

A Notice was not issued on the morning of 13 July because the inspectors did not believe that they had any reasonable cause to do so. Relying on the assurances given by Mr McCracken, the acknowledged expert, and the presumed adequacy of the exclusion zone, they judged that there were no reasonable grounds for assuming a risk of "*imminent and serious injury to a person at or near the workplace"* – as required by the *OH&S Act.* It became clear only in hindsight, that the protective measures on the lake side of the demolition site were not sufficient given the amount and configuration of explosives used to implode the two buildings. They were not enough to protect the spectators outside the seemingly adequate 200 metre exclusion zone.

This final situation was the culmination of a chain of causation that began well before WorkCover was involved. It is difficult to chart all the many reasons for each of the cascade of failures, bad judgements and inappropriate actions that ended with the final fatal failure of the implosion. However, whatever the other contributing factors, it is clear that all those involved at all stages under-estimated the potential risk to public safety. The reasons and consequences of this are further discussed in Chapter 4

# 4. WHY WAS THERE UNDERESTIMATION OF RISK?

It is clear that all the principals, contractors and government bureaucracies involved in the failed implosion project under-estimated the level of risk to public safety at all stages. This chapter explores why this happened, the contributing factors and the implications for WorkCover and the inspectors directly involved in the systemically flawed project. The analysis made here is based on Henry Rothstein's identification of factors that contribute to institutional attenuation of risk. That is institutional factors that, taken together, can lead to regulatory officials underestimating risk and failing to effectively enforce associated regulations.

In Rothstein's words:

" … *complex risk regulation regimes are vulnerable to a phenomenon of 'institutional attenuation'* (that is) *institutional processes that serve to diminish inspectors' perceptions or awareness of a risk, and/or diminish inspectors' perception of the policy importance of associated regulations."*[108]

His work provides some insight into why the individuals and organisations involved in the implosion project, separately and together, failed to appreciate the public safety risks inherent in the way the project was implemented.

### Institutional attenuation of risk

There can be little argument that institutional or organizational factors, including corporate culture, can contribute to workplace risk levels – for better or worse. Numerous accident investigations have uncovered and documented the various ways in which established institutional policies and practices, organizational arrangements and corporate cultures have contributed to a diverse range of workplace accidents. These include instances of failing to identify risk, normalizing and underestimating it and responding inappropriately. Documented Australian examples include, for example, a fatal fire on board the naval ship HMAS Westralia,[109] rail crashes and long term exposure of RAAF maintenance workers to toxic substances.[110] They all highlight a causal chain of interactive cultural and organizational factors and associated failures of officials at all levels to recognize the potential risks emerging from their actions or omissions.

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[108] H Rothstein (2002) *Neglected Risk Regulation: the institutional attenuation phenomenon.* Discussion paper DP7. Centre for Analysis of Risk and Regulation, London School of Economics and Political Science. London. Also in Health Risk & Society 5(1) 2003, p 1.

[109] Westralia Board of Inquiry Royal Australian Navy (2003). *Report of the Board of Inquiry into the fire in HMAS Westralia www.navy.gov.au/sites/default/files/documents/Wra_exec.pdf.*

[110] See, Board of Inquiry into F-111 (Fuel Tank) Diesel/Reseal and Spray Seal Programs (2002) *Chemical Exposure of Air Force Maintenance Workers Vol 1.Entrenching Safety in the RAAF*. Royal Australian Air Force, Canberra; A Hopkins (2005a) *Safety, Culture and Risk. The Organisational Causes of Disasters.* CCH Australia Ltd. Sydney.

There has been relatively little empirical study of how public officials' perception of public health and safety risks shapes attitudes to their regulation, and consequently to associated policy decisions and enforcement practice. Rothstein's analysis of UK risk regulation regimes concerned with public and occupational health issues in the 1990s, provides an insight into the impact of the perceptions and attitudes of officials at different levels of institutions. For example, he highlights the impact of differences between those responsible for setting risk standards and those responsible for their enforcement.[111]

Rothstein suggests that regulatory enforcement officials' perception of risk, and their attention to the associated regulatory requirements, are generally, *"... intimately related to the institutional contexts and cultures within which* (they) *work and the specific problems and pressures they face in managing those risks*." From a bounded rationality perspective[112] their *"... understanding and perceptions of risk are bounded within organizational paradigms of what is possible, legitimate and important."*[113]

In the case of the implosion project, the combination of ongoing and project-specific problems and pressures significantly constrained what was possible for WorkCover. The inspectors' view of what was most important – workplace and public safety - was clearly not replicated by others on site and in the administrative hierarchy. The contractors – of necessity – and the concerned bureaucrats driving the project – as a matter of departmental priority – were primarily concerned with the implosion-as-public-event occurring on time and on budget. Whilst neither group intentionally downgraded its importance, public safety was not the major focus of their concern about the project. The by-passing of safeguards that marked the start of the project, continued throughout its implementation. Inconvenient engineers' reports were hidden from WorkCover inspectors' scrutiny and technical decisions were compromised by timeline pressures. Emerging risks were not acknowledged by the project principals and contractors and remained unknown to WorkCover. Overall, the conduct of the project was, in many ways, far from legitimate.

### Contributing factors

Rothstein identified five interactive institutional factors that contributed to institutional attenuation of risk [114]. He concluded that the institutional attenuation of risk in regulatory

[111] C Hood, H Rothstein & R Baldwin (2001) *The Government of Risk. Understanding Risk Regulation Regimes.* Oxford University Press Oxford.

[112] Bounded rationality is the idea that when individuals make decisions, their rationality is limited by the information they have, the cognitive limitations of their minds, and the time available to make the decision.

[113] H Rothstein (2003) *Neglected Risk Regulation: the institutional attenuation phenomenon.* Discussion paper DP7. Centre for Analysis of Risk and Regulation, London School of Economics and Political Science. London. Also in Health Risk & Society 5(1), p 17.

[114] Rothstein identified five contributing interactive institutional factors, as follows:

i. Institutional attenuation effects are most likely when officials monitoring and enforcing regulation are confronted with unfamiliar risks and insufficient attention has been paid to remedying expertise deficits within the regime as a whole.

bureaucracies, and the consequent failure to effectively enforce associated regulations, was most likely when:

- inspectors are confronted with unfamiliar risks and they and their colleagues lack relevant expertise, and are not adequately trained and resourced, to deal with them;

- institutional fragmentation distorts the flow and control of information and creates obstacles to overcoming or compensating for any misalignment between regulatory demands and officials' actions;

- central governments or bureaucracies attempt to resolve policy uncertainties or ambiguities by shifting responsibility for their resolution to inspectors;

- officials' attention to bureaucratic requirements are diminished by the lack of clear, well targeted institutional incentives to overcome established obstacles to effective monitoring and enforcement; and

- institutional fragmentation results in co-existing multiple, incompatible regulatory cultures that dispose policy makers and inspectors to perceive, understand and respond differently to risks.

Rothstein might well have been referring to the implementation of the failed implosion project. The contributing institutional factors he identified were all present and variously applicable to all involved, as outlined below.

### Unfamiliar risks and expertise deficits

Because demolition of large buildings by implosion was unprecedented in the ACT in 1997, the inherent public safety risks were unfamiliar to the ACT Cabinet initially contemplating and then approving it. It was also an unknown quantity for the departments and regulatory authorities subsequently administering and monitoring it. Consequently, throughout the project, the significant public safety risks went largely unrecognized. When risks were recognized they were discounted or under-estimated. This was sometimes through ignorance, sometimes as a matter of expediency and at times because

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ii. Institutional fragmentation can, in some cases, contribute to information distortion and control problems and can make it harder to compensate for misalignment of bureaucratic behaviour and regulatory demands.

iii. Such misalignments are particularly critical if central government passes the buck in attempting to resolve policy uncertainties by shifting responsibility onto enforcement officials.

iv. Bureaucrats' attention to bureaucratic requirements are likely to be diminished by a range of well-established obstacles to effective monitoring and enforcement if institutional incentives are not orientated towards overcoming those obstacles.

v. Institutional fragmentation can result in multiple regulatory cultures that dispose those charged with monitoring and enforcement to understand and respond to risks differently to those charged with policy. *making."* H Rothstein (2003) *Neglected Risk Regulation: the institutional attenuation phenomenon.* Discussion paper DP7. Centre for Analysis of Risk and Regulation, London School of Economics and Political Science. London. Also in Health Risk & Society 5(1), p 18.

there was no remaining mechanism for allocating the responsibility to monitor or control them.

The initial impact  project's unfamiliarity was exacerbated by the transfer of management away from bureaucrats with technical knowledge or industry experience to bureaucrats who had neither. The usual regulatory safeguards were by-passed and the regulatory authorities retaining a role, were unaware of their responsibilities (Dangerous Goods Unit),[115] or unable to effectively enforce them (WorkCover).  WorkCover inspectors did not have the expertise to critically scrutinise the unfamiliar and technically complex project. Nor did they have access to those who did. The Dangerous Goods Unit inspectors claimed that they were simply unaware of their statutory roles.

### Institutional fragmentation and the flow of information

By-passing the usual regulatory procedures for ensuring the safety of major construction projects, lead to failure of associated administrative arrangements and procedures. Since there were no procedures for reallocation of the regulatory responsibilities – nowhere and nobody to allocate them to – they were not done. This in turn led to a breakdown of the usual flow of information, through both formal and informal channels, that usually informed decisions and actions.

The fragmentation of responsibility and failure of procedures occurred throughout the project. Because ACT Building Commission was by-passed, the project proceeded without the usual expert scrutiny and approvals. Administrative control was transferred from the ACT DUS staff with technical expertise to those with neither the industry experience nor the technical knowledge needed to manage it. Tendering for the project, usually the responsibility of the appropriate government department was instead done by the ill-qualified private company, PCAPL – resulting in acceptance of a non-conforming tender bid. The contractual monitoring and directing roles of the Project Director, TCL, and Project Manager, PCAPL, were in practice abrogated to the contractors, whose decisions were compromised by lack of information[116] and by external pressures to meet imposed timelines.

The uncertainties created by overturning the usual roles of the regulatory authorities created gaps in the monitoring processes. They were filled – if at all – by Workcover. For example, approval of the workplan, usually done by ACT Building Commission, was left to WorkCover inspectors – who did not have the statutory power or expertise to approve it. Similarly, the Project Director's and Manager's failures to ensure the contractors met their regulatory and contractual responsibilities, left WorkCover to require compliance. It is not unusual for OHS inspectors to regularly resolve the uncertain demands of

[115] Dangerous Goods Unit staff claimed to be were unaware of, and to lacked the knowledge to, enforce their regulatory responsibilities under the ACT Occupational Health and Safety Office, *Demolition ACT Code of Practice* (Second Revised Edition, May 1993).

[116] For example, the full details of the buildings to be demolished were not disclosed in the tender documents.

regulatory policy through their practical in-field advice and enforcement decisions. However, in this case, the abrogated responsibilities of others were shifted to inspectors working in a situation of ignorance about the many hidden risks and the unacknowledged competing interests that they could do little to resolve.

### Multiple regulatory cultures, incentives and misalignments

At a day-to-day level the competing interests of the individuals and organisations involved in the project created a variety of practical obstacles to ensuring its safe implementation. For example, the contractor's concern to meet the deadline established by the CMO and CMD for the implosion-as-public-event, limited his choice of explosives.[117] But the competing regulatory cultures of the institutions involved in the project had more insidious effects.

In reviewing reports of the implosion project one is surprised, as clearly the Coroner was, by the apparent lack of concern about public safety – in part he labeled it '*almost incomprehensible.'* It was remarkable that those involved at all stages failed to even question whether their actions or omissions might have any implications for public safety. The Inquest identified many examples of incompetence, lack of care and lack of probity in planning and approving the project, appointing the contractors, by-passing the conventional regulatory procedures and restructuring the usual departmental responsibilities. However, it is unlikely that they were so widespread as to fully explain this failing to consider the safety implications. It is more likely that those involved simply did not realise that the proposed implosion involved significant public safety risks.

Nor did they appreciate that their individual actions or omissions could increase those risks or limit the effectiveness of mitigation measures. This was likely due, at least in large part, to the removal or by-passing of those with the experience and knowledge to recognise the risks. Experienced and qualified staff, employed in government departments to advise on the technical aspects of construction projects, were not consulted. Management of the project devolved to officials in departments that had neither the knowledgeable staff nor the safety culture common in the departments usually responsible for construction safety.

When control of the implosion project transferred to the Chief Minister's Office and Department, it was subsumed into a different regulatory culture – one not directly concerned with the practicalities of ensuring public safety. The Chief Minister's Department was primarily concerned with the administration of government and the Chief Minister's Office with maintaining the role and public image of the Chief Minister. The staff were primarily concerned with and trained in areas such as public and financial administration, policy development, law, public relations and communications. In this cultural climate, the importance of public safety, whilst undoubtedly acknowledged, was

[117] Reportedly Mr McCracken did not use some of his preferred explosives because the delay in obtaining them from overseas would have prevented meeting the deadline for the public event.

not the pivotal constant it was for ACT Building Commission and regulatory authorities such as WorkCover. For these organisations, considerations of public safety are paramount and necessarily central to all aspects of their work.

It is perhaps not surprising therefore that the staff of the Chief Minister's Office and Department, as noted in evidence to the Inquest, showed little appreciation of the potential public safety risks. They presumably did not see that a focus on ensuring public safety should be a major part of their acquired role in the project. This is not surprising since it had not previously been a usual part of their role. Nor would it have been in this case if all the usual government agencies had been scrutinizing the project. Their focus from the start was on the implosion-as-public-event not on the implosion-as-potential-public-safety-risk. The usual primacy of safety related technical decisions was unintentionally compromised by the demands of expediency – to ensure the implosion-as-public-event occurred on time and on-budget.[118] That was the primary goal, and its achievement constituted the main focus, of the project as driven by the bureaucrats of the Chief Minister's Office and Department – although doubtless they would not have intentionally compromised public safety in its pursuit. The government agencies liable to focus on the public safety aspects of the implosion-as-public-event were either absent or relatively powerless to influence the administration of the project. WorkCover, the only regulatory agency remaining, had some limited role but the inspectors were not *'in the loop'* – not informed, not consulted and with no input into the management and priorities of the project.

### In conclusion

The factors identified by Rothstein were clearly present in the implementation of the implosion project. The initial underestimation of risk, which marked its adoption, was exacerbated by the breakdown of established frameworks, uncertainty about regulatory and administrative responsibilities and lack of communication and coordination. When the established institutional and regulatory framework was by-passed, the usual lines of regulatory responsibility and communication were dismantled and no alternatives were established. The devolution of project management to a disparate group of inexperienced bureaucrats, lead to a largely unacknowledged conflict between project priorities – between the project's public relations potential and the public safety risks inherent in its promotion. This in turn resulted in co-existing incompatible regulatory cultures, functioning in ways that concealed developing risks and obscured possible mitigation measures. In the end, the usual primacy of public safety was – doubtless unintentionally – compromised by the underestimation of risk and the associated failure of the regulatory system.

[118] Shane Madden, above n 2, p 175 para 139.

# 5. IMPLICATIONS FOR WORKCOVER

The Coroner clearly acknowledged that responsibility for the safe conduct of the implosion project rested with the demolition contractors and those who employed and supervised them. But he also expressed particular concern about the actions of the WorkCover inspectors, claiming significant failures and questioning whether their behaviour was appropriate. A reading of his report and the Inquest transcripts of evidence, suggests both ambivalence about the role of WorkCover and its inspectors and an imperfect understanding of their responsibilities in relation to the project.

The OHS inspector's statutory role is clear – to secure compliance with the requirements of the legislation. To do this Australian OHS inspectors have always performed a dual role as both enforcement agent and advisor. They are expected to negotiate acceptable levels of compliance that contain the level of risk within limits that accord with current regulatory requirements and social norms, without undue recourse to prosecution. Inspectors in the field are expected to exercise considerable discretion in determining what constitutes 'acceptable' compliance in the particular circumstances and consequently how to exercise their discretionary enforcement powers most appropriately. This is the norm that underpinned and informed the standard operating procedures for ACT WorkCover inspectors in the mid-1990s. And the inspectors directly involved in the implosion project were, they argued, acting accordingly.

However, the Coroner claimed that the WorkCover inspectors "*failed to meet the standards that could reasonably be expected of a competent WorkCover inspector",* citing failures to issue Notices, seek independent expert advice and appreciate the limits of their own lack of expertise. Yet on close examination[119] the cited actions were, in each case, in accord with established standards and procedures and statutory requirements. Indeed a subsequent Public Service Inquiry into the actions of Inspector Hopner cited by the Coroner, dropped the proposed disciplinary charges as groundless when he contested them.[120]

The Coroner similarly criticised WorkCover generally for lack of efficiency and failure to adequately assess the contractor's workplan, properly supervise the use of explosives and liaise with Dangerous Goods Unit. But WorkCover did not have the statutory power to approve the workplan.[121] Nevertheless Inspectors Purse and Hopner assessed it, in accordance with advice previously provided by the ACT Government Solicitor, and found that it met the minimum performance requirements of the *ACT Demolition Code of Practice.*

[119] See previous chapters.
[120] Mr Purse had by that stage resigned from WorkCover and Inspector Kennedy did not contest the disciplinary charges brought against her.
[121] That power rested with the ACT Building Commission as previously noted.

Liaison between WorkCover and the Dangerous Goods Unit was undoubtedly inadequate – by both organisations. This was largely due to the longstanding failure of public service management to resolve the regulatory ambiguities and inter-departmental organisational issues required to clarify the demarcation of responsibilities. And finally WorkCover's general lack of 'efficiency' is more than adequately explained by the government's longstanding failure to ensure that the levels of staffing and resourcing were sufficient to effectively implement the organisation's statutory responsibilities.[122]

WorkCover's role in the implosion project may well have been flawed. However, it is clear that the chain of events that culminated in the failed implosion and the death of Katie Bender, began well before any involvement by WorkCover. And it included many other individuals and organisations with greater control over the cascading sequence of causal factors. It began with the wrongly informed choice of implosion by Cabinet and continued with a litany of failures and inadequacies. They included the Cabinet's inappropriate decision to make it a public spectacle, the flawed tender process that appointed an incompetent Project Manager and contractors, failure to consult regulatory agencies and by-passing of regulatory safeguards, control by public officials without the requisite knowledge or experience, the incompetence of the Project Manager and Director and the contractors' failure to follow appropriate procedures. And overall there was a wholesale failure by all involved to appreciate, and respond appropriately, to the public safety risks inherent in the manner of the project's implementation.

As documented in previous chapters, the circumstances of the implosion project were, from start to finish, unprecedented and very unusual and had significant implications for the outcomes of the WorkCover inspectors' actions. WorkCover inspectors were well entitled to claim that they had carried out their regulatory duties as they usually did and in accordance with statutory requirements and established policies and practice. However, it is also clear that they failed to fully appreciate how the circumstances of the project compromised their established role and ways of working, creating unintended consequences from their legitimate actions.

WorkCover inspectors in-field decisions about acceptable levels of compliance in particular circumstances, are largely based on their judgment about the risk associated with non-compliance. Judging that level of risk can be informed by reference to a clear breach of a regulation. Failing that, inspectors must necessarily make a subjective judgment about risk levels to inform the appropriate exercise of their enforcement powers. The implosion project was a case in point.

A Prohibition Notice was issued in response to clear regulatory breaches on 8 May – use of bobcats on suspended floors without engineering certification and no workplan. As the Coroner noted, Notices were not issued on other occasions when inspectors queried the adequacy of arrangements – a site meeting on 2 July and a site inspection on the morning

[122] It is notable that the Coroner recommended that WorkCover and Dangerous Goods Unit be merged into an independent statutory OHS Authority with adequate funding and resourcing.

of 13 July. On 2 July, issue of an Improvement Notice was considered but delayed pending the provision of information, which was duly provided. On 13 July the Chief Inspector, relying on the contractor's assurances, judged that there were no reasonable grounds for assuming a risk of "*imminent and serious injury to a person at or near the workplace"* – as required by the *OH&S Act.* In each case the actions taken were informed by the inspector's subjective assessment of risk.

In hindsight it is clear that the WorkCover inspectors' assessment of risk was flawed. Given the circumstances of the project, as discussed in previous chapters, this is not surprising. They were working in unusual circumstances and were unaware of the extent to which others involved in the project had failed to meet their regulatory and contractual obligations. Consequently the resulting risk factors were largely hidden from them, invalidating their risk assessments and thereby compromising their enforcement decisions.

This was not a failure "*to meet the standards that could be reasonably expected of a competent WC inspector*", as claimed by the Coroner and assumed by Public Service bureaucrats who brought disciplinary charges against them. The inspectors had little control over the circumstances of their involvement in the project. Even more importantly, they had no appreciation of the extent to which their risk assessments were invalidated. Firstly by the actions and omissions of those who conducted the implosion – the contractors, the Project Manager and Project Director. Secondly by the failures of the government departments responsible for ensuring the probity and good governance of the project.[123]

In the aftermath of the failed implosion, many sought to apportion blame for the tragic outcome. Some blamed WorkCover for not preventing it. The role of the WorkCover inspectors was poorly understood – even by the eminent lawyers at the Inquest. WorkCover staff frequently corrected the assumptions made by lawyers questioning them – explaining that they were not the ones responsible for the safe conduct of the project. It may be generally acknowledged that employers are responsible for ensuring that work is done safely under their watch. But for many the OHS inspector is also, even equally, responsible for preventing such unsafe work – as their in-field actions frequently do. However, as the outcome of the implosion Inquest shows, when inspectors do not prevent accidents resulting from unsafe work practices they may be held, in some way, responsible for their occurrence. The subtleties of the inspectors' statutory responsibilities, and the practical realities of their work, were not easily understood or accepted – not even by the Coroner, the Inquest lawyers or the ACT Public Service bureaucrats.

The implosion project was, as described by the Coroner, a systemic failure. As such, it is a good example of how unintended consequences can result from a concatenation of seemingly inconsequential individual actions and omissions, unrecognised

[123] Discussed in previous chapters.

communication failures, avoided responsibilities, lack of probity, unacknowledged conflicting priorities and disregard of established procedures and safeguards. The fatal outcome of the implosion had multiple interactive causes, each involving many of those operating at various levels over the course of the project. The defences and safeguards that existed to ensure construction safety were dismantled or by-passed – some with deliberation and some without any appreciation of the dangers inherent in doing so. The conflict between the implosion's public relations potential and the potential public safety risk was, from start to finish, unacknowledged and unresolved – and unintentionally compromised the usual primacy of public safety. And potential opportunities to safely manage the unusual circumstances of the implosion project were compromised by the latent inadequacies of the ACT OHS regulatory system.

And finally the failed implosion project can be seen as a warning for OHS regulators and inspectors. As noted by Bridget Hutter, who has wide experience of the work of regulatory inspectors:

*"Inspectors fulfil their role according to principles which already structure the laws, most prominently according to the costs and risks associated with compliance. These are matters which pervade regulation and which, of necessity, are part of the regulatory inspector's world view. Resolving the tensions between costs and risks are both a broad rationale for the inspector's job and a point upon which the regulatory agency and officials can become the fall-guys of a system which fails to specify how stringently compliance should be defined." (Bridget Hutter, 1997)*

## Appendix 1:

## Organisations & people involved in implosion project

| | |
|---|---|
| **ACT Principal (Client) Chief Ministers Office & Department** | **Chief Ministers Office (ACT CMO)**<br>***Kate Carnell*** *Chief Minister*<br>***Gary Dawson*** *Media Adviser to Chief Minister*<br>***Ian Wearing*** *Political advisor to Chief Minister*<br><br>**Chief Ministers Dept (ACT CMD)**<br>***John Walker*** *CEO*<br>***Linda Webb***<br>***Moiya Ford*** *(Acting CEO BASAT at time of implosion project)*<br>***Michael Hopkins –*** *liaison for implosion project* |
| **Totalcare Industries Ltd (TCL)**<br>*Implosion Project Director.*<br>*Public company wholly owned by ACT government.* | ***Mike Sullivan*** *– A/Director Works & Commercial Services TCL from 1/1/97.*<br>***Warwick Lavers*** *– Project Director (CAMMS from 16/10/95 to TCL 1/1/97. Liaison between PCAPL & Gary Dawson, Media Adviser to Chief Minister*<br>***Gary Hotham*** *– TCL Site Representative*<br><br>*(All above at ACT DUS prior to 1/1/97)* |
| ***Department of Urban Services (ACT DUS) -***<br>*Roles transferred to TCL 1/1/97* | ***John Turner*** *CEO*<br>***Rod Templar*** *- Chair of Acton Steering Committee. (Co-ordinated drafting of Aug 1995 DUS submission to Cabinet)*<br>***Mike Sullivan*** *– A/Director Works & Commercial Services (Cleared 1995 DUS submission to Cabinet)*<br><br>***John Kaine*** *– Minister, ACT DUS. Not involved in project.*<br>***Rod Woolley*** *Minister's Chief of Staff & Principal Adviser* |
| **Project Coordination (Australia) P/L (PCAPL)**<br>*Project Manager* | ***Paul Murphy****. Managing Director. Assisted with preparation of 1995 RGA Feasibility Study.*<br>***Cameron Dwyer****. Acton Project Manager*<br>***Kevin O'Hara****. Director of PCAPL* |
| **City & Country Demolition (Australia) PL (CCD)** | ***Anthony Fenwick*** *Director CCD. Demolition Contractor* |

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| **Controlled Blasting Services (CBS)** | ***Rod McCracken*** *Director CBS. Explosives Sub-Contractor* |

| | |
|---|---|
| ***Dangerous Goods Unit (ACT DGU)*** *Located in ACT Emergency Services Bureau (ACT ESB)* | ***Bill McTernan*** *Chief Inspector*<br>***Tony Smith*** *Inspector (Acting Chief Inspector at time of implosion project)* |
| **ACT WorkCover (ACT WC)** Located in *Planning & Land Management Division, BASAT*<br><br>***BASAT*** *ACT Department of Business, Sport, Arts & Tourism* | ***Greg Ash*** *Acting Manager & Registrar*<br>***Kevin Purse*** *Chief Inspector*<br>***Peter Hopner*** *Inspector*<br>***Margaret Kennedy*** *Inspector*<br>***Phil Adams*** *Inspector/Asbestos Control Officer*<br><br>***Annabelle Pegrum –*** *CEO (on leave 17/6/97 – July 1997)*<br>***Moiya Ford –*** *Acting CEO 17/6/97 - July 1997*<br>***Jocelyn Plovits*** *– Manager, Organisation Development, BASAT at time of implosion project. Previously at Chief Minister's Department. Later General Manager of ACT WorkCover.* |
| **Richard Glenn & Associates (RGA)** | ***John Deeble*** *Director. Civil Engineer (35 years) prepared RGA reports for ACT DUS*<br>***Andrew Derbyshire*** *(Melbourne office, RGA) Advised re implosion method based on RGA 1992 implosion, St Vincent's Hospital Melbourne.* |

**OTHERS**

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| ***Adam Hugill*** *Senior Structural Engineer, Northrop Engineers PL* |
| ***Gordon Ashley*** *Consulting Structural Engineer* |
| ***Rohan Chabaud*** *Radio station MIX 106.3* |

# APPENDIX 2: ROLE OF THE INSPECTORATE

### Inspector's Dual Role

Although Australian OHS agencies' *de jure* objective may be full regulatory compliance, the *de facto* objective has always been negotiated levels of compliance that constitute an appropriate balance between the practicability and costs of compliance and the risks associated with non-compliance. Risk has generally taken precedence. It has always been and remains the role of the OHS inspectorate to achieve this de facto objective through negotiation in the field with minimal recourse to prosecution. To do this, individual inspectors are expected to exercise considerable discretion in determining what constitutes 'acceptable' compliance in the particular circumstances and consequently how to exercise their discretionary enforcement powers most appropriately.

This dynamic process of judging what is 'acceptable' compliance both relies on and is necessitated by inspectors' mandated responsibility to negotiate levels of regulatory compliance that contain the level of risk within limits that accord with current regulatory requirements and social norms, without undue recourse to prosecution. To achieve this end, OHS inspectors are required to perform a dual role of both enforcement agent and advisor – simultaneously enforcing regulatory requirements and providing advice that encourages compliance.[124] Generally, their in-field default role is that of advisor, which is regarded as more compatible with achieving change whilst avoiding prosecution. The enforcement role generally only predominates in more exceptional circumstances, such as unacceptably high levels of risk, continued recalcitrance from duty holders, serious injuries or fatalities or when external influences require that enforcement action is (and is seen to be) taken.

This is the norm that underpinned and informed the standard operating procedures for OHS inspectors in all Australian jurisdictions in the mid-1990s.

### Legislative change and acceptable risk

In the 1980s, sweeping legislative change added an extra dimension of complexity to the work of the OHS regulatory authorities. New legislation was introduced into all Australian OHS jurisdictions bringing a shift from prescriptive standards 'command-and-control' style to a more self-regulatory style of process based regulation. The changes

[124] It should be noted that this dual role was not unique to Australian OHS inspectorates. It is based on the traditional British model, reflects the practice in many industrialized societies, and is broadly in accord with Article 3 of the Labour Inspection Convention 1947 (Convention 81) which identified the functions of labour inspection equally as enforcing legal provisions relating to conditions of work and the protection of workers; supplying compliance advice to employers and workers; and advising the appropriate authorities of abuses or defects not covered by existing legal provisions. The most recent ILO guide to labour inspection practice notes that despite continuing debate about what is a proper balance, it is *"accepted that if the objective of inspection is to ensure compliance with the law, then clearly it has both an enforcement and an advisory component. It is not an "either or" question."* W Von Richthofen (2002) *Labour Inspection. A guide to the profession*. International Labour Organisation Geneva, p 100.

carried major implications for everyone in workplaces. Employers (and other duty holders) now had to do more than comply with a plethora of detailed technical specification standards – although many of these also remained in force. Employers now had to maintain, as far as reasonably practicable, a safe workplace and safe system of work. Properly done, this entailed a systematic approach to OHS management that comprehensively identified hazards, assessed the nature and level of associated risks and controlled them. And this was to be done in consultation with the workers themselves. Regulatory compliance became much less straightforward for all in the workplace. It also had major implications for OHS regulators and their inspectorates, creating what Andrew Hopkins has described as "*a fundamental challenge to regulators*".[125]

In negotiating acceptable levels of regulatory compliance, OHS inspectors have necessarily to take into account the potential risks associated with non-compliance. Traditionally, judging the level of risk associated with non-compliance in particular situations was informed and validated by reference to the relevant specification standard based regulations. Determining compliance with the relevant regulations was sometimes complex, but it was nevertheless a relatively clear process which provided an agreed yardstick for assessing risk and thus guiding enforcement decisions. Not so in the new regulatory regime, which largely shifted the responsibility for risk assessment to the inspectors, as Hopkins noted:

*"Whereas under a prescriptive regime, those drafting the prescriptive rules are making the judgments about risk and inspectors judge compliance with those rules, in a non-prescriptive regime it is the inspector on the spot who must make the judgments about risk. A non-prescriptive regime, in short, places far greater responsibility on its inspectors".*[126]

And in the absence of an accident, near-miss incident or other unwanted outcome, this in-field risk judgment became a more-than-previously-difficult and more subjective process for the OHS inspector. Hopkins notes that the difficulty becomes very apparent in the issue of Prohibition and Improvement Notices to prohibit an activity that, in the inspector's view, poses a significant risk to health and safety. That is, to avoid an unwanted outcome that might, but has not yet, happened:

*"How is an inspector to decide whether there is an imminent danger? Under a prescriptive regime, the inspector might point to a regulatory violation as the reason for the notice, but in the absence of such a violation the inspector must fall back on subjective judgment of the level of risk. .... inspectors must make a judgment that the level of risk is unacceptable, a judgment which is informed by the inspector's expertise and which cannot be deduced simply from any regulatory requirement. The judgment*

[125] A Hopkins (2005) *New Strategies for Safety Regulators: Beyond Compliance Monitoring.* Working Paper 32. National Research Centre for Occupational Health and Safety Regulation. Australian National University. Canberra, p 7.
[126] Ibid.

*about whether there is immediate danger, therefore, is not a judgment about compliance, except in the most formal sense; it is a judgment about risk.*[127]

In this changed context, inspectors still had to negotiate an acceptable level of compliance with the relevant regulations – albeit a different sort of regulations. In doing so inspectors had, as always, to make decisions about what was (or not) an acceptable level of risk. But assessment of risk could no longer rest solely on violation of some clearly specified rule – although these could still inform and be included in an overall risk assessment. A different approach to the practical process of inspection was needed since, as the authors of an international study of OHS inspectorates note, *"... inspecting the management of* (the quality of) *OHS is a very different task from surveillance of compliance with material OHS regulatory provisions."*[128]

The 2002 ILO guide to labour inspection, in describing the implications of such regulatory changes, similarly notes that it was no longer *"adequate or appropriate"* for inspections to "(emphasise) *achieving compliance with specific, often very narrow or limited requirements, rather than adopting a holistic, prevention-oriented approach to OSH. ... The traditional approach whereby inspectors aimed simply to identify legal irregularities and then give advice or impose sanctions, depending on the seriousness of the offence, is increasingly discredited."*[129]

And Richard Johnstone, in discussing the changes necessary for effective enforcement of OHS regulations in Australia, used similar terms:

*The challenge is for inspectorates to change their inspection and enforcement to inspect OHSM* (OHS management systems). *In this approach, the traditional focus on hazardous conditions and work practices is not abandoned but provides signals of weaknesses in OHSM to be uncovered. Observation of conditions and activities is part of the 'evidence' of effectiveness (or otherwise) of OHSM ... Further the inspectorates not only have to inspect workplaces but also to develop strategies to motivate duty holders to develop their approaches to systematic OHSM, ..."*[130]

Their greater responsibility for making the increasingly complex decisions occasioned by the regulatory changes, significantly increased inspectors' need for easy access to independent expert advice. As noted by Hopkins, the new regulatory regime required inspectors to base their decisions about acceptable levels of compliance on their subjective judgements about risk levels rather than regulatory violations alone. Given the diversity of workplaces and systems of work, and the variety of hazards and risks encountered, it is unlikely that any inspector could rely solely on her personal experience

[127] A Hopkins, above n 125, p 8.
[128] D Walters et al (2011) *Regulating Workplace Risks: A Comparative Study of Inspection Regimes in Times of Change*. Edward Elgar Publishing Ltd UK, p 8.
[129] W Von Richthofen, above n 124, p 204-205.
[130] R Johnstone (2004) *Rethinking OHS Enforcement.* In Bluff, L, Gunningham, N & Johnstone, R *OHS Regulation for a Changing World of Work*. Federation Press, Sydney, p 146-178.

to make the diverse and complex assessments required. The support of expert advice, as well as comprehensive professional training, is needed. Yet neither was forthcoming in adequate measure for OHS inspectorates in the 1990s.

### Avoiding prosecution

Regardless of the increased responsibility and complexity created by the new legislation, the overriding requirement to minimise recourse to prosecution remained. It continued to circumscribe inspectors' negotiation of acceptable compliance, and the exercise of their regulatory enforcement powers. This requirement had always been, and remained, the acknowledged consensus at all levels of Australian OHS (and many other) regulatory agencies.

The long established power of this consensus is indicated by studies of the policies and practice of Australian regulatory agencies in the 1980s, which found the great majority formally averse to prosecution except as a last resort. One seminal study[131] found that the great majority of Australian business regulatory agencies did not regard law enforcement as their primary function, rarely exercised their often considerable statutory enforcement powers and rarely used even the threat of prosecution other than as (explicit or implicit) "*bargaining chips*".[132] Some 78% of the agencies studied, including 7 of the 8 OHS regulators, explicitly cited education and persuasion as more important in achieving acceptable levels of regulatory compliance. A study of the enforcement practice of the Victorian OHS inspectorate from 1980-1988[133] similarly found that prosecution was rare, and most matters were dealt with informally or through warnings or the issue of Notices. Breach reports, when issued, most frequently recommended no prosecution and no further action.

### Implications for the inspectorate

Whilst much of established practice remained, the sweeping legislative and institutional changes of the 1980/90s had significant and wide reaching implications for the work of the OHS inspectorates. Yet, despite these implications, the *'fundamental challenge*' to the OHS inspectorates' role and work methods received little practical acknowledgement as the changes were adopted in all jurisdictions. In 1995, a major national Inquiry[134] considering ways to improve the regulation and practice of OHS, challenged the balance struck in the inspectors' dual role as advisor and enforcement agent. *"Advice and education – an important element of prevention – are not the primary role of enforcement and therefore government inspectorates."*[135] Nevertheless it too accepted the need for the

[131] P Grabosky & J Braithwaite (1986) *Of Manners Gentle. Enforcement Strategies of Australian Business Regulatory Agencies*. Melbourne University Press Melbourne in association with Australian Institute of Criminology. Canberra.
[132] Ibid, p 190.
[133] Joint La Trobe and Melbourne University Project reported in R Johnstone, above n 130.
[134] Industry Commission, above n 71.
[135] Industry Commission, above n 71, vol 1 p 109.

continued primacy of persuasion over prosecution despite its cited concerns about the efficacy of the approach.

The final Inquiry report proposed that whilst inspectors should give higher priority to enforcement, they should continue to rely primarily on persuasion. They should exercise both discretion and restraint in the sparing application of a (proposed) greater range of graduated penalties in ways *"that give workplaces the strongest incentive to invest in prevention,"*[136] *"give compliance notices and advice without penalties where the imposition of a penalty would be counter-productive;"* and only impose penalties for *"significant"* but not *"trivial"* breaches.[137] The determination of what was '*significant', 'counter-productive'* or *'trivial'* continued to be at the discretion of the OHS inspector pursuing the '*sparing' application of penalties*"[138] – albeit with (again proposed but not specified) clearer guidelines and the provision of more resources, training and management support.[139]

### Slow transition

In practice the Inquiry recommendations did little to inform or assist inspectors' adaptation to the new legislative paradigm, with its corollary of greater inspectorial responsibility for increasingly complex in-field risk assessment. The Inquiry recommendations for the increased resources, training and management support, needed to facilitate inspectors' effective exercise of their changed enforcement role, were ignored or given minimal effect in all OHS jurisdictions over the next several years. Notably so in the ACT.[140] OHS regulatory authorities continued to be characterised by limited resources, heavy workloads and under-staffing sufficient to hinder any rapid transition to effective implementation of the new regulatory model.

Overall, and notably so in the ACT, there was little and slow progress in transitioning to the new model of inspection and enforcement. And indeed Richard Johnstone, in reviewing the development of Australian OHS regulations almost 20 years later, commented:

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[136] Ibid, p 137.
[137] Ibid, p 141.
[138] Again this "*consensus-based process of negotiated compliance between state inspectors and management"* is not unique to Australian regulatory institutions. It is the approach recommended by the ILO for labour inspection and adopted by industrialised countries throughout the world over the last century. R Johnstone, above n 130.
[139] The intent of these recommendations is largely mirrored by more recent ILO recommendations that, while inspectors should be allowed sufficient discretion to adapt to particular circumstances, the limits of discretion must be clearly delineated and clear guidance given on the circumstances in which various options are appropriate by "*… guidelines both sufficiently wide to allow a proper response to circumstances, and also sufficiently defined to ensure consistency"* (W Von Richthofen, above n 124, p 104).
[140] See discussion in Chapter 3

*"While OHS standard setting in Australia has changed significantly over the past 20 years, changes in OHS enforcement have lagged behind. OHS inspection and enforcement is still biased towards 'traditional' hazards such as plant and falls, enforcement is still dominated by advice and persuasion strategies, and prosecutions are still largely brought in response to serious injuries and fatalities."*[141]

[141] R Johnstone, above n 130, p146.

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Much of this study is based on confidential interviews and access to the private papers and files of those involved, including transcripts of evidence to the Inquest and Australian Federal Police. After the failed implosion all those involved were interviewed by members of the Australian Federal Police and subsequently given copies of the transcripts of those Records of Interview (ROIs). Some ROIs were loaned to me for the purpose of this study only – they are confidential documents that are not publicly available. Where an ROI is given as reference here, the date is given but the person's identity is not stated in order to respect that confidentiality.

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