

Cave Creek: A national tragedy (A): TEACHING NOTE:

There are a number of important issues and questions raised in this graphic case study of circumstances in which the acts of omission and commission by a government department led directly and unambiguously to a human tragedy. Some of these issues are generic, while others relate to the particular circumstances of New Zealand public management and administration.

Generic issues and questions

The generic issues relate to the behaviour of organisation members, whose actions – or lack of them – bore directly on the tragic outcome. In other words, why did organisationally committed, well-meaning and enthusiastic individuals fail to engage adequately in what Donald Schön calls ‘reflection-in-action’?¹

- Leaving aside questions relating to the management structures of the Department of Conservation (DOC), how was it possible that the four men who actually built the platform could do so, seemingly blind to the fact that none of them were technically competent to build this particular platform, cantilevered over a 30-metre drop?
- Les Van Dyk, who had drawn up plans for the platform’s construction, was not assigned to the working bee that built the platform. Nor were his plans used. Can we say why not, in both instances?
- Why, according to Judge Noble, did organisation members think of the Building Act requirements as an administrative rather than a safety matter?

This teaching note was written by Associate Professor Robert Gregory, School of Government, Victoria University of Wellington. It has been prepared to support class discussion of the case 2004-2.1. The use and circulation of teaching notes is restricted to accredited academics and other approved persons.

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¹ Donald A Schön (1983) *The Reflective Practitioner: How Professionals Think in Action*, New York: Basic Books.

- DOC officer, Shirley Slatter, was concerned when she felt the platform flex the day before the tragedy. Why didn't she ensure that it was safe before the group stood on it the next day?

Accountability and responsibility (how do they differ?)

There are numerous questions relating to the exercise and nature of accountability and responsibility (and blame-shifting?) in a Westminster-styled Parliamentary democracy like New Zealand's, including:

- Did the State Sector Act 1988 and the Public Finance Act 1989 clarify the respective roles and responsibilities of ministers and departmental chief executives?
- What impact did under-funding have on the building of the Cave Creek platform?
- The West Coast conservator, Bruce Watson, resigned after the tragedy. The Minister resigned his portfolio more than a year after the tragedy, but remained a full cabinet member. DOC's CE announced his resignation 21 months after the event. Should either the Minister or the CE have resigned earlier? If so, why? If not, why not?
- Why were adequate safety management systems not in place in DOC in the years immediately before the tragedy?
- How justified was Judge Noble's finding that 'systemic failure' was the essential cause of the tragedy, and that it would be 'quite inappropriate to point the finger of blame at any one of the individuals. It was uniquely an institutional failure'?
- Were proper accountability requirements fulfilled by DOC in the aftermath of the event?
- Should prosecutions have been laid against any individuals on the grounds of their failure to exercise a duty of care in regard to the platform's construction?
- Was the State Services Commission justified in finding, in its report on DOC after the event, that the department as a whole was well structured and managed?
- Why did DOC itself undertake a massive reorganisation in the following two years?
- Was the State Services Commissioner justified in finding that DOC's CE, Bill Mansfield, had done an exemplary job in that position during the period of his contract before the tragedy occurred?

Two hypotheticals

1. If the tragedy had occurred under the organisational structures developed by DOC after the actual tragedy, would these have been seen to have been totally inadequate, and how might the department then have been reorganised?
2. Had the viewing platform been built according to Les Van Dijk's specifications (which would have made it a safe construction), and therefore if no Cave Creek tragedy had occurred, would DOC have undertaken the massive programme of organisational restructuring that it undertook after the actual tragedy?

Case study teaching strategy

Either

1. Role-Playing Scenario

Ten players in each team: (a) Prime Minister, (b) Minister of Conservation, (c) DOC CE, (d) DOC Deputy CE, (e) DOC Media Liaison Officer, (f) West Coast Conservator, (g) Newspaper Journalist, (h) Victims' Families Representative, (i) Leader of the Opposition, (j) State Services Commissioner.

This strategy requires the various role players to play out their responses, *as if* during the first three days after the event. Additional information can be supplied on request for all parties by the case study facilitator as events and decisions unfold during the exercise. The facilitator will divide the case study time into compressed 'single day' periods.

Or

2. Group discussion (groups of no fewer than four members)

To determine what the Minister of Conservation and the DOC's CE should have done 'in the public interest' in the two weeks after the tragedy, and immediately after the release of Judge Noble's Commission of Inquiry Report.

Case study information resources:

Cave Creek: a national tragedy (A)

Cave Creek: rebuilding the department (B)

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These information resources were used in preparation of the cases 2004-2.1 and 2004-4.1, written by Janet Tyson for the Australia and New Zealand School of Government (ANZSOG), with supervision by Professor John Alford, ANZSOG, and Dr Richard Norman, Victoria University of Wellington.

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