
The missing dimension of safety

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Accommodating
complex systems of
networked
governance in tort

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Roads are places where life happens and people suffer injuries. The accidents that produce these injuries are often complex and difficult to prevent. One outcome of these accidents are actions in tort by those injured to recover compensation from statutory authorities that are responsible for designing, building, maintaining and managing roads. The gist of these actions is that these authorities have failed to prevent harm. These actions give rise to concern about the role of the law of tort. Where these actions are successful, publicly funded bodies with limited resources are required to support the payment of compensation. These bodies often have a limited capacity to prevent the accidents that produced the harm. But a failure to find that statutory authorities are responsible for failing to prevent harm also appears to collude in a pattern of inaction by those bodies. Notwithstanding these concerns there is a role for the law of tort in improving safety. It comes out of the potential for tort law to focus on the failure of many statutory authorities to develop the institutional capacities that are necessary to improve safety in the use of roads. Tort law can be a mechanism for exploring the vulnerability of all road users to suffer injuries in accidents. It can be a forum in which courts recognise the failure of statutory authorities, governments and other organisations to implement safety systems. It can play this role without imposing onerous burdens of liability on statutory authorities. This is an important role for tort law because statutory authorities and the governments which create them often seek to avoid for responsibility for implementing safety systems.

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Introduction

The goal of improving safety is an emergent project; systems of regulation and governance aimed at improving safety are unstable and only partly formed, and their capacity to prevent these harms is not completely known or understood.¹ This view is in contrast with claims that safety culture ‘can be confidently instrumentalized to prevent catastrophic outcomes from complex technologies’.² Analysing safety as an emergent project, rather than as the purely instrumental one of solving individual discrete problems, shifts attention to the limited capacity of existing systems of governance and regulation to improve safety.³ Processes of governance and regulation facilitate the production of injury just as they also facilitate the production of goods and services. This article investigates the capacity of tort law to encourage rather than impede the conditions for the emergence of systems of governance that are oriented towards safety and the prevention of harm.

The goal of improving safety is sometimes defined as preventing the occurrence of organisational accidents.⁴ One model of accidents focuses on particular unsafe acts and errors as the cause of those accidents. In contrast, organisational accidents can be defined as complex accidents that have multiple causes involving many different people and parts of organisations. They are the result of the interaction between latent conditions in organisations along with unsafe acts or errors. Organisational accidents often literally burst into public consciousness in the form of catastrophes – nuclear power accidents, plane crashes and industrial accidents.⁵ There is though, a second path by which unsafe acts can combine with latent conditions to produce organisational accidents. In this form, organisational accidents appear to be produced by recurrent patterns of unsafe acts and latent conditions. It is useful to describe these recurrent patterns of injury as organisational accidents because the most effective remedy is to make complex changes in the organisations that are responsible for the delivery of goods and services.⁶ Arguably these organisational changes may either be encouraged, or facilitated by, the development of appropriate systems of regulation and governance.

The focus in this article is on the way that systems of governance and regulation effectively limit the capacity of governments, regulators, and organisations to improve safety in the use

¹ Susan Silbey, ‘Taming Prometheus: Talk about Safety and Culture’ (2009) 15 *Annual Review of Sociology* 17.3.

² Silbey, above n 1, 17.3.

³ Silbey, above n 1, James Reason, *The Human Contribution: Unsafe Acts, Accidents and Heroic Recoveries* (2009); Charles Perrow, *The Next Catastrophe: Reducing Our Vulnerabilities to Natural, Industrial, and Terrorist Disasters* (2007). For a particular example in the domain of safety and quality of health care, see Institute of Medicine, *To Err is Human, Building a Safer Health System* (2000).

⁴ See for example, James Reason, *Managing the Risks of Organisational Accidents* (1997).

⁵ Reason, *The Human Contribution*, above n 3, 113-118; Perrow, above n 3.

⁶ Reason, *Managing the Risks of Organisational Accidents*, above n 4. The organisational changes which Reason proposes are not just ones at the level of the ‘systems’ within organisations. He also argues for training and support for those on the sharp end so they become ‘error wise’ by developing ‘individual mindfulness’; Reason, *The Human Condition*, above n 3, 103.

of roads. Roads are complex human artefacts and, as a result, they provide an important perspective on the way that systems of governance both enable improvements in safety and, at the same time, disable the capacity of all those who use, design, build, maintain and manage roads to improve safety. They are essential parts of our daily lives and are a location for many different activities.

What place would that be, a whole world without roads? It was a panicking thought. A world without roads! He would go nowhere in such a place. He would be trapped where he was, he would have lived out his life only where he was born.⁷

In all of their manifestations, from rarely used suburban lanes to large systems of freeways, roads are complex forms of social organisation.⁸ They are the sinews of cultural and commercial life that everyone, young and old, reclusive and well-connected, need to support their everyday lives. They also seamlessly produce harm. Roads are a site for clearly authorised and expected activities, such as pedestrian and vehicle traffic. But they are also the site of related activities, such as commercial activities, and of opportunistic activities, for example, talking on mobile phones,⁹ selling goods from roadside stalls, or, using a bridge as a platform for diving. Our capacity to control and coordinate these activities is influenced by the way roads both connect and separate communities and individuals. They connect people with places but they also weaken communities and parts of cities by restricting movements over and across them.

As complex forms of organisation, roads produce harm in the form of 'organisational accidents'. Each individual accident will usually be the result of an active failure by one of the participants in the accident. But, when considered together, these individual accidents are part of larger patterns of harm that can be characterised as organisational accidents produced by the interaction between latent conditions and active failures. The relevant body in New South Wales, with responsibility for managing the road network, and for providing road capacity and maintenance solutions, the Roads and Traffic Authority ("RTA") has adopted a model for reducing the potential for the occurrence of organisational accidents. It is committed to the notion that 'human error is inevitable and requires roads and roadside environments that are forgiving of error'.¹⁰ This approach to improving safety involves a combination of changes at an organisational level in the RTA along with the development of broader systems of networked governance. The challenge for the RTA, and for all those institutions that monitor the effectiveness of the RTA, is to grasp the complexity of the

⁷ Lydia Millet, *How the Dead Dream* (2008)

⁸ Suzanne Heywood, Jessica Spungin, David Turnbull, 'Cracking the complexity code' [2007] 2 *The McKinsey Quarterly* 85, 87-88.

⁹ For example a report prepared by the U.S. National Highway Traffic Administration estimated that in 2002 use of mobile phones by drivers was causally related to 955 deaths and 240,000 injuries: Matt Richtel, 'U.S. Withheld Data on Risks of Distracted Driving', *New York Times* (New York), 21 July 2009, 1.

¹⁰ Roads and Traffic Authority of New South Wales ('RTA'), *Annual Report* (2008) 54.

problem of integrating changes at an organisational level into broader systems of networked governance.¹¹

Statutory authorities that have responsibility for designing, building, maintaining and managing roads, therefore, face a 'wicked problem' as they endeavour to reduce harm.¹² This problem of regulation and governance is a complex undertaking that involves coordinating many complementary and competing interests.¹³ These statutory authorities fully comprehend neither the multi-dimensional problems associated with improving safety, nor the institutional capacities they will need to resolve these problems. One aspect of this larger regulatory problem is whether law can accommodate or facilitate the transformation of nascent, partly-formed, emergent systems of governance to achieve complex public policy goals such as safety.¹⁴ This article focuses on one part of this problem, tort law, and the way it can accommodate and facilitate the growth of systems of governance needed to improve safety for all those who use roads.¹⁵

There is a general concern shared by torts scholars about whether a body of law concerned with imposing liability for wrongful conduct has any role in supporting the emergence of systems of regulation oriented towards safety.¹⁶ One manifestation of this concern lies in considering whether statutory authorities should be liable to pay compensation to plaintiffs who sustain injuries in circumstances where a statutory authority has failed to prevent the

¹¹ In the field of health care, see for example, Institute of Medicine, *To Err is Human*, above n 3; Bill Runciman, Alan Merry and Merrilyn Walton, *Safety and Ethics in Healthcare, A Guide to Getting it Right* (2007), 197-217 (Chapter 9: When Things Go Wrong: Preventing a Recurrence).

¹² The term 'wicked problem' was first used to describe the difficulty of formulating solutions to policy problems, Horst Rittel and Melvin Webber, *Dilemmas in a General Theory of Planning* (1973) 4 *Policy Sciences* 155.

¹³ John Braithwaite, *Regulatory Capitalism: How it works, ideas for making it work better* (2008), 1-4.

¹⁴ John Braithwaite and Christine Parker, 'Conclusion' in Christine Parker, Colin Sott, Nicola Lacey and John Braithwaite, *Regulating Law* (2004) 274-279 (the role of law in systems of networked governance). See also Julia Black, 'The Decentred Regulatory State?' in P. Vass (ed) 2006-7 *CRI Regulatory Review* (Centre for Regulated Industries, University of Bath, 2007) (role of law and regulation in the 'decentred regulatory state'); Christine Parker, 'The pluralization of regulation' (2008) 9 *Theoretical Inquiries in Law* 349-369. See Angus Corbett, 'Regulating Compensation for Injuries Associated with Medical Error' (2006) 28 *Syd Law Rev* 259 (an analysis of the capacity of law to facilitate improvements in safety and quality of health care) ('Corbett, 'Regulating compensation').

¹⁵ This article deals with issues of tort liability in ways that parallel work being undertaken by Simon Halliday, Jonathan Ilan and Colin Scott 'A Compensation Culture? A Comparative Investigation of the Risk Management of Legal Liability in Public Services in Scotland and Ireland'. This project is jointly funded by the UK Economic Research Council and by the Irish Research Council for Humanities and Social Sciences. It studies the way public agencies use risk management of legal liability as a way of governing their relationships with third parties.

¹⁶ See for example, Jane Stapleton, 'Regulating Torts' in Christine Parker, Colin Scott, Nicola Lacey and John Braithwaite (eds), *Regulating Law* (2004) 122-134; Carol Harlow, *State Liability: Tort Law and Beyond* (2004), 14-30.

harm sustained by the plaintiff.¹⁷ This is predominantly a question about when the failure to exercise statutory powers to prevent harm can be characterised as wrongful in the sense that the statutory authority is in breach of its duty to exercise reasonable care to prevent the plaintiff from sustaining harm.¹⁸ In this field of scholarship there is a lack of confidence that the payment of damages in tort can promote safety.¹⁹ There are also criticisms about the way tort law supports the creation of a 'blame culture' by imposing liability on governments for all kinds of 'loss or death or wrongful injury'.²⁰ In consequence, Professor Carol Harlow argues, 'the share of collective goods assigned by the courts to individuals for their personal use is beginning to impinge on the share at the disposal of government and public authorities for the collective benefit of the community'.²¹

The argument here is that the law of tort does have a role in identifying the limits of governance and creating the conditions that will facilitate the emergence of the systems of governance needed to improve safety. The source of this argument is the insight of Charles Perrow that, while disasters are a 'normal part of life,' the damage which follows those disasters is neither, normal nor inevitable.

Disasters expose our social structure and culture more sharply than other important events. They reveal starkly the failure of organisations, regulations and the political system. But we regard disasters as exceptional events, and after a disaster we shore up our defences and try to improve our responses while leaving the targets in place. However ... disasters are not exceptional but a normal part of our existence. To reduce their damage will require probing our social structure and culture to see how these promote our vulnerabilities.²² (footnotes omitted)

While the complex social, economic and cultural interactions on roads are a 'normal' part of our existence, the injuries and harms that are seamlessly produced by these activities are not. To reduce the damage arising out of the use of roads will require 'probing our social structure and culture to see how these promote our vulnerabilities'.²³

The current approaches to determining liability of statutory authorities fail to recognise the complexity of the problem of governance that those authorities face as they seek to identify risks of harm and comprehend the appropriate kind of governance needed to reduce or manage those risks of harm. The problem of identifying the right kind of governance is crucial because this may require statutory authorities to develop systems of networked governance with other public bodies, private organisations and communities.²⁴ These

¹⁷ See generally Harlow, above n 16, 1-9; Mark Aronson, 'Government Liability in Negligence' (2008) 32 *Univ of Melb Law Rev* 46. See also Law Commission, *Administrative Redress: Public Bodies and the Citizen*, Consultation Paper No 187 (2008) 54-99.

¹⁸ Harlow, above n 16, 10-22,

¹⁹ Harlow, above n 16, 22-30; Stapleton, above n 16, 130-134.

²⁰ Harlow, above n 16, 22, quoting Patrick Atiyah, *The Damages Lottery* (1997), 139.

²¹ *Ibid*, 85-86.

²² Charles Perrow, *The Next Catastrophe*, above n 3, 3.

²³ *Ibid*.

²⁴ Multiple levels of interdependent regulation can be described as a form of 'networked governance', see Christine Parker, Colin Scott, Nicola Lacey and John Braithwaite, 'Introduction' in *Regulating Law*,

networks have the potential to alter the conditions that produce accidents by changing the ways in which individuals and communities use roads. In recognising the magnitude of this task, tort law can probe existing systems of governance to reveal the ways that the failure of statutory authorities to develop these capacities promotes 'our vulnerabilities' to harm. The failure to identify the complexity of the problem of governance may mean that tort law not only loses the opportunity to have a role in probing our vulnerabilities, but may actually impede the emergence of networked systems of governance that are needed to improve safety.

The article is made up of three parts. The first part outlines some of the organisational capacities that statutory authorities and other bodies responsible for roads will have to develop to improve safety. The second part evaluates how well the law of tort accommodates emergent systems of regulation and the concept of an organisational accident. The third part proposes a way of fashioning a concept of fault that accommodates the complexity of the problem of governance in improving safety.

What is a safety system?

The goal of improving safety is a complex problem for organisations and for governments. As Professor James Reason recounts,

Some years ago, I heard a newly appointed director of safety announce that safety management was not rocket science. And he was absolutely right. Rocket science is trivial compared to the complexities and difficulties that confront those charged with assuring that their operational risks are *kept as low as reasonably practicable* (the ALARP principle) while *still staying in business* (the ASSIB principle). ALARP without ASSIB would be relatively easy: it is trying to achieve both of those things at same time that is so hard.²⁵

Safety and the application of the ALARP principle require managers to reach an appropriate balance between the risks and hazards that are part of the production process and the defences that are designed to intervene between these 'local hazards and their potential victims'.²⁶

Organisations responsible for delivering goods and services face the task of navigating through 'safety space' as they weigh up the cost of introducing defensive measures that are designed to intervene between the production processes and the risk of harm generated by those processes. At one end of the spectrum organisations face a high potential for catastrophe when the defences are inadequately maintained in the face of apparent dangers created by productive operations. At the other end of the spectrum are organisations that face bankruptcy because the costs of defending against the dangers created by productive operations are so high that the organisation cannot survive. The principle of keeping risks as low as reasonably practicable (the 'ALARP' principle) describes a point of balance between meeting production goals and providing acceptable levels of defence. This is the point at

above n 16, 6-7. John Braithwaite, *Regulatory Capitalism*, above n 13, 1 97-100, (drawing on the concept of 'nodal governance').

²⁵ James Reason, 'Foreword' in Bill Runciman, Alan Merry and Merrilyn Walton, *Safety and Ethics in Healthcare, A Guide to Getting it Right* (2007), xiii.

²⁶ Reason, *Managing the Risks of Organisational Accidents*, above n 4, 3.

which an organisation is able to carry on its business profitably while at the same time exposing stakeholders to acceptably low levels of risk of harm.²⁷

Navigating through this 'safety space' is a complex organisational problem. Safe operations 'generate a constant – and hence relatively uninteresting – non-event outcome'.²⁸ The goal of improving safety is one of creating a 'dynamic non-event'. Organisations with this aim direct attention to the problem of preventing the occurrence of accidents. Thus 'prevention' of harm entails a different conception of accidents than the "blame and shame" model. This latter model identifies individual error as the cause and seeks to identify 'unsafe acts' or 'active failures' by particular individuals. Measures to prevent these individual accidents will 'include 'fear appeal' poster campaigns, rewards and punishments (mostly the latter), unsafe act auditing, writing another procedure (to proscribe the specific unsafe acts implicated in the last adverse event), retraining, naming, blaming and shaming'.²⁹ In contrast, a framework built around prevention of harm involves a transition from this individuated analysis of accidents, based on 'unsafe acts,' into 'organisational accidents'.³⁰ Organisational accidents 'have multiple causes involving many people operating at different levels of their respective companies'.³¹ Unlike individual accidents, 'organisational accidents' are the result of the interaction of complex systems with 'latent conditions'.

Latent conditions are to technological organisations what resident pathogens are to the human body. Like pathogens, latent conditions – such as poor design, gaps in supervision, undetected manufacturing defects or maintenance failures, unworkable procedures, clumsy automation, shortfalls in training, less than adequate tools and equipment – may be present for years before they combine with local circumstances and active failures to penetrate the system's many layers of defences.³²

Systems of governance and regulation that are aimed at improving safety are concerned with removing or altering the latent conditions in ways that make production processes more resilient and less vulnerable to unsafe acts. Unsafe acts that include 'momentary inattention, misjudgement, forgetting, misperceptions and the like, are often the least manageable part of a contributing sequence that stretches back in time and up through the levels of the system'.³³ These unsafe acts are often unpredictable, but the 'latent conditions that give rise to them are evident before the event'.³⁴ While it is not possible to remove the potential for individual error, it is possible to change working conditions to make unsafe acts less likely and easier to remedy.³⁵

²⁷ Ibid, 3-4, 175-180.

²⁸ Reason, *Managing the Risks of Organisational Accidents*, above n 4, 37.

²⁹ Reason, *The Human Contribution*, above n 3, 72.

³⁰ Reason, *Managing the Risks of Organisational Accidents*, above n 4, 1-20.

³¹ Ibid, 1.

³² Ibid, 10.

³³ Reason, *The Human Contribution*, above n 3, 76.

³⁴ Ibid.

³⁵ Ibid.

Systems of regulation or governance that are aimed at preventing harm therefore involve a complex and multi-dimensional understanding of how unsafe acts and latent conditions can combine to produce accidents.

Organisational accidents are difficult events to understand and control. They occur very rarely and are hard to predict and foresee. To the people on the spot, they 'happen out of the blue'. Difficult though they may be to model, we have to struggle to find some way of understanding the development of organisational accidents if we are to achieve any further gains in limiting their occurrence.³⁶

One of the goals of a system of regulation or governance is to encourage the development and creation of the organisational capacities needed to reduce the risk of organisational accidents.³⁷

Safety, governance, and organisational capacities

Effective safety management is a very active process. It involves actively navigating through this safety space. In order to do this:

[M]anagers must understand the nature of the forces acting upon the organization, as well as the kinds of information needed to fix their current position. To reach the target region and then stay there, two things are necessary: an internal 'engine' to drive the organization in the right direction, and 'navigational aids' to plot their progress.³⁸

There are three 'vital ingredients' that give the safety engine both traction and the capacity to move the organisation into that area of safety space where the risks of harms are kept as low as reasonably practicable. These are commitment, competence and cognizance. Understanding of the ingredients of this safety engine reveals how current systems of governance place real limits on the capacity of governments, regulators and organisations to improve safety. The following account underscores this point as a means of avoiding glib assertions about both the need to develop safe systems, and the potential for a system of liability to induce statutory authorities to develop such systems.³⁹

Commitment means two things – motivation and resources. It is extremely difficult for organisations to maintain a commitment to safety over a long period. It is for this reason that 'a culture of safety' is important because this culture will outlive particular changes in management style and vision. Resources here refer to both the quality and quantity of money and human resources, and 'has to do with the calibre and status of the people assigned to direct the management of system safety'.⁴⁰

In addition to motivation, organisations must have technical competence:

³⁶ Reason, *Managing the Risks of Organisational Accidents*, above n 4, 1-2.

³⁷ Reason, *The Human Condition*, above n 3, 107-127.

³⁸ Ibid, 112.

³⁹ Harlow, above n 15, 22-26.

⁴⁰ Ibid, 113. See also Susan Silbey, above n 117.3.

Competence is very closely related to the quality of the organization's safety information system. Does it collect the right information? Does it disseminate it? Does it act upon it?⁴¹

Some indicators of good safety performance for organisations are commitment from senior management to safety and the possession of a good safety information system.⁴²

Finally, organisations need to be cognisant of the dangers that threaten their operations. This cognisance is threatened by two different but related phenomena. First, there is the tendency for those at the top of the organisation to blame accidents and safety lapses on those who operate at the 'sharp end' of the production process. This is notwithstanding the knowledge that for the most part those at the sharp end are following established procedures and working with the equipment they have been given. Secondly, there is the tendency for middle level managers and those at the sharp end to bureaucratise safety; that is, to believe that adopting specified processes will necessarily produce safe outcomes. Cognisant organisations:

[U]nderstand the true nature of the 'safety war'. They see it for what it really is – a long guerrilla struggle with no final conclusive victory. For them, a lengthy period without a bad accident does not signal the coming of peace. They see it, correctly, as a period of heightened danger and so reform and strengthen their defences accordingly.⁴³

Managers in cognisant organisations approach the problem of improving safety in a state of 'chronic unease'.

Studies of high-reliability organisations – systems having fewer than their 'fair share' of accidents – indicate that the people who operate and manage them tend to assume that each day will be a bad day and act accordingly.⁴⁴

There are therefore several different capacities which organisations must develop in order to support effective safety systems. There is a culture of safety: technically competent and able people managing safety and effective safety information systems. Then there is a continuing 'chronic unease' that should afflict all managers and employees, but particularly senior management about the risk of harm generated by the organisation's activities.

This overview of the nature of safety and of the capacities that organisations need in order to navigate through safety space is an indication of the magnitude of the problem facing statutory authorities who are responsible for designing, building and maintaining roads. In addition to providing road systems that meet the expectation of the various stakeholders who use them, these statutory authorities must develop and maintain safety systems. In order to design, build and maintain roads that are both effective and safe these authorities will have to develop a number of sophisticated organisational capacities. These include the capacity to collect and analyse information about the cost to the community of injuries arising out of the use of roads, the capacity to manage a risk management system that allows a statutory authority to give priority to the most immediate and significant risks of harm, and finally the

⁴¹ Reason, *Managing the Risks of Organisational Accidents*, above n 4,113.

⁴² Ibid.

⁴³ Ibid,114.

⁴⁴ Ibid.

capacity to monitor the effectiveness of the steps taken to reduce the risk of harm to road users.

In building and developing a 'safety engine' these authorities will need to establish a commitment to safety that is clearly expressed and supported by adequate resources. This is difficult for statutory authorities that face multiple, competing claims from their stakeholders – including those who provide funds to the authority, those who ride bikes, drive cars and trucks, those who carry on business near roads, those who conduct recreational activities on roads and pedestrians. Statutory authorities will have to develop the technical competence to build and maintain complex information systems and the risk management systems that make use of this information. Finally, these statutory authorities will need to facilitate and support a culture where managers and employees diligently maintain a state of 'chronic unease' about the dangers associated with roads.

How does tort integrate fault and safety?

Tort law is a system of law framed around a concept of fault that is concerned with a focus on 'active failures' and 'unsafe acts' at the sharp end of organisational processes. The challenge for tort law is to fashion a concept of fault that is relevant to, and consistent with, the obligation of statutory authorities to develop the systems of governance to prevent organisational accidents. The problem for tort is to fashion a concept of fault, or wrongful conduct that clearly differentiates between circumstances where a statutory authority is liable for harm and circumstances where the authority has failed to prevent the occurrence of the organisational accident. The imperative to find a principled distinction between fault and a failure of governance to prevent harm arises because in many instances a plaintiff will sustain harm in a context in which the statutory authority has failed to develop even the rudiments of the systems of governance. It is the need to distinguish between fault and regulatory failure that gives tort law the opportunity to probe the failures in the systems of governance that render all of us who use roads vulnerable to harm.

There are two elements of the tort of negligence that can be used to fashion a concept of fault applicable to the failure of statutory authorities to prevent harm. A statutory authority may not be subject to a duty to exercise reasonable care to alleviate the particular risk of harm. This is characterised as an omission or a failure to prevent harm in circumstances where a statutory authority had a broadly based public law obligation or power to prevent that harm. This is distinguished from a finding that the statutory authority has not breached its duty of care.

Duty of care

In applying the law of tort to statutory authorities that are responsible for designing, building, maintaining and managing roads, courts are acutely aware of the need to accommodate the competing interests of all those who have an interest in proper functioning of a system of roads. In *Hughes v Hunters Hill Municipal Council* Mahoney A-P described these competing interests as:

[T]he cost to the community (or the responsible portion of it) for maintaining highways, the allocation of priorities for expenditure of public moneys, and the interests of individuals in safe use of those highways. To require expenditure sufficient to remove

most if not all risks would be too extreme; to abandon citizens to hazardous road conditions also would be unacceptable.⁴⁵

It is the awareness of the need to accommodate these competing interests that requires tort law to differentiate between fault giving rise to liability for harm and a failure of a statutory authority to implement a system of governance to prevent harm to those who use roads.

The approach to this problem in the United Kingdom is to limit the scope of a statutory authority's duty to exercise reasonable care to prevent harm to those who use roads. The mechanism for limiting the duty of care is to characterise safety as form of public benefit that a statutory authority has a broadly defined public law duty to provide. In *Gorringe v Calderdale Metropolitan Borough Council* this was a duty to 'maintain a highway'.⁴⁶ When safety is characterised as a form of public benefit that a statutory authority has the power to bestow upon the public, the failure to prevent harm can be characterised as an omission, that is, as a failure to act. The circumstances in which tort law recognises affirmative duties of care are very limited.⁴⁷ In *Gorringe* Lord Hoffman stated that:

Speaking for myself, I find it difficult to imagine a case in which a common law duty can be founded simply upon the failure (however irrational) to provide some benefit which a public authority has power (or a public law duty) to provide.⁴⁸

His Lordship concluded by stating that:

[I]n this case the council is not alleged to have done anything to give rise to a duty of care. The complaint is that it did nothing. Section 39 is the sole ground upon which it is alleged to have had a common law duty to act. In my opinion the statute could not have created such a duty.⁴⁹

Lord Hoffman acknowledged that it would be in the public interest for local authorities to take steps to promote road safety. However his Lordship argued that the recognition of the public interest in improving safety was not a reason for recognising a private law duty to bestow the benefit of safety:

Of course it is in the public interest that local authorities should take steps to promote road safety. And it would be unwise of them to assume that all drivers will take reasonable care for their own safety or that of others ... But the public interest in promoting road safety by taking steps to reduce the likelihood that even careless drivers

⁴⁵ *Hughes v Hunters Hill Municipal Council* (1992) 29 NSWLR 232, 236 quoted in *Brodie v Singleton Shire Council* (2001) 206 CLR 512, 542 (Gaudron, McHugh and Gummow JJ) ('*Brodie*').

⁴⁶ *Gorringe v Calderdale Metropolitan Borough Council* [2004] 1 WLR 1057 ('*Gorringe*'), *Highways Act 1980* (UK) s.41

⁴⁷ *Stovin v Wise* [1996] AC 923, 931-935 (Lord Nicholls of Birkenhead), 943-944 (Lord Hoffman). See also *Mitchell v Glasgow City Council* [2009] 2 WLR 481, 488-491 (Lord Hope of Craighead), 496-498 (Lord Scott of Foscote), 501-503 (Lord Rodger of Earlsferry), 506-507 (Baroness Hale of Richmond), 507-509 (Lord Brown of Eaton-under-Heywood). For an example of the rejection of the existence of a police officer's affirmative duty to exercise reasonable care to prevent a person from taking their own life, see *Stuart v Kirkland-Veenstra* (2009) 254 ALR 432.

⁴⁸ *Gorringe* [2004] 1 WLR 1057, 1067. This proposition was supported 1059 (Lord Steyn), 1077-78 (Lord Scott of Foscote), 1084 (Lord Rodger of Earlsferry), 1086-87 (Lord Brown of Eaton-Under-Heywood).

⁴⁹ *Gorringe* [2004] 1 WLR 1057, 1070.

will have accidents does not require a private law duty to a careless driver or any other road user.⁵⁰

This definition of the scope of the duty of care for statutory authorities creates a clear boundary between the factors that are relevant in determining the existence of a duty of care and the nature and extent of a statutory authority's obligation to take steps 'to promote road safety'.⁵¹

The obligation of statutory authorities to design, build, maintain, and manage roads is framed by the reference to the obligation of road users to exercise reasonable care for their safety. Lord Scott of Foscote stated that:

But an overriding imperative is that those who drive on public highways do so in a manner and at a speed that is safe having regard to such matters as the nature of the road, the weather conditions and the traffic conditions. Drivers are first and foremost themselves responsible for their own safety.⁵²

Recognizing that a statutory authority is entitled to rely on the expectation that drivers, and other road users will use reasonable care for their own safety limits the liability that is imposed on statutory authorities for failing to prevent harm. This approach is particularly concerned to ensure that tort law does not impose unreasonable burdens on statutory authorities as they carry out their obligations to design, build, maintain, and manage roads.⁵³ This concern about the potential for liability imposed by tort law to have adverse and unintended consequences on how statutory authorities fulfil their obligations is one that applies to many areas of regulation.⁵⁴

Defining the scope of the liability of statutory authorities is explicitly designed to insulate the courts from *any* consideration of the capacity of those authorities to implement the systems of governance needed to improve safety. Where there is no duty of care, there is no obligation on the defendant statutory authority to adduce evidence about the steps taken by the statutory authority to prevent harm.⁵⁵ It is the clear intention of the House of Lords to limit the length and complexity of litigation of proceedings brought against statutory authorities. This is despite a finding by Potter LJ in *Gorringe* in the Court of Appeal that at the trial,

[T]he judge justifiably found that, while there was an adequate and rational policy in respect of the long-term improvement of stretches of road, there was a total absence of any policy, and indeed no consideration had been given, in respect of measures for the

⁵⁰ *Gorringe* [2004] 1 WLR 1057, 1068.

⁵¹ *Ibid.*

⁵² *Gorringe* [2004] 1 WLR 1057, 1079. See also 1068 (Lord Hoffman), 1085 (Lord Rodger of Earlsferry),

⁵³ *Gorringe* [2004] 1 WLR 1057, 1067 (Lord Hoffman). See generally, Stapleton, above n 16, 122-134.

⁵⁴ For the impact of liability in tort on some aspects of police work, see *Chief Constable of the Hertfordshire Police v Van Colle* [2008] 3 WLR 593, [74]-[76] (Lord Hope of Craighead), [102] (Lord Phillips of Worth Matravers), [108] (Lord Carswell), [130]-[132] (Lord Brown of Eaton-under-Heywood). For the impact of tort law on a local authority responsible for public housing, see *Mitchell v Glasgow City Council* [2009] 2 WLR 481, 493-494 (Lord Hope of Craighead), 504-505 (Lord Rodger of Earlsferry), 509 (Baroness Hale of Richmond).

⁵⁵ *Gorringe* [2004] 1 WLR 1057, 1067 (Lord Hoffman), 1079 (Lord Scott of Foscote).

short-term alleviation of obvious dangers by inexpensive signage on an interim basis pending long-term road improvement measures.⁵⁶

By ignoring the failure of statutory authorities such as the one in *Gorringe* to develop the organisational capacities needed to support safety, the House of Lords insulates tort law from any need to recognise the vulnerabilities of all road users to harm arising out of unsafe design or maintenance or management of roads.

Breach of duty

In contrast to the approach in the United Kingdom, in Australia there is more likely to be consideration of whether a statutory authority has breached its duty of care. In *Brodie v Singleton Shire Council* the Australian High Court rejected the existence of a special immunity for roads authorities. Chief Justice Gleeson characterised the special rule applying to highway authorities in the following way:

The essence of the rule is that a highway authority may owe to an individual road user a duty of care, breach of which will give rise to liability in damages, when it exercises its powers, but it cannot be made so liable in respect of a mere failure to act.⁵⁷

In *Brodie*, the High Court in a majority decision abolished the 'highway rule'.⁵⁸ Justices Gaudron, McHugh and Gummow in a joint judgment framed the duty of care of statutory authorities in the following way:

Authorities having statutory powers ... to design or construct roads, or carry out works or repairs upon them, are obliged to take reasonable care that their exercise or failure exercise those powers does not create a foreseeable risk of harm to a class of persons (road users) which includes the plaintiff. Where the state of the roadway, whether from design, construction works or non-repair, poses a risk of loss to that class of persons, then, to discharge its duty of care, an authority with power to remedy the risk is obliged to take reasonable steps by the exercise of its powers within a reasonable time to address the risk.⁵⁹

In contrast to the approach adopted by the House of Lords in *Gorringe*, this approach shifts attention to the question of whether a statutory authority has breached its duty of care:

The perception of the response by the authority calls for, to adapt the statement by Mason J in *Wyong Shire Council v Shirt*, a consideration of the various matters; in particular, the magnitude of the risk and the degree of probability that it will occur, the expense, difficulty and inconvenience to the authority in taking the steps described above

⁵⁶ *Gorringe v Calderdale Metropolitan Borough Council* [2002] RTR 446, 477, quoted in *Gorringe v* [2004] 1 WLR 1057, 1075 (Lord Scott of Foscote).

⁵⁷ *Brodie* (2001) 206 CLR 512, 527.

⁵⁸ *Brodie* (2001) 206 CLR 512, 540, 547, 577-578 (Gaudron, Gummow and McHugh JJ), 600-604 (Kirby J). The minority would have upheld the 'highway rule', 536 (Gleeson CJ), 634-636 (Hayne J), 639-643 (Callinan J).

⁵⁹ *Brodie* (2001) 206 CLR 512, 577. See also 604 (Kirby J). The dissenting speech of Lord Nicholls of Birkenhead in *Stovin v Wise* [1996] AC 923, 937-941, would have resulted in the law in England following a similar path.

to alleviate the danger, and any other competing or conflicting responsibility or commitments of the authority.⁶⁰ (footnotes omitted)

Their Honours concluded this account of the law by noting that ‘the duty does not extend to ensuring the safety of road users in all circumstances’.⁶¹

The transformation of the issue of liability of statutory authorities into one of breach of duty requires courts to fashion a concept of fault that differentiates between the obligation to exercise reasonable care and the obligation to improve safety. One approach defines fault as the failure to adopt and implement a safety system. Another approach severs the connection between the concept of fault in tort and the failure of a statutory authority to develop safety systems that could prevent harm. This latter approach fashions a concept of fault that prevents any review of a statutory authority’s organisational capacities to implement safety systems. In effect, this conception of fault insulates statutory authorities from the impact of an external review of the state of their safety systems. Legislative tort law reform rejected this approach and re-introduced a form of immunity for roads authorities for non-feasance.⁶² This aspect of tort law reform provides statutory authorities with a further layer of insulation from the possibility of being held accountable for failing to implement safety systems.

Fault and safety fused

One model of fault finds its source in the knowledge, held by statutory authorities about the risk of harm to populations of road users who are exposed to particular designs of roads or particular activities on roads. This knowledge about risk of harm is typically expressed in the form of statistics that seek to measure or estimate the likelihood of certain populations of road users sustaining particular injuries. A statutory authority can be characterised as being at fault for failing to identify, and implement a safety system to prevent this particular risk of harm. On this basis, the injury to the plaintiff is a reasonably foreseeable consequence of the statutory authority’s failure to implement that part of the safety system most closely associated with the plaintiff’s harm. In this way, the statutory authority’s act or omission that amounts to a breach of duty is the failure to implement a safety system. The decision of the Court of Appeal in New South Wales in *Royal v Smurthwaite* is a very clear example of this approach.⁶³

This case concerned an accident between two cars at an intersection that had been designed and upgraded by the Roads and Traffic Authority of NSW (the ‘RTA’) in 1993. In this case the issue was one of whether the RTA was liable for the harm sustained by the plaintiff on the ground that the poor design of the road adopted by the RTA exposed the

⁶⁰ *Brodie* (2001) 206 CLR 512, 577. These factors are also set out in legislation, see for example, *Civil Liability Act 2002* (NSW), s.5B.

⁶¹ *Brodie* (2001) 206 CLR 512, 577-578.

⁶² See for example, *Civil Liability Act 2002* NSW, s.45.

⁶³ *Royal v Smurthwaite* [2007] NSWCA 76 (*Royal*). See also the dissenting speech of Lord Nicholls of Birkenhead in *Stovin v Wise* [1996] AC 923, at 9, as an example of this approach to determining that a statutory authority breached its duty of care.

plaintiff to an increased risk of harm.⁶⁴ Justice Santow, who delivered the reasons of the majority, found that the particular intersection, which was designed and built by the RTA, was a design that was 'pregnant with avoidable risk'.⁶⁵ His Honour then found that the RTA's failure to adopt a safer design for the intersection had created a 'heightened risk of such an accident', and as a result, amounted to a breach of duty.⁶⁶

The approach taken by Justice Santow in *Royal* was to characterise the accident as an organisational accident in the sense that the court needed to look at the latent conditions that produced the accident rather than the unsafe acts of the individual drivers that were its immediate causes. The court focused on whether the RTA could have prevented the accident by taking steps that would have modified the latent conditions that produced the accident.⁶⁷ In this context, it was the RTA's knowledge of 'a statistical inevitability of a proportion of cross-vehicle crashes, as demonstrated by statistics'⁶⁸ that should have led the RTA to adopt a different design for the intersection.⁶⁹ This approach to determining whether or not the RTA was in breach of its duty of care is important in one sense. It acknowledged the long history of crashes at this intersection and the failure of the RTA to respond to this knowledge.⁷⁰

While the failure of the RTA to respond to knowledge of this pattern of accidents is significant, the concept of 'fault' fashioned in this case is too broad in its application. It focuses on the failure of the RTA to put in place a system of governance to reduce the risk of accidents at the particular intersection. It accommodates the regulatory problem of implementing systems to improve safety by using an ideal model of a safety system as the standard to determine whether the RTA breached its duty of care.

⁶⁴ *Royal* [2007] NSWCA 76, [56]-[58] (Santow J).

⁶⁵ *Ibid*, [92] (Santow J). Tobias J agreed with Santow J, [104]. Basten J dissented.

⁶⁶ *Ibid*, [85], [92] (Santow J). The High Court upheld the appeal by the RTA on the ground that Justice Santow had not established that the particular risk created by the design of the intersection, had made a material contribution to the plaintiff's harm: *RTA v Royal* [2008] HCA 19, at [30]-[34]. See also dissenting judgment of Basten J in *Royal* [2007] NSWCA 76, [155].

⁶⁷ For an example of this approach to determining the issue of breach of duty see the dissenting judgment of Kirby J in *Roads and Traffic Authority of NSW v Dederer* (2007) 234 CLR 330, 371-376. After considering the RTA's knowledge that the signs were ineffective in preventing young people from using the bridge as a diving platform Justice Kirby argued that:

The foregoing made it important that the RTA should respond to its demonstrated knowledge of the sources of risk of which it was aware by taking accident prevention measures beyond mere reliance on signs, which can never be an 'automatic, absolute and permanent panacea' for that purpose(373-374).

Justice Kirby decided that the RTA was in breach of its duty of care in not installing better signage and in not modifying the bridge to make it more difficult for young people to dive off the bridge (374-375).

⁶⁸ *Royal* [2007] NSWCA 76, [85] (Santow J).

⁶⁹ *Royal* [2007] NSWCA 76, [92] (Santow J).

⁷⁰ *Royal* [2007] NSWCA 76, [57], [87] (Santow J).

This approach does integrate the goal of regulation to improve safety with the decision about whether to impose liability for harm in tort. But, it does so in a way that avoids recognising the complexity, or the real cost, of the task of improving safety. The problem of either reducing or avoiding the risk of occurrence of such organisational accidents is a complex, multi-dimensional problem. The relevant statutory authority needs to have the capacity to identify, and then modify, the latent conditions that increase the risk of occurrence of particular accidents. But, this process requires the statutory authority to assess the significance of the risks of accidents created by a particular set of latent conditions in the light of knowledge of all the other known risks that are connected with the use of roads. In *Royal*, the RTA did not appear to have a safety system that could either identify the relevant risks of harm or keep those risks as low as reasonably practicable.

The result is that liability is imposed on statutory authorities where they do not have the systems and capacities needed to prevent accidents or to reduce the risk of harm. The transformation of the absence of appropriate safety systems into an act or omission that is a breach of duty to exercise reasonable care imposes a form of strict liability. Imposing strict liability leads courts to make decisions to allocate resources that the legislative and executive arms of government would make in the ordinary course of political processes. The result is that courts make decisions that allocate the 'the share of collective goods ... to individuals for their personal use' without any reason to believe that the decision will facilitate improvements in the capacity of statutory authorities to prevent harm.⁷¹ Finally, and perhaps more importantly, this approach fails to provide any way of recognising the magnitude of the problem of governance in improving safety. It gives the impression that individual statutory authorities are at fault whereas the problem of safety is a complex problem which is broader and deeper than this simple characterisation would indicate.

Fault and safety severed

A second and equally problematic approach for deciding whether a statutory authority is liable for failing to prevent harm relies on a different analysis of the breach of duty to exercise reasonable care. This approach determines whether a statutory authority is in breach of duty without reference to the question of whether or not the statutory authority has developed the capacities needed to implement a safety system. This approach allows a court to sever the connection between the duty to exercise reasonable care to alleviate a foreseeable risk of harm and *any* consideration of whether the statutory body has implemented safety systems to prevent the occurrence of that harm. This approach also enables courts to avoid the complexity of the problem of implementing safety systems to prevent harm. This is the approach taken by the majority of the High Court in *Roads and Traffic Authority of NSW v Dederer*.⁷²

On the 31st of December 1998 Philip Dederer, a boy aged 14 years and six months of age, dived 8.5 meters into the water channel below the Foster-Tuncurry Bridge in NSW. Mr Dederer hit the bottom of the channel and was as a result rendered a partial paraplegic.⁷³

⁷¹ Harlow, above n 16, 85-86.

⁷² *Roads and Traffic Authority of NSW v Dederer* (2007) 234 CLR 330 ('*Dederer*').

⁷³ *Dederer* (2007) 234 CLR 330, 357 (Kirby J).

The Roads and Traffic Authority of NSW (the 'RTA') was responsible for maintaining the Foster-Tuncurry Bridge. Maintenance work on the bridge was shared with the Greater Lakes Shire Council (the 'Council') but the cost of capital works on the bridge was the responsibility of the RTA. Sometime in the 1980's 'no-diving' pictograms had been placed on the bridge. In 1995 the Council had replaced these pictograms using funds provided by the RTA.⁷⁴ The RTA had knowledge about young people jumping and diving off the bridge after the 'no-diving' pictograms were first installed and after they were replaced by the Council in 1995.⁷⁵ The RTA took no further action of any kind to stop young people diving off the bridge.⁷⁶ The issue for the High Court in *Dederer* was whether the failure of the RTA to take steps to prevent Mr Dederer using the bridge as a diving platform, in the light of its knowledge that young people continued to dive off the bridge after the installation of the 'no-diving pictograms', amounted to a breach of its duty of care to Mr Dederer.

The missing dimension of safety

The practice of young adults diving off the Foster-Tuncurry Bridge was known to all parts of the community. Justice Kirby stated in his judgment:

Discovery prior to suit, and evidence otherwise given during the trial, established for a long time, probably soon after the bridge was opened in 1959, it came to be used by young people as a *de facto* point of entry into the water channels.⁷⁷

The Council admitted that it was aware that children jumped and dived off the bridge. Indeed, a senior council officer gave evidence that he was not only aware of the practice but that he had 'actually remonstrated with his own children for jumping off the bridge'.⁷⁸ The Council had informed the RTA that young people were using the bridge to jump into the water in 1993.⁷⁹ Local police were also aware of, and had made some unsuccessful attempts to, stop the practice.⁸⁰ The RTA admitted that it had been aware that young people were jumping off the bridge.⁸¹ Although the RTA made no admission that it was aware of children diving from the bridge, a majority of the High Court found that the practice was reasonably foreseeable by the RTA.⁸² Finally, it seems very likely that the broader community in Foster-Tuncurry was aware of this practice.

Despite knowledge of this practice and concern for the safety of the young people diving off the bridge, none of these agencies, or any community organisations, were able to take any

⁷⁴ *Dederer* (2007) 234 CLR 330, 339 (Gummow J), 359 (Kirby J).

⁷⁵ *Dederer* (2007) 234 CLR 330, 339, 354-355 (Gummow J), 360-361 (Kirby J), 406 (Callinan J).

⁷⁶ *Dederer* (2007) 234 CLR 330, 361-363 (Kirby J).

⁷⁷ *Dederer* (2007) 234 CLR 330, 360, [95] (Kirby J).

⁷⁸ *Ibid*, 361, [99] (Kirby J).

⁷⁹ *Ibid*, 361-362, [100]-[101] (Kirby J).

⁸⁰ *Ibid*, 391-392, [232]-[235] (Callinan J).

⁸¹ *Ibid*, 360, [94] (Kirby J).

⁸² *Ibid*, 337, [15] (Gleeson CJ agreed with Kirby J), 354-355, [70] (Gummow J), 367, [118] (Kirby J), 406, [272] (Callinan J), 408, [283] (Heydon J agreed with Gummow J).

effective steps to stop it, or to reduce the risks associated with it. The RTA had no capacity to respond to the risks associated with diving off the bridge by implementing strategies to reduce the number of young people engaging in it. The trial judge found that:

[T]he RTA has no policy or programme for dealing with this type of issue, and there is no funding allocated for such an issue.⁸³

The Council and the Police had each made some desultory attempts at enforcing the 'no diving' restriction but without any success. A council ranger had found, after several efforts to catch and remonstrate with young people jumping off the bridge, that the restriction was 'just unenforceable'.⁸⁴ Indeed at various times both the Council and the Police had drawn each other's attention to the practice without being able to develop a successful strategy to stop it.⁸⁵

It is therefore abundantly clear that the RTA and the other public authorities had failed to develop even the rudiments of an effective safety system to deal with the problem of using the bridge as a diving platform. More generally, the RTA lacked the organisational capacity to develop a safety system to respond to unsafe practices that arise out of opportunistic and perhaps unauthorised uses of roads and bridges. The RTA had no information about the nature or extent of the risks generated by opportunistic uses of the road. It had no capacity to assess the costs or benefits of taking steps to reduce or eliminate those risks.⁸⁶ Finally, the RTA had no capacity to coordinate its role in reducing risks associated with emergent activities with other public authorities or community groups.⁸⁷

Insulating tort from safety

In the Court of Appeal the appeal brought by Mr Dederer was successful on the grounds that the RTA had failed to take steps to reduce these risks. The basis of this argument was that the RTA was aware of the risk of harm created by young people and that it had failed to take any measures to prevent the use of bridge as a diving platform.⁸⁸ In particular, the RTA had failed to improve the signs warning of the risks of diving⁸⁹ or to make relatively inexpensive modifications to the bridge to make access to the bridge for young people more difficult.⁹⁰ It

⁸³ Ibid, 363, [108] (Kirby J).

⁸⁴ Ibid, 392, [235] (Callinan J).

⁸⁵ Ibid, 391-392, [231]-[235] (Callinan J).

⁸⁶ See eg, Raymond Cripps, 'Australian Spinal Cord Injury, 2006-2007' (Injury research and statistics series: number 48), 24. (In the period 2006-2007 there were 21 cases of severe spinal cord injury in Australia that were associated with water. Eight cases involving complete injuries to the spinal cord involved diving into shallow water).

⁸⁷ *Great Lakes Shire Council v Dederer* [2006] NSWCA 101, [362]-[368] (Tobias JA).

⁸⁸ *Great Lakes Shire Council v Dederer* [2006] NSWCA 101, [46]-[50] (Handley JA, dissenting), [301]-[307] (Ipp JA), [368] (Tobias JA).

⁸⁹ *Great Lakes Shire Council v Dederer* [2006] NSWCA 101, [236]-[251], [304]-[307] (Ipp JA), [361]-[368] (Tobias JA).

⁹⁰ *Great Lakes Shire Council v Dederer* [2006] NSWCA 101, [252]-[267], [304]-[307] (Ipp JA), [361]-[368] (Tobias JA).

was an important part of the decision of the Court of Appeal that the RTA failed to take either of these steps despite the knowledge that the existing warning signs were completely ineffective.⁹¹ In this sense the approach adopted by the Court of Appeal was to find that the RTA was in breach of its duty of care because it failed to implement part of a safety system. This is the approach taken by a differently constituted Court of Appeal in *Royal v Smurthwaite*.⁹²

The High Court found that the RTA had not breached its duty of care to the plaintiff.⁹³ Justice Gummow framed the RTA's duty to exercise reasonable care with reference to that class of people who were taking reasonable care in their use of the bridge:

The RTA's duty of care was owed to all users of the bridge, whether or not they took ordinary care for their own safety; the RTA did not cease to owe Mr Dederer a duty of care merely because of his own voluntary and obviously dangerous conduct in diving from the bridge. However, the extent of the obligation owed by the RTA was that of a roads authority exercising reasonable care to see that the road is safe 'for users exercising reasonable care for their own safety'.⁹⁴

By characterising the duty to exercise reasonable care with reference to those users who take reasonable care for their safety, Justice Gummow was able to distinguish between a duty to exercise reasonable care and the RTA's failure to develop the capacity to prevent the harm sustained by Mr Dederer. The duty to exercise reasonable care to alleviate the risk of foreseeable harm to the plaintiff required the RTA to take steps to alleviate the risk that careful users of the bridge would sustain harm. By implication, a sign warning of the risks of harm associated with diving would alleviate the risks because those exercising reasonable care for their own safety would follow the instructions on the sign.⁹⁵

In contrast, the majority of the Court of Appeal had reasoned that the RTA had breached its duty of care by failing to take steps to reduce the risk of diving off the bridge once it became aware of the apparent failure of the existing warning signs to stop its occurrence.⁹⁶ Justice Gummow argued that:

The error in that approach lies in confusing the question of whether the RTA failed to prevent the risk-taking conduct with the separate question of whether it exercised reasonable care. If the RTA exercised reasonable care, it would not be liable even if the risk-taking conduct continued.⁹⁷

⁹¹ *Great Lakes Shire Council v Dederer* [2006] NSWCA 101, [215]-[220] (Ipp JA), [354], [364]-[368] (Tobias JA).

⁹² See above text accompanying nn 63-70.

⁹³ *Dederer* (2007) 234 CLR 330, 337 (Gleeson CJ, dissenting), 356 (Gummow J), 379 (Kirby J, dissenting), 408 (Callinan J), 408 (Heydon J).

⁹⁴ *Dederer* (2007) 234 CLR 330, 346, quoting from *Brodie v Singleton Shire Council* (2001) 206 CLR 512, 518.

⁹⁵ *Dederer* (2007) 234 CLR 330, 346, [79] (Gummow J).

⁹⁶ *Dederer* (2007) 234 CLR 330, 349, [53] (Gummow J).

⁹⁷ *Dederer* (2007) 234 CLR 330, 349, [54] (Gummow J).

Whereas the Court of Appeal focused on the obligation to reduce the known risk of harm to those diving off the bridge, Justice Gummow focused on the RTA's lack of control over the practice of diving.

However in the present case the RTA did not create the risk of shallow water of variable depth, nor did it exhort or encourage young people to dive from the bridge.⁹⁸

Justice Gummow proceeded to apply the elements of the calculus of negligence.⁹⁹ After finding that the injury to Mr Dederer was reasonably foreseeable,¹⁰⁰ His Honour assessed the probability of the occurrence of harm. Justice Ipp in the Court of Appeal had focused on the risk of harm by focusing on the large numbers of young people diving off the bridge.¹⁰¹ In contrast, Justice Gummow focused on the probability of the occurrence of the injury, that is, the probability of those diving sustaining injuries of the kind suffered by Mr Dederer. On this point Justice Gummow argued that as Mr Dederer's injury was the first of its kind since the building of the bridge that probability must be 'very low'.¹⁰² Justice Gummow did not refer to any evidence about the prevalence of jumping or diving off the bridge and did not refer to any assessment of the probability that diving from the bridge would be productive of serious harm. On the basis of the very low probability of harm His Honour then considered the costs of remedial action that the RTA could have taken to reduce the risk of injury. Justice Gummow stated that it was unreasonable to require the RTA to erect further signs or to make modifications to the bridge,¹⁰³ and that these steps would, in any event, have had little utility in preventing the Mr Dederer's injury.¹⁰⁴

The duty to exercise reasonable care to alleviate the risk of reasonably foreseeable harm is thus narrowed down to those matters that were within the immediate control of the RTA. The majority of the High Court was able to sever the connection between liability in tort and the complexity of the problem of implementing systems of governance that were needed to 'promote traffic safety'.¹⁰⁵ This analysis excluded any consideration of the failure of the RTA to implement a safety system and of the complexity of the problem of implementing any such system. The implementation of such a safety system would have involved the RTA

⁹⁸ *Dederer* (2007) 234 CLR 330, 352, [64] (Gummow J).

⁹⁹ *Dederer* (2007) 234 CLR 330, 353-355 (Gummow J), 408 (Heydon J), 406-408 (Callinan J), applying *Shirt v Wyong Shire Council* (1980) 146 CLR 40, 48-48.

¹⁰⁰ *Dederer* (2007) 234 CLR 330, 354-355, [70] (Gummow J).

¹⁰¹ *Great Lakes Shire Council v Dederer* [2006] NSWCA 101, [212]-[214] (Ipp JA), [353]-[356], (Tobias JA).

¹⁰² *Dederer* (2007) 234 CLR 330, 351, [61] (Gummow J), 407, [274] (Callinan J). Compare Reason above text accompanying nn 28-32, where the non-occurrence of an accident in a system of production is no basis for inferring that the system will continue in a safe state.

¹⁰³ *Dederer* (2007) 234 CLR 330, 355, [72] (Gummow J), 407-408, [274]-[278] (Callinan J). The proposed modifications to the bridge were of the order of \$268,000: *Great Lakes Shire Council v Dederer* [2006] NSWCA 101, [304] (Ipp JA).

¹⁰⁴ *Dederer* (2007) 234 CLR 330, 356, [78] (Gummow J).

¹⁰⁵ *Transport Administration Act 1988* (NSW), s.52A. See also Roads and Traffic Authority of New South Wales ('RTA'), *Annual Report* (2008) 4.

developing networks of governance with other public authorities and with community groups.¹⁰⁶ The aim of developing such a governance network would have been to form a community of interest around the use of the bridge. Such a community could have implemented an integrated strategy that would have involved each member of the network taking coordinated steps to reduce the number of young people diving off the bridge. In effect, Justice Gummow formulated the RTA's duty to exercise reasonable care in a way that facilitated the failure of the RTA to implement a governance network to improve safety.

Tort reform

In February 2001 Maria Roman stepped into a pothole on Princes St in McMahons Point in the municipality of North Sydney.¹⁰⁷ When she fell Ms Roman injured her leg. Her injury did not fully heal because of damage to the nerves in her ankle. Ms Roman's damages were calculated by the trial judge to be \$475,485. Ms Roman led evidence to show that 'the hole was about half a metre wide and about four to five inches deep'.¹⁰⁸ Ms Roman brought an action against North Sydney Council for failing to fill the pothole. The trial judge Ainslie-Wallace DCJ found that North Sydney Council had breached its duty of care to Ms Roman in two steps. The first step was a finding that the Council 'had knowledge of the hole from a time well before the plaintiff's fall and took no step to rectify it'.¹⁰⁹ The second step was that a failure to repair the pothole was a breach of duty on the grounds that there was a foreseeable risk of harm and that the costs of avoiding the harm by repairing the hole were small in contrast to the potential for harm.¹¹⁰

The primary issue in this case was not the question of whether North Sydney Council breached its duty of care but rather whether the Council could claim the benefit of the immunity provided by s.45(1) of the *Civil Liability Act* 2002. This provision stated that:

A roads authority is not liable in proceedings for civil liability to which this Part applies for harm arising from a failure of the authority to carry out road work, or to consider carrying out road work, unless at the time of the alleged failure the authority had actual knowledge of the particular risk the materialisation of which resulted in the harm.

The trial judge found that the Council was a 'roads authority' and that the Council had 'actual knowledge of the particular risk'.¹¹¹ The trial judge's reasoning did embody some confusion about when and under what circumstances the Council could be said to have 'actual knowledge of the particular risk'. However, the significant step in the trial judge's reasoning was the characterisation of the accident as an organisational accident. In particular, the trial judge reasoned that senior managers and supervisors in the council should have known of the pothole because there was an informal system in place to ensure that street sweepers would inform their supervisors once they had identified a hazard. The knowledge of the

¹⁰⁶ Braithwaite, *Regulatory Capitalism*, above n 13.

¹⁰⁷ *Roman*, (2007) 69 NSWLR 240, 243 (McColl JA).

¹⁰⁸ *Ibid*, 243, [2].

¹⁰⁹ *Ibid*, 245, [12] (McColl JA).

¹¹⁰ *Ibid*, 245-246, [13].

¹¹¹ *Ibid*, 245, [12] (McColl JA).

street sweepers about the pothole was attributed to the Council on the basis that an effective safety system would have ensured that this knowledge would have set off a train of events that would have resulted in the Council filling the pothole. On this view the Council was not able to rely on the immunity in s.45. This tracks the process of reasoning used by Justice Santow in *Royal v Smurthwaite*.¹¹²

The missing dimension of safety

The decision of the trial judge in *Roman* did not even begin to grapple with the complexity of the problem of establishing a safety system to prevent harm from the occurrence of potholes. The occurrence of a pothole on a road is a straightforward example of an organisation's productive operations exposing road users to danger. The risks of harm associated with potholes are not trivial ones to particularly vulnerable classes road users. Large numbers of older people, for example, walk as a primary mode of transportation.¹¹³ In 2005-2006 the Australian Institute of Health and Welfare reported that there were 66,894 falls of older people that resulted in hospitalisation. Of this total number, 4% or 2,897 falls occurred on a street or highway.¹¹⁴ Potholes in roads are hazards that arise out of the design, building and maintenance of roads. In *Roman* the overseer of the maintenance work gangs responsible for the maintenance of roads gave evidence that 'potholes such as the one into which the [Ms Roman] fell were expected to develop in the roadway adjacent to the face of the kerb because petrol leaking from cars onto the bitumen caused it to break up'.¹¹⁵ These hazards create the need for 'forms of protection to intervene between the local hazards and their possible victims'.¹¹⁶

Safety from the hazards created by potholes is a 'dynamic non-event' that arises out of the interaction between the hazards created by productive operations and the forms of protection that intervene between the hazard and a person who may be injured. In deciding upon the appropriate level of protection, North Sydney Council, the body responsible for the maintenance of the particular street in North Sydney, had to identify a degree of protection somewhere between one so expensive that it exposed the Council to potential insolvency and one so minimal that it created a high risk of the occurrence of catastrophic harm.¹¹⁷ This requires that a statutory body like North Sydney Council be able to determine two separate but related questions. First, what level of protection is needed in order to ensure that the risk of harm to individuals and to assets is kept as low as reasonably practical? Second, what

¹¹² See above text accompanying nn 64-66.

¹¹³ C A Gorrie and P M E Waite, 'A Survey of older pedestrians in metropolitan Sydney: walking patterns, perceptions and risk exposure' (2005), ix.

¹¹⁴ Clare Bradley and Sophie Pointer, 'Hospitalisations due to falls by older people, Australia 2005–06' (Injury and Statistics Series: Paper No.50, 2009), 3,10
www.aihw.gov.au/publications/index.cfm/title/10683

¹¹⁵ *Roman*, (2007) 69 NSWLR 240, 243-244, [8].

¹¹⁶ Reason, *Managing the Risks of Organisational Accidents*, above n 4, 3.

¹¹⁷ *Ibid*, 3-4.

forms of protection are actually in place and how effective are these systems in protecting against the hazards created by the potholes.¹¹⁸

In *Roman* the trial judge found that there was 'no system in place for inspection of the kerbs and guttering'.¹¹⁹ Council workers, including street sweepers, were required to notify the Council of any hazards including potholes. Street sweepers were given some training in an induction program to identify hazards. When street sweepers identified a hazard they were required to notify the supervisor of street cleaning who would inform the relevant part of the Council. Mr Wetherill, the supervisor of street sweepers, gave evidence that he had not seen the pothole and that it had not been reported to him. In evidence 'he opined that it was a hazard which he would have reported had he seen it. He also said he would have expected a street sweeper to report such a pothole'.¹²⁰ By the time of the trial photographs showed that the pothole had been repaired but no-one in the council had any knowledge of how or when that repair occurred.¹²¹

In brief it is clear that North Sydney Council had established a system of governance to manage the hazards created by potholes that included none of the ingredients of a 'safety engine'.¹²² The Council had no effective system of risk management to identify the risks and to put in place the appropriate level of protection. As part of this failure the Council had no system for collecting the information about the injuries or harms created by potholes. Furthermore, Council had no knowledge whatever about how effective the casual systems of inspections were in identifying hazards. Council did not assess the effectiveness of the training given to employees in identifying hazards, nor did it assess the effectiveness other supervisors and managers who responded to reports about hazards. Finally, in place of what Reason has referred to as 'chronic unease', there appeared to be a very 'casual ease' about the potential for potholes to cause harm to people or vehicles that made use of the road.¹²³

Insulating tort

In contrast to the decision of the trial judge, Justice Basten, who delivered the majority judgment, reasoned that s.45 severed the connection between the failure of the council to establish safety systems to prevent harm and the question of whether the Council should have been liable for those injuries. His Honour stated that where the Council did not have

¹¹⁸ See generally Christine Parker, *The Open Corporation: Effective Self-Regulation and Democracy* (2002), 197-245 (Chapter 8: 'The three strategies of 'permeability' in the open corporation'). This chapter describes the ways in which a compliance system can be used to induce management of a corporation to adopt measures that make the corporation responsible for meeting goals that are defined as being in the public interest. This is also applicable to a statutory authority that is endeavouring to implement systems of governance to improve safety associated with the use of roads.

¹¹⁹ *Roman*, (2007) 69 NSWLR 240, 245, [12].

¹²⁰ *Ibid*, 244, [6].

¹²¹ *Ibid*, 245, [10].

¹²² See above text accompanying nn 38-44.

¹²³ See above n 44.

systems of inspection in place the immunity in s.45 was designed to protect the Council from any liability associated with the failure to identify or report on hazards present on the roads.¹²⁴ In this sense Justice Basten argued that s.45 was designed to recognise the limited capacity of the Council to have in place a system of governance oriented to safety and then to ensure that the Council was not liable for any harm associated with that failure. Justice Basten argued that Council would only have 'actual knowledge' of the risk, where officers responsible for authorising repairs had actual knowledge of the pothole.

The section confers an immunity on a roads authority where harm arises 'from a failure of the authority to carry out road work'. The exception only arises where 'at the time of the alleged failure' the authority had actual knowledge of the particular risk. A purposive construction would require that the relevant knowledge exist in an officer responsible for exercising the power of the authority to mitigate the harm. The existence of the power is only coupled with a duty to act in circumstances where such knowledge exists. Accordingly, the knowledge must exist at or above the level of the officer responsible for undertaking necessary repairs.¹²⁵

On this basis, the street-sweepers' knowledge of the pothole could not be construed as 'actual knowledge' of the Council. This would be the case even where a street sweeper had knowledge of a defect and failed to report that defect to responsible officers in the council. Council would only lose the immunity when an officer responsible for undertaking repairs became aware of the defect.¹²⁶ The ultimate decision was that the Council was entitled to immunity in s.45 because none of the relevant supervisors or managers were aware of the pothole, or of the risk of harm created by the pothole.¹²⁷

Justice Basten was keenly aware of the counterintuitive result which his approach to s.45 yielded. He noted that:

To the extent that the potential for financial liability may be an incentive to act, and the absence of such liability a disincentive to act, it could be argued that s 45 places a premium on ignorance. However, that consideration cannot affect the proper construction of the provision, nor lead to some diminution of the requirement of actual knowledge as a precondition to liability for 'non-feasance'.¹²⁸

Justice Basten reasoned that Parliament had made the policy decision that statutory authorities responsible for building and maintaining roads should not be liable where they lacked knowledge of particular risks of harm even if they failed to implement networked systems of governance to affirmatively seek out information about sources of harm for road users.

This interpretation of s.45 has the effect of severing the connection between the failure to implement safety systems and the issue of liability for failing to prevent those harms. In this way s.45 reproduces the position in the common law prior to the decision in *Brodie*. In effect,

¹²⁴ *Roman*, (2007) 69 NSWLR 240, 267, [128] (Bryson JA agreed with Basten JA).

¹²⁵ *Roman*, (2007) 69 NSWLR 240, 273, [157] (Basten JA).

¹²⁶ *Ibid.*

¹²⁷ *Ibid.*, 278-279 [186]. Justice McColl delivered a dissenting judgment that affirmed the decision of the trial judge that the Council was not entitled to rely on the immunity in s.45.

¹²⁸ *Ibid.*, 271, [152].

safety can be characterised as a 'public benefit' and statutory authorities have no duty to exercise care by establishing effective safety systems. The characterisation of safety as a 'public benefit' draws attention away from the complexity of the problem of improving safety. It does not allow or require governments, regulators and other organisations to probe the absence of safety systems and the impact of this absence on road users. Indeed it appears to facilitate an approach to governance that ignores the risks of harm to road users that arise because of the failure to develop the organisational capacities needed to improve safety. The decision in *Roman* is a good example of this outcome. The immunity provided by s.45 facilitates an approach to governance that ignores the risks of harm to road users created by the failure to implement systems of governance to improve safety.

How can tort accommodate safety?

How then can the rules in tort law accommodate the complexity of the systems of governance that are needed to improve safety. As I have argued elsewhere, there are two criteria for judging whether a reformulation of the rules in the tort of negligence would be both legitimate and effective into in recognising the complexity of the problem of implementing safety systems.¹²⁹ First, the reformulation of the rules needs to accommodate the rationale for, and the implementation of, systems of networked governance to improve safety.¹³⁰ Second, the reformulation of the rules must be consistent with the underlying principles for determining fault or, more particularly of determining whether a defendant has breached their duty to exercise reasonable care to alleviate a risk of harm to a relevant class of plaintiffs.

There is a path by which tort law can both facilitate the emergence of the networked systems of governance needed to improve safety and retain its integrity as a body rules supported by a principled fault-based model of responsibility. This pathway is directed towards probing the systems of governance used by statutory authorities to see how they promote conditions that render all road users vulnerable to risks of harm. Probing the integrity of these systems of governance provides courts with the opportunity to open up a space for ethical and political decision-making about the need to improve safety.

This decision-making space is bounded on the one side by the recognition that statutory authorities in many instances lack the organisational capacities that are needed to support the emergence of networked systems of governance oriented to safety. It is bounded on the other side by the ethically disturbing conclusion that even the complete failure of statutory authorities to develop these organisational capacities may not amount to a failure to exercise reasonable care to alleviate foreseeable risks of harm. This is because it is impermissible for courts to use their own assessment of the effectiveness of regulatory systems in determining whether particular defendants are in breach of their duty to exercise reasonable care.

¹²⁹ Corbett, 'Regulating Compensation', above n 14 (an analysis of the capacity of law to facilitate improvements in safety and quality of health care). See also Angus Corbett, 'The (Self)Regulation of Law: A Synergistic Model of Tort Law and Regulation' (2002) 25 *UNSWLJ* 616.

¹³⁰ See for example, *Leichardt Municipal Council v Montgomery* (2007) 230 CLR 22, 33-34, [20]-[22] (Gleeson CJ, a discussion of integrating a duty of care on statutory authorities in the context of an authority's statutory responsibilities for designing, building, maintaining and managing roads).

Decisions about the effectiveness of systems or regulation, and the need to create systems, will involve judgments that are 'ordinarily decided through the political process'.¹³¹ What is important is the combination: the recognition of the failure of statutory authorities to develop the organisational capacities to support the development of necessary networked systems of governance; and the recognition that statutory authorities have a limited obligation to alleviate the risk of foreseeable harm and will not usually be liable to pay compensation for failing to prevent harm. This combination may create a space for ethical and political decision-making about orienting systems of regulation of roads towards safety and the prevention of harm.

Including safety in the calculus

The problem of determining whether particular statutory authorities are in breach of their duty of care is that there is a big divergence between the apparent costs of alleviating the risks of the accident when compared with the magnitude of the often catastrophic harm suffered by the plaintiff. This is the case in *Dederer* where the court considered whether the RTA's failure to provide better signage was a breach of its duty of care, or whether the failure to make modifications to the bridge amounted to a breach of duty. The costs of the RTA taking action to alleviate the risk of harm to the plaintiff appear to be relatively small by contrast with the catastrophic harm sustained by the plaintiff.¹³² In *NSW v Fahy* in a joint judgment Justices Gummow and Hayne addressed this problem:

In particular, arguments of the kind made, and rejected, in *Vairy* and in *Mulligan v Coffs Harbour City Council* may suggest a misunderstanding of the so-called 'calculus' that would seek to determine questions of breach in some cases by balancing the cost of a single warning sign against the catastrophic consequences of a particular accident. But the fact, if it be so, that *Shirt* has not always been applied properly does not provide any persuasive reason to reconsider its correctness.¹³³

Earlier in their joint judgment their Honours affirmed that in determining whether a defendant breached their duty of care it was important to focus on what a reasonable person would do in light of the magnitude and probability of the harm sustained by the plaintiff. They expressed the view that in some circumstances a reasonable person would do nothing.¹³⁴ Section 5B of the *Civil Liability Act* NSW 2005 requires courts to take these factors into account in determining whether a defendant is in breach of its duty of care. Each of the judges in the majority in *Dederer* followed this approach in deciding whether the RTA was in breach of its duty care.

In *Dederer*, this process for determining whether the RTA breached its duty of care is misleading and unhelpful. The decision diminished the significance of the risk of harm associated with diving by focusing on the 'very low' probability of harm to the class of

¹³¹ *Graham Barclay Oysters Pty Ltd v Ryan* (2002) 211 CLR 540, 533. See also Aronson, above n 17, 50-52, Harlow, above n 16, 1-9, 22-30.

¹³² See above nn 88-90.

¹³³ *New South Wales v Fahy* (2007) 232 CLR 486, 511, [78]. See also *Civil Liability Act* 2002 NSW, s.5B.

¹³⁴ *New South Wales v Fahy* (2007) 232 CLR 486, 506, [58] (Gummow and Hayne JJ).

plaintiffs including Mr Dederer.¹³⁵ While the probability of a serious injury of the kind sustained by Mr Dederer may have been a low one, the sheer numbers of young people using the bridge as a diving platform ensured that this use of the bridge would consistently produce a pattern of serious injuries. At the same time the focus on the 'very low' probability of harm drew attention away from the failure of the RTA to take any steps to assess or respond to the risk of harm to the young people jumping and diving off the bridge.¹³⁶ Indeed, it is possible to characterise the High Court's process of reasoning as one that contributes to a degree of casual ease about the capacity of systems of governance for managing and maintaining roads to incorporate concerns about safety. This is very different from what Professor Reason has described as a state of 'chronic unease' felt by employees in organisations with an embedded safety culture.¹³⁷

It would be far better to frame the analysis of breach of duty as one in which the failure to take steps to alleviate the risk of harm to Mr Dederer arose out of the absence of systems of governance to detect and respond to risks of harm associated with the use of roads. In this frame of reference, the costs associated with the exercise of reasonable care to alleviate harm may not be limited to the costs associated with taking steps to remedy the particular breach. In *Dederer*, where the breach of duty was defined as the failure to erect a warning sign, the costs of alleviating the risk of harm to the plaintiff were not limited to the cost of erecting a particular warning sign. Rather, the cost of erecting a warning sign included the costs of implementing a safety system that would have identified where, when and how to erect effective warning signs. The costs of alleviating the risk of harm include all the costs of implementing an effective safety system. Without these organisational capacities, which the RTA was not even aware it needed, it was not possible for the RTA to make any rational judgment about the measures that it could have, might have, or should have taken to prevent Mr Dederer's injury. In effect, the identification of the breach of duty as the failure to install better signage gives rise to the same difficulties that Justice Santow encountered in *Royal v Smurthwaite*.¹³⁸ It is to identify the failure to implement one isolated part of a safety system as the breach of duty where the absence of a larger safety system is the real problem.

If the particular breach of duty of care were framed as the failure to develop the organisational capacities needed to support a safety system, it would be possible for the courts to give a more comprehensive account of the costs of alleviating the risks of harm to the plaintiff. It would have been appropriate to assess the costs of taking action to alleviate the risk of harm by assessing the costs of implementing a networked system of governance. This would include costs of obtaining, processing and verifying information needed to identify risks of harm associated with the use of roads: the costs associated with deciding when and how to respond to particular risks of harm; and the costs associated with ensuring that the

¹³⁵ *Dederer* (2007) 234 CLR 330, 351, [59] (Gummow J), 407, [274] (Callinan J).

¹³⁶ The 'No Diving' signs that were in place at the time of the accident were erected by the Great Lakes Shire Council, *Dederer* (2007) 234 CLR 330, 338 (Gummow J), See also *Great Lakes Shire Council v Dederer* [2006] NSWCA 101,[362]-[368] (Tobias JA).

¹³⁷ See above n 44.

¹³⁸ See above nn 63-70.

steps designed to mitigate risks of harm are implemented. Finally, a full assessment of the costs would have included the costs of developing the capacity to assess whether the steps taken to mitigate risks of harm were effective.¹³⁹

This more complete assessment of the costs would have allowed the High Court in *Dederer* to avoid down-playing the risk of injury to individual plaintiffs by referring to the low probability of the occurrence of catastrophic harm to those individuals. In contrast the High Court could have referred to the actual risks of harm produced by the practice of young people diving off the bridge. In particular, it would have allowed the Court to acknowledge that though the risk to any individual young person was small, the large numbers of young people who dived off the bridge would inevitably and predictably result in the occurrence of a range of injuries, including, catastrophic injuries, to a small number those young people. Finally, reference to the costs and complexity of implementing a system of networked governance for the RTA would have allowed the Court to recognise the particular institutional and budgetary limitations placed upon the RTA.¹⁴⁰ This argument applies with equal force to the decisions in *Royal v Smurthwaite*,¹⁴¹ *Gorringe v Calderdale Metropolitan Borough Council*,¹⁴² and *Roman v North Sydney Council*.¹⁴³

This approach to accommodating complex systems of governance in tort would allow Courts to recognise that in many circumstances there are too many institutional limitations imposed on a statutory authority to allow for the development of a safety system, and that the statutory authority has none of the capacities or systems of governance needed to improve safety. Recognising the limited capacity of many statutory authorities and regulatory bodies to implement safety systems would be an invitation for governments and other organisations to investigate the ways in which social, economic and cultural practices create vulnerabilities that expose individuals, organisations and the community broadly to unsafe practices. This approach does not preclude circumstances arising in which a statutory authority is in breach of its duty to exercise reasonable care to alleviate the risks of harm on the grounds that the magnitude of the risk of harm to the plaintiff is sufficiently high and the opportunity to alleviate the risk of harm is one of the main functions of the statutory authority.

Reformulating the process for determining whether statutory authorities are in breach of their duty of care will not create a new form of immunity for statutory authorities. Rather, there are instances in which statutory authority should be found to be liable to pay compensation to a plaintiff for failing to exercise reasonable care to alleviate the risk of harm to the plaintiff. In these instances tort can recognise both the complexity of the governance problem of improving safety, and the failure of the statutory authority to implement such a system and still conclude that a statutory authority has breached its duty to exercise reasonable care to alleviate the risk of harm. The distinguishing feature of these cases is a combination of factors relevant to determining the issue of whether the authority has breached its duty of

¹³⁹ See above, 'What is a safety system?'.

¹⁴⁰ See above nn 105-106.

¹⁴¹ See above text following n 70.

¹⁴² See above text accompanying n 56.

¹⁴³ See above text accompanying nn 107-111,

care. These factors include the following: the particular risk of harm to the class of plaintiffs is significant, known to the authority and the steps to alleviate this risk are within the power of the statutory authority. A statutory authority will breach its duty of care where the risks to the class of plaintiffs is high and where the costs of alleviating the risk are reasonable in light of the magnitude of potential harm to those who may be injured. The breach of duty that will crystallise out of this bundle of factors will be closely aligned with the statutory authority's failure to implement a safety system.

A failure to prevent harm

On the 28th of August 1998, two cars travelling on the F5 freeway at 100 kph hit Ms Nicole Edson. She sustained severe injuries.¹⁴⁴ Ms Edson brought an action in negligence against the RTA for the failure to build and maintain an effective fence to restrict access to the freeway from suburbs that ran alongside the freeway. She also argued that the RTA was negligent in failing to build a walkway across the freeway to facilitate travel between the two suburbs on opposite sides of the freeway.¹⁴⁵ This latter proposition was rejected by the trial judge and not challenged by Ms Edson on appeal.¹⁴⁶ The NSW Court of Appeal unanimously found in favour of Ms Edson on the ground that the RTA had failed to build and maintain appropriate fencing along the boundary line of the freeway.¹⁴⁷

The accident in which Ms Edson was injured is an example of an organisational accident – there were multiple failures by a large number of statutory authorities and individuals. The F5 freeway is the main highway between Australia's two largest cities, Sydney and Melbourne. The point at which Ms Edson was struck by the cars on the F5 freeway was the most direct route between the suburbs of Raby and St Andrews. These were described as 'dormitory' suburbs that had been built around the 'satellite city' of Campbelltown. The suburbs of Raby and St Andrews had been built after the construction of the freeway. These suburbs were constructed around two overpasses that crossed the F5 freeway. These overpasses also carried traffic between the suburbs and connected the suburb of Raby with the City of Campbelltown. These overpasses provided pedestrian access but each also required pedestrians to walk a number of kilometres to reach the overpasses to cross the freeway. The local high school was built in Raby and had approximately 500 students. The evidence in the case suggested that the favoured location for young people to meet was in Raby and not St Andrews. There was no effective system of public transport and children in St Andrews were, in any event, not entitled to free public transport to travel to and from school because they lived within a two kilometre radius of Raby High School.¹⁴⁸

The combined effect of these planning decisions was that the residents of St Andrews, who did not have access to a car, used the freeway as a 'natural' crossing point rather than the

¹⁴⁴ *Edson v Roads and Traffic Authority* (2006) 65 NSWLR 453, 455-456,[3] (Ipp JA) ('Edson').

¹⁴⁵ *Ibid*, 456, [10] (Ipp JA).

¹⁴⁶ *Ibid*, 456, [10] (Ipp JA).

¹⁴⁷ *Ibid*, 471, [106] (Ipp JA), 455, [1], (Beasley JA agreed with Ipp JA), 477, [170] (Hunt AJA agreed with Ipp JA).

¹⁴⁸ *Ibid*, 457, [13]-[19].

more circuitous route required by the overpasses. The evidence was that many residents moved directly between the suburbs of Raby and St Andrews by crossing the freeway. The photographic evidence in the trial showed a well worn path through the thick vegetation and the fence marking the boundary between the suburb of Raby and the freeway. This path was so well travelled that it had produced problems of soil erosion. In 1997 a Senior RTA Manager, Mr Gregory Upton, had written a report in which he estimated that as many as 25,000 people per year crossed in the freeway in this way.¹⁴⁹ When answering questions on this report the trial, Mr Upton testified that:

There was a very high frequency of crossings at the time I was there ... I can recall that there was a young person on a skateboard going across the Freeway. I also noted a woman pushing a stroller across the Freeway. And I was frightened by the – with what I saw.¹⁵⁰

In the period 1993 to 1997 there were seven reported accidents involving pedestrians crossing the freeway between Raby and St Andrews. In an inquest of a person fatally injured crossing the freeway in 1993 the Coroner had drawn the attention of the RTA to the need to maintain proper fencing to prevent pedestrians gaining access to the freeway.¹⁵¹

On the night Ms Edson was injured she attended a friend's birthday party which was held in St Andrews. Early in the evening Ms Edson and her group of friends, who were aged between 13 and 15, crossed the freeway to go to the Raby shops. One young person purchased food and alcohol and the group then started to walk back to St Andrews. When the group was close to the fence that was designed to prevent entry to the freeway a police car pulled up and shone torches at the group. Soon afterwards a police officer started in pursuit of the young people who scattered. Ms Edson and several friends moved to cross the freeway. It was at this point that the car struck Ms Edson.¹⁵²

Professor Reason has argued that organisational accidents are the result of many inter-related factors. He argues that such accidents occur when weaknesses in defences that are designed to protect people from harm come into alignment and create the conditions for an accident. In effect these latent conditions, when combined with errors and mistakes create the conditions for the occurrence of an organisational accident.¹⁵³ The accident that resulted in Ms Edson sustaining serious injuries followed this pattern. The overpasses which were designed to provide access between Raby and St Andrews had little impact on pedestrian traffic because of their placement. There were few if any public transport services provided to the communities of St Andrews and Raby. The fences which were designed to prevent access to the freeway were not built to withstand the pressures produced by the sheer number of physically fit young people crossing the freeway. The actions of the police in their pursuit of the young people crossing the freeway heightened the risk that they would commit errors and unsafe acts in crossing the freeway. Finally Ms Edson and her friends committed

¹⁴⁹ Ibid, 458-, [23]-[26].

¹⁵⁰ Ibid, 459, [35].

¹⁵¹ Ibid, 458-459, [27]-[32].

¹⁵² Ibid, 460-461, [42]-[53].

¹⁵³ Reason, *Managing the Risks of Organisational Accidents*, above n 4 **Error! Bookmark not defined.**, 9-11.

the error of failing to keep a proper lookout because of their haste to escape the police. When Ms Edson was struck by the cars on the freeway the accident was the result of the combined operation of these latent conditions and unsafe acts.

And a breach of duty

It is hard to read of the circumstances of Ms Edson's injury with any degree of equanimity. The latent conditions that produced the accident in this case were complex and were the result of many decisions. It is though, possible to conclude that the RTA was able to detect the risks of harm of the kind to which Ms Edson was exposed. But importantly, the RTA did not have the capacity to decide what steps to take, or what resources to draw on, to modify the conditions which produced the accident and the serious injuries to Ms Edson. It is important to note these failures by the RTA could have had truly catastrophic consequences. The potential for uncontrolled pedestrian crossings of the F5 to produce multi vehicle accidents involving trucks and buses put the apparent inactivity of the RTA into a more realistic and chilling perspective.

Recognising the complexity of the problem of implementing safety systems to prevent harm of the kind sustained by the plaintiff in *Edson* reveals an important way in which tort law can accommodate concerns about safety within the framework of individuated justice that gives rise to a right to recover compensation for harm. This involves an acknowledgement that the concept of taking reasonable care to alleviate the risk of harm is quite different from the capacity of a networked system of governance to prevent harm. In *Edson* the latter would have involved the coordinated response of a number of statutory authorities, parts of the NSW government, and the communities in Raby and St Andrews.¹⁵⁴ The implementation of coordinated strategy of this kind would have involved the emergence of a networked system of governance to improve safety. For the reasons suggested earlier in this article this is a costly exercise that requires commitment of resources and attention from governments and communities.

The injury to Ms Edson occurred in circumstances where the RTA failed *both* to exercise reasonable care *and* develop the capacities to support a system of governance oriented towards safety. In *Edson* a networked system of governance would have given the RTA the capacity to engage in a systematic attempt to prevent the injury by ensuring that residents of the two suburbs could move freely between the two suburbs without having to cross the Freeway. Such a system of governance would have allowed a network of people in the RTA, in other public bodies, and in the communities of Raby and St Andrews to address the risk of harm created by uncontrolled crossings of the Freeway. The failure to develop the capacities needed to support this system of governance is one that exposed many who used this road to risks of catastrophic harm in a casual and irresponsible way.¹⁵⁵

¹⁵⁴ Braithwaite, above n 13, 87-108 (as a form of nodal governance).

¹⁵⁵ Scott Veitch, *Law and Irresponsibility: On the legitimation of human suffering* (2007) 72-73. This book explores the thesis that law supports and facilitates irresponsibility by and through organizations and individuals. The inaction of the RTA in the light of the knowledge of the risk of harm to both pedestrians and drivers can be described as an example of the phenomenon of the 'organisation of irresponsibility'.

The issue in *Edson* though, was a different one. It involved the question of whether the RTA was in breach of its duty of care to exercise reasonable care to alleviate the risks of harm to those pedestrians crossing the F5 Freeway between the suburbs of Raby and St Clare. Justice Ipp emphasised the probability that a class of persons, that included Ms Edson, would suffer harm making unregulated crossings of a major freeway was small but predictable. His Honour argued that this knowledge of the risk of harm was supported by the RTA's control over access to the freeway, and its control of all building over or under the freeway. As Justice Ipp argued that the RTA:

[K]new that this was an extremely hazardous practice and had led to a number of people being killed and seriously injured. It knew of the attractions of Raby to the person who lived in St Andrews and the incentives to them to cross by the path. The RTA's own senior officers had enjoined it to take appropriate steps to remove or reduce the danger. The users of the freeway and the persons living adjacent to it had no one else on whom they could rely to deal with dangers that the freeway and its surrounds might cause.¹⁵⁶

It was against this background that Justice Ipp concluded that the RTA had breached its duty of care by failing to build and maintain an appropriate fence.¹⁵⁷ His Honour went on to find that an appropriate fence 'would have substantially deterred people from crossing the freeway' and that Ms Edson would not have attempted to cross the freeway had the RTA installed appropriate fencing.¹⁵⁸ Justice Ipp was able to reach this conclusion without the need for calling on expert evidence concerning the regulation or management of freeways by responsible public authorities.

This analysis of the breach of duty in *Edson* reveals an important distinction in the way that the tort of negligence should apply to *Edson* in contrast to its application in *Dederer*. In *Edson*, as it was in *Dederer*, the circumstances that produced the accident can be described as a maze of ineffective acts punctuated by the inactivity of the RTA and other organisations. However in *Edson*, as distinct from *Dederer*, there is a matrix of acts and omissions, supported by a detailed knowledge of the risks of harm that crystallises into a pattern that is recognisable as a breach of duty. The obligation to erect a better fence may not have prevented the harm to Ms Edson in the sense that it would have removed the latent conditions that created the accident; that is, the large number of people make uncontrolled crossings of the freeway. But, the obligation to erect a better fence limiting access to the freeway was an act which would have alleviated the risks of harm to the plaintiff. This obligation was a reasonable one in light of the RTA's knowledge of the risks created by uncontrolled crossings of the freeway, and its obligations to maintain and manage the freeway.

In a case such as *Edson*, there are sound reasons for imposing liability on a statutory authority in the position of the RTA – even if the body in the position of the RTA lacks the capacity to prevent the relevant harm by implementing a safety system. The complexity of the problem of implementing a safety system may be a reason why a statutory authority fails to exercise reasonable care in a particular instance. It may be that the complexity of the problem of preventing harm is an explanation for why statutory bodies fail to accept any

¹⁵⁶ Ibid, 468, [97].

¹⁵⁷ Ibid, 471, [106].

¹⁵⁸ Ibid, 473, [126]-[127].

responsibility for either alleviating or preventing the risk of harm. However this lack of capacity to prevent harm and the failure to accept this kind of responsibility does not diminish the significance of the RTA's failure to exercise reasonable care to alleviate the risks of harm to Ms Edson. There will be relatively few instances in which a statutory authority will fail to take reasonable care to alleviate risks of harm of the magnitude to which all those who used the F5 Freeway were exposed. The imposition of liability will in these cases be an instance of tort law probing our systems of governance to see how these promote our vulnerabilities. As in other cases such as *Dederer*, this is an important role for tort law. It is furthermore one that tort law can fulfil without making decisions of the kind that, 'are ordinarily decided through the political process'.¹⁵⁹

Conclusion

The central theme developed here is that tort law is part of a broad continuum of institutions, laws and practices that are concerned with governance. Tort law is part of the continuum of institutions, laws and practices that frame the systems of governance concerned with the management and safety of roads. In this context tort law, along with a number of other bodies of practices is part of a continuum of failures in these systems of governance. Current approaches in tort law overestimate the capacity of public and private bodies to prevent harm, justify inaction by statutory authorities, and underestimate the importance of harms that arise out of the use of roads.

There is a role for tort law in creating the conditions for supporting emerging systems of networked governance that are oriented to safety. This role is not founded on the signalling effect arising out of the defendant's obligation to pay damages. The definition of the role of tort in this way would be a quixotic project. Rather, it is founded on the capacity of tort law to 'probe our social structure and culture to see how these promote our vulnerabilities'.¹⁶⁰ This capacity of tort to probe the integrity of systems of governance rests on the possibility of tort law acknowledging the complexity of the governance problem of improving safety. This is a way for courts to accurately assess the costs of alleviating the risk of harm when considering whether statutory authorities have breached their duty of care. This process of assessing the costs of alleviating the risks of harm is particularly important in those cases where defendant authorities do not have the rudiments of the institutional capacities that are needed to prevent harm. In these cases a full assessment of the costs implementing the safety systems will be an important factor in limiting the liability of those statutory authorities for failing to prevent the risks of harm to particular plaintiffs.

The affirmation that statutory authorities face limited exposure to liability in tort for failing to prevent harm even where those authorities have few if any of the organisational capacities needed to prevent harm has important consequences. It recognises that statutory authorities lack the capacity to make informed risk assessments about the safety of road users and to identify and implement strategies to reduce the risk of those harms. Recognising a lack of capacity to prevent harm and the vulnerability of particular classes of road users to suffer harm has the potential to create a space for ethical and political decision-making by

¹⁵⁹ *Graham Barclay Oysters Pty Ltd v Ryan* [2002] HCA 54, [6].

¹⁶⁰ Perrow, above n 3.

governments, statutory authorities, and other organisations that represent the broader community of citizens. As they reach this impasse, governments, statutory authorities, and private organisations may recognise an obligation to experiment with the implementation of governance structures that could keep risks of harm as low as reasonably practicable.

The potential for tort law to mark out this space is based on the claim that tort law can assist in identifying the problem of improving safety and disturb existing approaches to safety within organisations. It can disturb existing organisational and regulatory practices by creating ethical obligations to acknowledge the problem of safety and to experiment with the forms of organisations and governance that have the potential to improve safety. If tort law is able to act as this kind of irritant there are regulatory interventions and organisational mechanisms that may facilitate the emergence of organisational capacities needed to support more effective safety systems.

At the level of the individual, Susan Silbey and others have identified a role for the 'sociological citizen' in seeing 'relational interdependence' and in using this 'systemic perspective to meet occupational and professional obligations'.¹⁶¹ The capacity of organisations to facilitate and support the activities of sociological citizens may be important for public bodies as they are forced to confront wicked problems in their areas of responsibility.¹⁶² At the level of the organisation there are suggestions that organisations may need to develop an 'experimental mind-set' in order to be able to assess the significance of ambiguous information about activities which could be productive of organisational accidents. This literature focuses on the kind of management structures in organisations that may support the development of experimental mindsets.¹⁶³ At the level of regulation of activities there are suggestions of the need to experiment with the structure of industries.¹⁶⁴

For some, the claim that tort law can be a force in disturbing existing approaches to safety in public bodies that are responsible for designing, building, managing and maintaining roads, will itself be an irritant. This bold claim follows the path set out by John Dewey when he said that 'Faith in the possibilities of continued and rigorous inquiry does not limit access to truth to any channel or scheme of things. It does not first say that truth is universal and then add there is but one road to it'.¹⁶⁵

¹⁶¹ Susan Silbey, Ruthanne Huisig and Salo Coslovsky, 'The "Sociological Citizen" Relational Independence in Law and Organisations' (2009) 59 *L'Année sociologique* 201, 202-203.

¹⁶² *Ibid*, 221-227.

¹⁶³ See for example, Michael Roberto, Richard Bohmer and Amy Edmondson, 'Facing Ambiguous Threats' (2006) *Harvard Business Review* 106.

¹⁶⁴ Braithwaite, above n 13, 27-29 (the potential for 'democratic experimentalism'). See also Perrow, above n 3 (an argument for encouraging networks of small firms to move away from large organizations as the basis for economic activity).

¹⁶⁵ John Dewey, *A Common Faith* (1934),