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# 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. Those injured often seek compensation from public bodies that are responsible for designing, building, maintaining and managing roads. The gist of these actions is the failure of these bodies to prevent harm. Where these actions are successful, publicly funded bodies that have a limited capacity to prevent harm are required to support the payment of compensation. But a failure to award compensation often appears to collude in a pattern of inaction by those bodies. This article charts out a path for tort law to take account of these concerns and to engage with the problem of improving safety. It argues that tort law can be a mechanism for exploring the vulnerability of all road users to suffer injuries in accidents. The recognition of our vulnerability to harm when using roads can create an ethical space in which citizens, governments and statutory authorities recognise the limited capacity of our institutions to reduce preventable harms on roads. The creation of this space would make it possible to have an informed discussion about the costs and benefits of improved safety systems.*

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## Introduction

There is increasing awareness of the potential for productive activities and processes to produce persistent patterns of harm. There is a long history of awareness of the potential for injury in the work place.<sup>1</sup> There is also significant activity directed to reducing harms that arise out of the use of roads. More recently health care providers have integrated knowledge of the capacity for health care processes to cause harm into the practice of health care.<sup>2</sup> But this project of improving safety is an emergent one; 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.<sup>3</sup>

One manifestation of the emergent understanding of safety is the problem of determining the liability of organisations for failing to prevent harm. Difficult questions concerning liability for failing to implement safety systems to prevent harm arise for both public and private organisations. These questions arise in a number of different social and economic areas of activity. They arise in relation to the liability of health care organisations for the occurrence of adverse events.<sup>4</sup> They also arise in relation to the liability of statutory authorities for failing to prevent harm arising out of the use 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.

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<sup>1</sup> Richard Johnstone and Richard Mitchell, 'Regulating Work' in Christine Parker, Colin Scott, Nicola Lacey and John Braithwaite, *Regulating Law* (2004), 101-121

<sup>2</sup> See generally Institute of Medicine (2000). *To err is human: building a safer health system*. Washington DC, National Academy Press. For review of interventions capable of improving patient safety, see Jha, A. (2008). Summary of the Evidence on Patient Safety: Implications for Research. A. Jha, I. Larizgoitia, D. Bates and N. Prasopa-Plaizier, World Alliance for Patient Safety, World Health Organisation. For a recent study on rates of occurrence of adverse events, see Landrigan, C. P., G. J. Parry, et al. (2010). "Temporal Trends in Rates of Patient Harm Resulting from Medical Care." *New England Journal of Medicine* **363**: 2124-2134

<sup>3</sup> Susan Silbey, 'Taming Prometheus: Talk about Safety and Culture' (2009) 15 *Annual Review of Sociology* 17.3.

<sup>4</sup> See generally, Tom Baker, *the medical malpractice myth* (2005), William Sage and Rogan Kersh (eds), *Medical Malpractice and the US Health Care System* (2006). See also 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').

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.<sup>5</sup>

In all of their manifestations, from rarely used suburban lanes to large systems of freeways, roads are complex forms of social organisation.<sup>6</sup> 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,<sup>7</sup> 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.

This article analyses liability of statutory authorities for failing to prevent harms that arise out of the use of this complex system of roads. It analyses the problem of determining liability for failing to prevent harm as if tort law were part of the system of governance that is concerned with improving safety in the use of roads. Viewing tort law through this lens provides some valuable insights on some difficult and unresolved problems in applying the tort of negligence to accidents where the basis of a defendant's liability can be described as a failure to implement a safety system to prevent harm. In particular it will highlight tensions between claims for compensation based on a failure to prevent harm and the limited organisational and regulatory capacity to implement safety systems to reduce the occurrence of preventable harm.

This analysis of the tort of negligence does not aim to provide a systematic account of the law governing the liability of those bodies that are responsible for designing, building, maintaining and regulating roads. This is detailed undertaking that involves analysis of specific bodies of law. In each of the jurisdictions of Australia this would involve analysis of the impact of the

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<sup>5</sup> Lydia Millet, *How the Dead Dream* (2008)

<sup>6</sup> Suzanne Heywood, Jessica Spungin, David Turnbull, 'Cracking the complexity code' [2007] 2 *The McKinsey Quarterly* 85, 87-88.

<sup>7</sup> 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.

common law and of tort reform legislation. The problem of understanding how tort law comprehends the project of improving safety, and how it comprehends the failure to implement safety systems needed to reduce preventable harm is a problem common to modern societies.

Rather than providing an account of tort law in any one place this article reviews different approaches to the problem of determining whether statutory bodies should be liable for failing to reduce preventable harm. This analysis identifies some of the reasons why courts and legislatures have difficulty in applying the central principles of the tort of negligence to this problem of defining liability for failing to prevent harm. It argues that the application of the principles of the tort of negligence to this problem has resulted either in the arbitrary imposition of liability or alternatively in the normalisation of the occurrence of preventable harm. The final part of the article suggests a way in which the principles governing liability in tort can accommodate the failure to develop safety systems without reproducing the dilemma of either imposing arbitrary liability or of normalising the occurrence of preventable harm.

The possibility of viewing the tort of negligence through the lens of safety opens up some paths for the development of tort law. These paths will be different in different jurisdictions depending upon the development of the law of tort and of the consequent enactment of tort reform legislation. This article does make use of the development of the tort of negligence in the state of New South Wales. In this context one of the aims of the article is to challenge the usefulness of the enactment of immunities by legislatures as part of tort law reform initiatives. But it is important to specify at the outset that the argument developed in this paper does not call for imposing added liability on statutory authorities. This article does not make use of an ‘accident deterrence’ model of tort law, that is, the approach using tort law to internalise the cost of harm on those responsible for carrying on the activity that produces the harm.

The article is made up of three parts. The first part uses a regulatory and organisational analysis of safety to define the problem of determining the liability of statutory authorities’ failure to prevent harm. The second part identifies the ways that the law of the tort of negligence ‘normalises’ the occurrence of preventable harm. The third part proposes a way of fashioning a concept of fault that distinguishes between liability for harm caused by the negligence of a defendant and the failure of the defendant to implement safety systems.

## **Defining the problem of tort and safety**

One model for understanding the occurrence of accidents focuses on particular unsafe acts and errors as the cause of the particular accident. The law of tort makes use of this method of analysing accidents. The tort of negligence is primarily concerned with determining whether a particular defendant is

responsible for harm caused to a particular person on the basis that the defendant is responsible for a particular unsafe act or omission. The goal of improving safety has a different focus. It is sometimes defined as preventing the occurrence of organisational accidents.<sup>8</sup> These 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.<sup>9</sup> 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.<sup>10</sup>

In this sense the various harms sustained by those that use roads can be characterised as the result of the occurrence of complex ‘organisational accidents’. The process for deciding on the liability of statutory authorities for failing to prevent the harms produced by these accidents can then be analysed as if this system of liability was part of the regulatory arrangements for reducing these harms. Each individual accident will usually be the result of particular unsafe acts 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.<sup>11</sup>

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<sup>8</sup> See for example, James Reason, *Managing the Risks of Organisational Accidents* (1997).

<sup>9</sup> Reason, *The Human Contribution*, above n **Error! Bookmark not defined.**, 113-118; Perrow, above n **Error! Bookmark not defined.**

<sup>10</sup> Reason, *Managing the Risks of Organisational Accidents*, above n 8. 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 **Error! Bookmark not defined.**, 103.

<sup>11</sup> 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.

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.<sup>12</sup>

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’.<sup>13</sup>

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 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.<sup>14</sup>

Navigating through this ‘safety space’ is a complex organisational problem. Safe operations ‘generate a constant – and hence relatively uninteresting – non-event outcome’.<sup>15</sup> 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

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<sup>12</sup> James Reason, ‘Foreword’ in Bill Runciman, Alan Merry and Merrilyn Walton, *Safety and Ethics in Healthcare, A Guide to Getting it Right* (2007), xiii.

<sup>13</sup> Reason, *Managing the Risks of Organisational Accidents*, above n 8, 3.

<sup>14</sup> *Ibid*, 3-4, 175-180.

<sup>15</sup> Reason, *Managing the Risks of Organisational Accidents*, above n 8, 37.

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’.<sup>16</sup> 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’.<sup>17</sup> Organisational accidents ‘have multiple causes involving many people operating at different levels of their respective companies’.<sup>18</sup> 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.<sup>19</sup>

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’.<sup>20</sup> These unsafe acts are often unpredictable, but the ‘latent conditions that give rise to them are evident before the event’.<sup>21</sup> 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.<sup>22</sup>

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,

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<sup>16</sup> Reason, *The Human Contribution*, above n **Error! Bookmark not defined.**, 72.

<sup>17</sup> Reason, *Managing the Risks of Organisational Accidents*, above n 8, 1-20.

<sup>18</sup> *Ibid.*, 1.

<sup>19</sup> *Ibid.*, 10.

<sup>20</sup> Reason, *The Human Contribution*, above n **Error! Bookmark not defined.**, 76.

<sup>21</sup> *Ibid.*

<sup>22</sup> *Ibid.*

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.<sup>23</sup>

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.<sup>24</sup>

### ***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.<sup>25</sup>

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.<sup>26</sup>

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’.<sup>27</sup>

In addition to motivation, organisations must have technical competence:

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<sup>23</sup> Reason, *Managing the Risks of Organisational Accidents*, above n 8, 1-2.

<sup>24</sup> Reason, *The Human Condition*, above n **Error! Bookmark not defined.**, 107-127.

<sup>25</sup> *Ibid*, 112.

<sup>26</sup> Harlow, above n 15, 22-26.

<sup>27</sup> *Ibid*, 113. See also Susan Silbey, above n 317.3.

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?<sup>28</sup>

Some indicators of good safety performance for organisations are commitment from senior management to safety and the possession of a good safety information system.<sup>29</sup>

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.<sup>30</sup>

Managers in mindful 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.<sup>31</sup>

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

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<sup>28</sup> Reason, *Managing the Risks of Organisational Accidents*, above n 8,113.

<sup>29</sup> Ibid.

<sup>30</sup> Ibid,114.

<sup>31</sup> Ibid.

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 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.

### ***Framing the problem of liability in tort***

Statutory authorities that have responsibility for designing, building, maintaining and managing roads, therefore, face a ‘wicked problem’ as they endeavour to reduce harm.<sup>32</sup> This problem of regulation and governance is a complex undertaking that involves coordinating many complementary and competing interests.<sup>33</sup> In the cases analysed in this article the relevant 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,

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<sup>32</sup> 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.

<sup>33</sup> John Braithwaite, *Regulatory Capitalism: How it works, ideas for making it work better* (2008), 1-4.

partly-formed, emergent systems of governance to achieve complex public policy goals such as safety.<sup>34</sup>

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.<sup>35</sup> 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 harm sustained by the plaintiff.<sup>36</sup> 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.<sup>37</sup> In this field of scholarship there is a lack of confidence that the payment of damages in tort can promote safety.<sup>38</sup> 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’.<sup>39</sup> 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’.<sup>40</sup>

Framing this difficult problem in the developing tort of negligence as if this body of law is part of the system of governance aimed at improving safety

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<sup>34</sup> 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’).

<sup>35</sup> 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.

<sup>36</sup> See generally Harlow, above n 35, 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.

<sup>37</sup> Harlow, above n 35, 10-22,

<sup>38</sup> Harlow, above n 35, 22-30; Stapleton, above n 35, 130-134.

<sup>39</sup> Harlow, above n 35, 22, quoting Patrick Atiyah, *The Damages Lottery* (1997), 139.

<sup>40</sup> *Ibid*, 85-86.

yields some important insights about the role of compensation. The argument here is that the law of tort does have a role in identifying the limits of the capacity of organisations and systems of governance and regulation to implement safety systems that have the capacity to reduce the occurrence of preventable harm. The source of this argument is the insight of Charles Perrow that, while disasters are a ‘normal part of life,’ their occurrence is neither, natural or 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.<sup>41</sup> (footnotes omitted)

The significant point is that injuries and harm that are seamlessly produced by complex social, economic and cultural interactions on roads are a ‘normal’ part of our existence. But the ‘normality’ of the occurrence of these harms does not mean that these harms are natural or inevitable. A first step in reducing the occurrence of these harms is that institutions of government and civil society probe ‘our social structure and culture to see how these promote our vulnerabilities’.<sup>42</sup>

Tort law, both in the common law and the modifications to the common law in statute, does not probe ‘our social structure and culture to see how these promote our vulnerabilities’. Rather, the law of the tort of negligence, has tended to simplify the problem of improving safety. The direction of tort law, as enunciated by courts and parliaments, has been to limit the liability of statutory authorities for failing to prevent harm arising out of the use of roads. Both courts and parliaments justify their decisions for reducing liability by highlighting the adverse consequences of imposing liability for failing to prevent harm.<sup>43</sup> Little attention is given to recognising road-users’ vulnerability to harm that arises out of a failure to implement safety systems. The outcome is that the law of the tort of negligence has ‘normalised’ failures to prevent harm as both normal and inevitable. This rush to normalise the occurrence of preventable harm may mean that tort law actually impedes the emergence of networked systems of governance that are needed to improve safety.

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<sup>41</sup> Charles Perrow, *The Next Catastrophe*, above n **Error! Bookmark not defined.**, 3.

<sup>42</sup> Ibid.

<sup>43</sup> Ipp and second reader

The problem 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 implement even the rudiments of a safety system. In these circumstances the problem of deciding whether to impose liability is a difficult one. On the one hand the imposition of liability may impose unfair burdens on the statutory authority that is responsible for designing, building, maintaining or regulating roads. On the other hand a failure to impose liability may normalise the occurrence of ‘preventable harm’.

The opportunity to distinguish between fault and regulatory failure may circumvent this dilemma. It 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. The following section analyses current approaches in the tort of negligence for determining when a failure to implement a safety system will give rise to an obligation to pay compensation for failing to prevent harm.

## **A failure to distinguish fault and safety**

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. The second element that can be used to fashion a concept of fault that can distinguish between fault and a failure to implement safety systems is the determination of whether the authority 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.<sup>44</sup>

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'.<sup>45</sup> 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.<sup>46</sup> 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.<sup>47</sup>

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

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<sup>44</sup> *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*').

<sup>45</sup> *Gorringe v Calderdale Metropolitan Borough Council* [2004] 1 WLR 1057 ('*Gorringe*'), *Highways Act 1980* (UK) s.41

<sup>46</sup> *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.

<sup>47</sup> *Gorringe* [2004] 1 WLR 1057, 1067. This proposition was supported 1059 (Lord Steyn), 1077-78 (Lord Scotte of Foscotte), 1084 (Lord Rodger of Earlesferry), 1086-87 (Lord Brown of Eaton-Under-Heywood).

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.<sup>48</sup>

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 will have accidents does not require a private law duty to a careless driver or any other road user.<sup>49</sup>

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'.<sup>50</sup>

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.<sup>51</sup>

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.<sup>52</sup> This concern about the potential for liability imposed by tort law to have adverse and unintended

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<sup>48</sup> *Gorringe* [2004] 1 WLR 1057, 1070.

<sup>49</sup> *Gorringe* [2004] 1 WLR 1057, 1068.

<sup>50</sup> *Ibid.*

<sup>51</sup> *Gorringe* [2004] 1 WLR 1057, 1079. See also 1068 (Lord Hoffman), 1085 (Lord Rodger of Earlsferry),

<sup>52</sup> *Gorringe* [2004] 1 WLR 1057, 1067 (Lord Hoffman). See generally, Stapleton, above n 35, 122-134.

consequences on how statutory authorities fulfil their obligations is one that applies to many areas of regulation.<sup>53</sup>

Limiting the scope of the duty of care in this way 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.<sup>54</sup> It is clear that the intention of the House of Lords is to limit any consideration of a failure to implement safety systems in almost any circumstances. This approach to the defining the duty of care is explicitly concerned 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 short-term alleviation of obvious dangers by inexpensive signage on an interim basis pending long-term road improvement measures.<sup>55</sup>

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:

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<sup>53</sup> 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).

<sup>54</sup> *Gorringe* [2004] 1 WLR 1057, 1067 (Lord Hoffman), 1079 (Lord Scott of Foscote).

<sup>55</sup> *Gorringe v Calderdale Metropolitan Borough Council* [2002] RTR 446, 477, quoted in *Gorringe v* [2004] 1 WLR 1057, 1075 (Lord Scott of Foscote).

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.<sup>56</sup>

In *Brodie*, the High Court in a majority decision abolished the ‘highway rule’.<sup>57</sup> 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.<sup>58</sup>

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 to alleviate the danger, and any other competing or conflicting responsibility or commitments of the authority.<sup>59</sup> (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’.<sup>60</sup>

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

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<sup>56</sup> *Brodie* (2001) 206 CLR 512, 527.

<sup>57</sup> *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).

<sup>58</sup> *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.

<sup>59</sup> *Brodie* (2001) 206 CLR 512, 577. These factors are also set out in legislation, see for example, *Civil Liability Act 2002* (NSW), s.5B.

<sup>60</sup> *Brodie* (2001) 206 CLR 512, 577-578.

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.<sup>61</sup> As we will see 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.

### ***Liability and a failure to implement a safety system***

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.<sup>62</sup>

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'.<sup>63</sup> This case concerned an accident between two cars at an intersection that had been designed and upgraded by the RTA in 1993. 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

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<sup>61</sup> See for example, *Civil Liability Act 2002 NSW*, s.45.

<sup>62</sup> *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.

<sup>63</sup> Roads and Traffic Authority of New South Wales ('RTA'), *Annual Report (2008)* 54.

adopted by the RTA exposed the plaintiff to an increased risk of harm.<sup>64</sup> 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’.<sup>65</sup> 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.<sup>66</sup>

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.<sup>67</sup> In this context, it was the RTA’s knowledge of ‘a statistical inevitability of a proportion of cross-vehicle crashes, as demonstrated by statistics’<sup>68</sup> that should have led the RTA to adopt a different design for the intersection.<sup>69</sup> 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

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

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

<sup>66</sup> *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].

<sup>67</sup> 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).

<sup>68</sup> *Royal* [2007] NSWCA 76, [85] (Santow J).

<sup>69</sup> *Royal* [2007] NSWCA 76, [92] (Santow J).

history of crashes at this intersection and the failure of the RTA to respond to this knowledge.<sup>70</sup>

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 recognition of the failure to implement a safety system by using an ideal model of a safety system as the standard to determine whether the RTA breached its duty of care.

This approach integrates the goal of improving safety with the decision about whether to impose liability for harm in tort. But, it does so in a way that avoids recognising 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.<sup>71</sup> 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.<sup>72</sup> 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

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

<sup>71</sup> See above What is a safety system?

<sup>72</sup> Harlow, above n 35, 85-86.

complex problem which is broader and deeper than this simple characterisation would indicate.

### ***Normalising preventable harm***

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*.<sup>73</sup>

### **No effective safety system**

On the 31<sup>st</sup> 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.<sup>74</sup> 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.<sup>75</sup> 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.<sup>76</sup> The RTA took no further action of any kind to stop young people diving off the bridge.<sup>77</sup>

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<sup>73</sup> *Roads and Traffic Authority of NSW v Dederer* (2007) 234 CLR 330 ('*Dederer*').

<sup>74</sup> *Dederer* (2007) 234 CLR 330, 357 (Kirby J).

<sup>75</sup> *Dederer* (2007) 234 CLR 330, 339 (Gummow J), 359 (Kirby J).

<sup>76</sup> *Dederer* (2007) 234 CLR 330, 339, 354-355 (Gummow J), 360-361 (Kirby J), 406 (Callinan J).

<sup>77</sup> *Dederer* (2007) 234 CLR 330, 361-363 (Kirby J).

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 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.<sup>78</sup>

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’.<sup>79</sup> The Council had informed the RTA that young people were using the bridge to jump into the water in 1993.<sup>80</sup> Local police were also aware of, and had made some unsuccessful attempts to, stop the practice.<sup>81</sup> The RTA admitted that it had been aware that young people were jumping off the bridge.<sup>82</sup> 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.<sup>83</sup> 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 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:

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<sup>78</sup> *Dederer* (2007) 234 CLR 330, 360, [95] (Kirby J).

<sup>79</sup> *Ibid*, 361, [99] (Kirby J).

<sup>80</sup> *Ibid*, 361-362, [100]-[101] (Kirby J).

<sup>81</sup> *Ibid*, 391-392, [232]-[235] (Callinan J).

<sup>82</sup> *Ibid*, 360, [94] (Kirby J).

<sup>83</sup> *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).

[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.<sup>84</sup>

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’.<sup>85</sup> 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.<sup>86</sup>

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It is 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.<sup>87</sup> Finally, the RTA had no capacity to coordinate its role in reducing risks associated with emergent activities with other public authorities or community groups.<sup>88</sup>

### Narrowing fault to exclude 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.<sup>89</sup> In particular, the RTA had failed to improve the signs warning of the risks of diving<sup>90</sup> or to make relatively inexpensive

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<sup>84</sup> Ibid, 363, [108] (Kirby J).

<sup>85</sup> Ibid, 392, [235] (Callinan J).

<sup>86</sup> Ibid, 391-392, [231]-[235] (Callinan J).

<sup>87</sup> 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).

<sup>88</sup> *Great Lakes Shire Council v Dederer* [2006] NSWCA 101, [362]-[368] (Tobias JA).

<sup>89</sup> *Great Lakes Shire Council v Dederer* [2006] NSWCA 101, [46]-[50] (Handley JA, dissenting), [301]-[307] (Ipp JA), [368] (Tobias JA).

<sup>90</sup> *Great Lakes Shire Council v Dederer* [2006] NSWCA 101, [236]-[251], [304]-[307] (Ipp JA), [361]-[368] (Tobias JA).

modifications to the bridge to make access to the bridge for young people more difficult.<sup>91</sup> It 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.<sup>92</sup> 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*.<sup>93</sup>

The High Court found that the RTA had not breached its duty of care to the plaintiff.<sup>94</sup> 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'.<sup>95</sup>

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.<sup>96</sup>

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<sup>91</sup> *Great Lakes Shire Council v Dederer* [2006] NSWCA 101, [252]-[267], [304]-[307] (Ipp JA), [361]-[368] (Tobias JA).

<sup>92</sup> *Great Lakes Shire Council v Dederer* [2006] NSWCA 101, [215]-[220] (Ipp JA), [354], [364]-[368] (Tobias JA).

<sup>93</sup> See above text accompanying nn 62-70.

<sup>94</sup> *Dederer* (2007) 234 CLR 330, 337 (Gleeson CJ, dissenting), 356 (Gummow J), 379 (Kirby J, dissenting), 408 (Callinan J), 408 (Heydon J).

<sup>95</sup> *Dederer* (2007) 234 CLR 330, 346, quoting from *Brodie v Singleton Shire Council* (2001) 206 CLR 512, 518.

<sup>96</sup> *Dederer* (2007) 234 CLR 330, 346, [79] (Gummow J).

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.<sup>97</sup> 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.<sup>98</sup>

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.<sup>99</sup>

Justice Gummow proceeded to apply the elements of the calculus of negligence.<sup>100</sup> After finding that the injury to Mr Dederer was reasonably foreseeable,<sup>101</sup> 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.<sup>102</sup> 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'.<sup>103</sup> 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

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<sup>97</sup> *Dederer* (2007) 234 CLR 330, 349, [53] (Gummow J).

<sup>98</sup> *Dederer* (2007) 234 CLR 330, 349, [54] (Gummow J).

<sup>99</sup> *Dederer* (2007) 234 CLR 330, 352, [64] (Gummow J).

<sup>100</sup> *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.

<sup>101</sup> *Dederer* (2007) 234 CLR 330, 354-355, [70] (Gummow J).

<sup>102</sup> *Great Lakes Shire Council v Dederer* [2006] NSWCA 101, [212]-[214] (Ipp JA), [353]-[356], (Tobias JA).

<sup>103</sup> *Dederer* (2007) 234 CLR 330, 351, [61] (Gummow J), 407, [274] (Callinan J). Compare Reason above text accompanying nn 15-19, 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.

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,<sup>104</sup> and that these steps would, in any event, have had little utility in preventing the Mr Dederer's injury.<sup>105</sup>

This approach to determining whether a statutory authority has breached its duty of care has the effect of normalising the occurrence of preventable harm. The duty to exercise reasonable care to alleviate the risk of reasonably foreseeable harm is narrowed down to those matters that were within the immediate control of the RTA. In this way the majority of the High Court distinguished a conception of fault from a failure to implement a safety system needed to 'promote traffic safety'.<sup>106</sup> But, 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 developing networks of governance with other public authorities and with community groups.<sup>107</sup> 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***

After the decision of the High Court in *Brodie* many Australian states, including New South Wales, enacted tort reform legislation to modify the impact of this decision. The form of this legislative reform of the common law was the creation of an immunity from liability. Section 45(1) of the *Civil Liability Act 2002* provides 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.

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<sup>104</sup> *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).

<sup>105</sup> *Dederer* (2007) 234 CLR 330, 356, [78] (Gummow J).

<sup>106</sup> *Transport Administration Act 1988* (NSW), s.52A. See also Roads and Traffic Authority of New South Wales ('RTA'), *Annual Report* (2008) 4.

<sup>107</sup> Braithwaite, *Regulatory Capitalism*, above n 33.

The enactment of this immunity from liability protects a roads authority from liability for non-feasance unless the authority had actual knowledge of the risk that gave rise to the harm.

The enactment of immunities from liability for public authorities is disarmingly simple way for legislatures to protect those authorities from liability to pay compensation. In the Second Reading Speech for the Civil Liability (Personal Responsibility) Bill NSW 2002 that included s.45 the Premier of NSW argued that:

The bill will also protect regulatory and roads authorities if they could have done something to avoid a risk but did not do so. It is more than reasonable that functions performed by a public authority are treated differently under the law. Public authorities carry out what is often a limitless task with necessarily limited resources. We must ensure, therefore, that it is not left to the courts to determine a public authority's expenditure on its tasks.<sup>108</sup>

The enactment of s.45 did not however resolve the underlying problem of defining the liability of roads authorities. In particular, it did not provide any way of distinguishing between a conception of fault and a conception of failure to reduce the occurrence of preventable harm. As the following case indicates the enactment of s.45 reproduces the problem of making this distinction in a new and somewhat surprising way.

### **Roman: No effective safety system**

In February 2001 Maria Roman stepped into a pothole on Princes St in McMahons Point in the municipality of North Sydney.<sup>109</sup> 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'.<sup>110</sup> 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'.<sup>111</sup> The second step was that a failure to repair the pothole was a breach of duty on the grounds that there was a foreseeable

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<sup>108</sup> Second Reading speech

<sup>109</sup> *Roman*, (2007) 69 NSWLR 240, 243 (McColl JA).

<sup>110</sup> *Ibid*, 243, [2].

<sup>111</sup> *Ibid*, 245, [12] (McColl JA).

risk of harm and that the costs of avoiding the harm by repairing the hole were small in contrast to the potential for harm.<sup>112</sup>

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 of those who use roads. Large numbers of older people, for example, walk as a primary mode of transportation.<sup>113</sup> 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.<sup>114</sup> 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'.<sup>115</sup> These hazards create the need for 'forms of protection to intervene between the local hazards and their possible victims'.<sup>116</sup>

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.<sup>117</sup> 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

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<sup>112</sup> Ibid, 245-246, [13].

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

<sup>114</sup> 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](http://www.aihw.gov.au/publications/index.cfm/title/10683)

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

<sup>116</sup> Reason, *Managing the Risks of Organisational Accidents*, above n 8, 3.

<sup>117</sup> Ibid, 3-4.

individuals and to assets is kept as low as reasonably practical? Second, what forms of protection are actually in place and how effective are these systems in protecting against the hazards created by the potholes.<sup>118</sup>

In *Roman* the trial judge found that there was ‘no system in place for inspection of the kerbs and guttering’.<sup>119</sup> 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 responsible officer 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’.<sup>120</sup> 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.<sup>121</sup>

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’.<sup>122</sup> 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

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<sup>118</sup> 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.

<sup>119</sup> *Roman*, (2007) 69 NSWLR 240, 245, [12].

<sup>120</sup> *Ibid*, 244, [6].

<sup>121</sup> *Ibid*, 245, [10].

<sup>122</sup> See above text accompanying nn 25-31.

‘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.<sup>123</sup>

### The impact of immunities

The primary issue in *Roman* 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. The trial judge found that the Council was a ‘roads authority’ and that the Council had ‘actual knowledge of the particular risk’.<sup>124</sup> 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 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*.<sup>125</sup>

In contrast to the decision of the trial judge, Justice Basten, who delivered the majority judgment, reasoned that s.45 created a complete immunity from the imposition of any liability arising out of a failure to establish safety systems to prevent harm. His Honour stated that where the Council did not have 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.<sup>126</sup> 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 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

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<sup>123</sup> See above n 31.

<sup>124</sup> Ibid, 245, [12] (McColl JA).

<sup>125</sup> See above text accompanying nn 64-66.

<sup>126</sup> *Roman*, (2007) 69 NSWLR 240, 267, [128] (Bryson JA agreed with Basten JA).

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’.<sup>127</sup>

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.

In *Roman* the minority judgment of Justice McColl assumes, for the purpose of determining the applicability of the immunity in s.45 that roads authorities have in place effective systems to ensure the proper flow of information to relevant officers in the authority about risks of harm. The capacity to ensure that there are effective flows information about risks of harm is an important, and surprisingly complex, part of an effective safety system. By assuming the existence of this part of a safety system Justice McColl leaves unresolved the problem of distinguishing between fault and a failure to reduce preventable harm. In *Roman* there was little evidence that North Sydney Council had in place any such system to ensure the proper flow of information about risks of harm to road users.

By contrast the approach of the majority provides that a roads authority is entitled to the benefit of the immunity unless the ‘officer responsible for exercising the power of the authority to mitigate the harm’.<sup>128</sup> In effect this decision normalises the occurrence of the preventable harm. There is no analysis of whether a roads authority has in place a safety system and there is consideration of whether this failure exposed road-users to specific risks of harm. This approach to defining the operation of the immunity in s.45 forestalls any consideration of whether there is a principled basis for distinguishing between fault and a failure to reduce preventable harm.

In subsequent decisions the Court of Appeal in NSW has expressed concern about the broad operation of the immunity set out by the majority in *Roman*. In *Blacktown City Council v Hocking* and *Angel v Hawkesbury City Council* appeals were heard consecutively by a bench made up of five judges to ensure consistency in the application of s.45.<sup>129</sup> In *Hocking* Justice Tobias expressed a strong view that the Court of Appeal should adopt the minority view of

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<sup>127</sup> Ibid, 271, [152].

<sup>128</sup> *Roman*, (2007) 69 NSWLR 240, 273, [157] (Basten JA).

<sup>129</sup> *Blacktown City Council v Hocking*[2008] NSWCA [144]; *Angel v Hawkesbury City Council* [2008] NSWCA 130, [10]-[13]

Justice McColl in expressed in *Roman*.<sup>130</sup> Justice Tobias was concerned that the approach of Justice Basten in *Roman* would ‘unjustifiably place a premium on ignorance’.<sup>131</sup>

The concerns expressed by Justice Tobias about the application of the immunity from liability for road authorities raise an important question about the role of immunities in the law. Justice Tobias was concerned that the immunity as defined by the majority in *Roman* insulated the roads authorities from liability without reference to any consideration of fault of those authorities in causing harm. Such a broad application of the immunity ignored the failure of roads authorities to adopt systems that were capable of alleviating harm for their negligence. The broad application of the immunity also normalized the failure of roads authorities to implement safety systems. In this way the enactment of the immunity in s.45 reproduced the problems that arose out of a failure to distinguish between fault and a failure to reduce preventable harm.

## **Distinguishing fault and safety**

The approaches in tort law to determining the liability of statutory authorities for failing to prevent harm appear to create a dilemma. Using a broad concept of fault, like the one used by Justice Santow in *Royal*, has the effect of imposing liability in an arbitrary way. It does so without any principled consideration of whether a statutory authority has the capacity to prevent harms to those who use roads. Narrowing the concept of fault down to those matters that are within the immediate control of a statutory authority avoids imposing liability arbitrarily. But it avoids this problem by seeming to normalise the occurrence of preventable harm. How then can tort law avoid both imposing liability in an arbitrary way without normalising the occurrence of preventable harm.

There is a path by which tort law can avoid this dilemma 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

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<sup>130</sup> *Blacktown City Council v Hocking*[2008] NSWCA [144], [209]-[223].

<sup>131</sup> *Id.*, [223(j)].

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. 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’.<sup>132</sup> 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.

### ***A new definition of fault***

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 either the failure to provide better signage or 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.<sup>133</sup> 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.<sup>134</sup>

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<sup>132</sup> *Graham Barclay Oysters Pty Ltd v Ryan* (2002) 211 CLR 540, 533. See also Aronson, above n 36, 50-52, Harlow, above n 35, 1-9, 22-30.

<sup>133</sup> See above nn 89-91.

<sup>134</sup> *New South Wales v Fahy* (2007) 232 CLR 486, 511, [78]. See also *Civil Liability Act 2002* NSW, s.5B.

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.<sup>135</sup> 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 normalises the occurrence of the occurrence of preventable harm. 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 plaintiffs including Mr Dederer.<sup>136</sup> 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 persistently 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.<sup>137</sup> 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.<sup>138</sup>

It is possible to frame a new conception of fault which takes into account the failure to implement safety systems to reduce the occurrence of preventable harm. It is possible 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 includes the failure to implement systems of governance to detect and respond to risks of harm associated with the use of roads. The costs associated with the exercise of reasonable care to alleviate harm would then not be limited to the costs associated with taking steps to remedy the particular breach. In *Dederer*, the breach of duty was defined as the failure to erect a warning sign. The proposed

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<sup>135</sup> *New South Wales v Fahy* (2007) 232 CLR 486, 506, [58] (Gummow and Hayne JJ).

<sup>136</sup> *Dederer* (2007) 234 CLR 330, 351, [59] (Gummow J), 407, [274] (Callinan J).

<sup>137</sup> 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).

<sup>138</sup> See above n 31.

modification to the calculus of negligence would not limit the assessment of the cost of alleviating the risk of harm to the cost of erecting a particular warning sign. Rather, the costs would include the cost of implementing a safety system that would have identified where, when and how to erect effective warning signs.

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 then be possible to assess the costs of taking action to alleviate the risk of harm by assessing the costs of implementing a safety system. 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 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.<sup>139</sup>

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. This 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 persistent occurrence of a range of injuries, including, catastrophic injuries. 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.<sup>140</sup> This argument applies with equal force to the decisions in *Royal v Smurthwaite*,<sup>141</sup> *Gorringe v Calderdale Metropolitan Borough Council*,<sup>142</sup> and *Roman v North Sydney Council*.<sup>143</sup>

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<sup>139</sup> See above, ‘What is a safety system?’.

<sup>140</sup> See above nn 106-107.

<sup>141</sup> See above text following n 70.

<sup>142</sup> See above text accompanying n 55.

<sup>143</sup> See above text accompanying nn 109-124,

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.

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 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. As the following case shows 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 often also be evidence of a failure of the authority to implement a safety system.

### ***The failure to implement a safety system***

On the 28<sup>th</sup> of August 1998, two cars travelling on the F5 freeway at 100 kph hit Ms Nicole Edson. She sustained severe injuries.<sup>144</sup> 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.<sup>145</sup> This latter proposition was

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

<sup>145</sup> *Ibid*, 456, [10] (Ipp JA).

rejected by the trial judge and not challenged by Ms Edson on appeal.<sup>146</sup> 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.<sup>147</sup>

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.<sup>148</sup>

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 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

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<sup>146</sup> Ibid, 456, [10] (Ipp JA).

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

<sup>148</sup> Ibid, 457, [13]-[19].

way.<sup>149</sup> 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.<sup>150</sup>

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.<sup>151</sup>

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.<sup>152</sup>

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.<sup>153</sup> 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

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<sup>149</sup> Ibid, 458-, [23]-[26].

<sup>150</sup> Ibid, 459, [35].

<sup>151</sup> Ibid, 458-459, [27]-[32].

<sup>152</sup> Ibid, 460-461, [42]-[53].

<sup>153</sup> Reason, *Managing the Risks of Organisational Accidents*, above n 8 **Error! Bookmark not defined.**, 9-11.

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 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.

### ***Applying the proposed definition of fault***

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.<sup>154</sup>

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 to distinguish between fault and a failure to reduce preventable harm as a basis for imposing liability on a statutory authority. This involves an acknowledgement that the concept of taking reasonable care to alleviate the risk of harm is quite different from the role of a safety system in reducing the occurrence of preventable 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.<sup>155</sup> The aim of this coordinated response would have been to reduce the number of people making uncontrolled crossings of the freeway. 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.

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<sup>154</sup> Scott Veitch, *Law and Irresponsibility: On the legitimization 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'.

<sup>155</sup> Braithwaite, above n 33, 87-108 (as a form of nodal governance).

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.<sup>156</sup>

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.<sup>157</sup> 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.<sup>158</sup> 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 been the most effective way of reducing the occurrence of preventable harm produced by the large number of people making 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 and, according to Justice Ipp, would have deterred Ms Edson from making this particular uncontrolled crossing of the

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<sup>156</sup> Ibid, 468, [97].

<sup>157</sup> Ibid, 471, [106].

<sup>158</sup> Ibid, 473, [126]-[127].

Freeway.<sup>159</sup> 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 responsibility for either alleviating this particular harm or reducing the occurrence of preventable harm. But 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 in these circumstances will not normalise the occurrence of preventable harm. It will allow tort law to probe our systems of governance to see how these promote our vulnerabilities harm. 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'.<sup>160</sup>

## 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

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<sup>159</sup> Id.

<sup>160</sup> *Graham Barclay Oysters Pty Ltd v Ryan* [2002] HCA 54, [6].

pay damages. Any proposal for tort law to fulfil this role would be a quixotic one. Rather, it is founded on the capacity of tort law to ‘probe our social structure and culture to see how these promote our vulnerabilities’.<sup>161</sup> 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 implement safety systems. 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 harm to particular plaintiffs by reducing the occurrence of preventable harm.

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 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

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<sup>161</sup> Perrow, above n **Error! Bookmark not defined.**

obligations'.<sup>162</sup> 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.<sup>163</sup> 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.<sup>164</sup> At the level of regulation of activities there are suggestions of the need to experiment with the structure of industries.<sup>165</sup>

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'.<sup>166</sup>

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<sup>162</sup> Susan Silbey, Ruthanne Huising and Salo Coslovsky, 'The "Sociological Citizen" Relational Independence in Law and Organisations' (2009) 59 *L'Année sociologique* 201, 202-203.

<sup>163</sup> Ibid, 221-227.

<sup>164</sup> See for example, Michael Roberto, Richard Bohmer and Amy Edmondson, 'Facing Ambiguous Threats' (2006) *Harvard Business Review* 106.

<sup>165</sup> Braithwaite, above n 33, 27-29 (the potential for 'democratic experimentalism'). See also Perrow, above n **Error! Bookmark not defined.** (an argument for encouraging networks of small firms to move away from large organizations as the basis for economic activity).

<sup>166</sup> John Dewey, *A Common Faith* (1934),