Should risk management become a statutory duty?

Few lawyers have seen cases exposing risk management deficiencies result in lasting reform, writes **Bernard Collaery**, who argues risk management should become a personal duty of care.

Many lawyers slip into risk management terminology only after a negative event. For workplace safety lawyers it may be a full-time concern, but for personal injury lawyers and some prosecutors the event involves a one-off identification of a risk that materialised, assessment of its probability and a calculation of the negative effect of the risk that was not managed properly for the victim. Litigation occurs.

The matter is resolved one way or another and the files are archived. I am sure that many lawyers have been involved in cases that expose risk management deficiencies but I venture to say that few cases have resulted in the acceptance of personal responsibility or lasting reforms.

Sometime before the Thredbo alpine landslide tragedy on 31 July 1997, Village Management employed a risk management firm whose audit recommended enhancement of fire protection for the village. Accordingly, a ring water main was installed above the village. In part, the fibrous-cement main ran through unstable road batter above the village. Combined with ineffective anchorage points and the use of non-ductile piping, fracture resulted, with the overburden becoming saturated. The rest is history. Thredbo was a classic example of intangible risk management. Namely, the type of risk that has a close to 100 per cent probability of occurring but is ignored because of a complete lack of identification of the risk.

On 18 April 1999, in total darkness, an RAAF F111 maritime strike aircraft executing a simulated missile attack flew into the steeply rising volcanic peak of Palau Aur in the South China Sea. At that time the squadron tactic was “Straight in Silent and Low” (SISAL). This tactic, which involved turning off radar systems that could “paint” the aircraft’s position, divested a sophisticated strike aircraft of its Terrain Following Radar (TFR) relegating crew safety to that of a Second World War Beaufighter. Possessed of one of the great technological marvels of the twentieth century, how did the RAAF justify SISAL?

On 30 January 2005 an RAF Hercules transport aircraft involved in high-risk missions in Iraq was brought down by perhaps one small calibre projectile. Fast jets in the RAF had inerting systems in their fuel tanks but not transport aircraft. Which fixed-wing aircraft were exposed for the longest time to enemy fire? Vulnerability had been identified but not acted on.

On 5 May 1998 the engine room in HMAS Westralia was filled with high-density fumes after a relatively small quantity of pressurised fuel sprayed a 60-second flame onto a bulkhead containing plastics etc. What the fire eater at Circular Quay could do with his fire spray could not be done in an old fashioned engine room, namely, quickly venting the fumes and lowering heat level. The engine room did not comply with international safety at sea requirements (SOLAS) in a number of critical respects. How did the RAN, which had never managed a tanker, purchase a tanker whose sister ship, some years earlier, had had an engine fire before being laid up as obsolete by the UK Ministry of Defence?

On 12 April 2004 the charter fishing vessel Karlissa T founded at the Narooma Bar. The maritime agency responsible for licensing the vessel also provided advice on how to cross the bar by timely positioning ahead of incoming waves which have an average speed of 15 to 17 knots, but Karlissa T had a maximum speed of 12 to 15 knots. How does one arm of an agency say one thing and license another?

On 13 July 1997, the former Royal Canberra Hospital, although it stood on open ground suitable for conventional demolition, was imploded. The government invited the public, despite advice that the implosion should be done early in the morning without public notice. Military Range Safety rules for high-explosive metal fragment events stipulated bunker protection and minimum distances. The 100,000 plus crowd was allowed to face the implosion at less than half the distance a soldier would – without protection. A lot of the non-masonry shrapnel fell behind the crowd but one piece showered a 12-year-old's family and bystanders with her body fragments. The event was a massive risk management failure.

On 21 April 1999 at a Canberra Hospital “P”, while in birth labour, was allowed to take a comforting one-hour warm shower after a non-reassuring Cardiotocographic (CTG) trace. After being reconnected to the CTG the trace was alarming. The child was born with severe hypoxic-caused cerebral palsy.

On 15 March 2002 in Canberra the parents of identical twin baby boys called for an ambulance when one infant was found late at night to have a high fever. Ambulance officers administered Panadol, reassuring the young parents. Should we expect the ambulance service to have in its protocols advice on the identification of meningococcal infection? Taken unconscious to casualty the following morning the infant was accidentally administered a massive dose of Dopamine (set aside for a psychiatric patient) instead of Dilantin, an anti-convulsant.

On 24 May 2008 in Canberra “F”, more than 6 weeks pregnant, went to hospital with some bleeding. After ultrasound a miscarriage was diagnosed. “F” was administered Misoprostol, without being told the drug was a drug of illegal abortion

choice in Catholic Brazil, with literature correlating infant brain deformities with its failed use. The diagnosis of miscarriage was wrong. The infant suffered brain deformities. No safety protocol existed.

The cost to loved ones and the community in every emotional and financial sense of dealing with the outcome of poor risk management is incalculable. Should risk management be mandated in all areas of known potential risk? At common law risk management becomes a lawful requirement ex post facto in terms of the duty of care. But, as Justice Michael McHugh, formerly of the High Court, often reminded us, the common law duty of care does not exist at large, rather, it is plaintiff and salient facts-specific. This tends to lessen the prospect of risk issues being critically analysed for common indicia.

Should risk management create a new range of defendants, particularly in corporate liability terms? Would risk management then become a game of contracting out risk management to avoid facing the risk rather than avoiding the risk itself? Do industrial manslaughter laws effectively attribute penalty for the failure to manage risk? Should management be punishable for a culpably incompetent first-aid officer or should the officer? To what extent is the tolerance of risk, for example, of potential structural metal fatigue or signalling software glitches a departure from acceptable standards of care to the criminal and/or civil standard and who would measure this?

Perhaps the answers lie in sector-by-sector reform. In the UK draft regulations have been issued recently for health care providers governing registration with the Care Quality Commission. The regulations will require providers to "... identify, assess and manage risks relating to the health, welfare, and safety of service users and others". In this endeavour providers should take expert advice and, where necessary, make changes to treatment or care in the light of analysis of incidents.

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The Australian Commission on Safety and Quality in Health Care collects Root Cause Analysis (RCA) reports from providers but the outcome in Australia is opaque in terms of open risk management and shrouded by legislative provisions that deny even to patients (and their lawyers) many "incident reports" that are not included in patient clinical records. In the Misoprostol incident in Canberra none of the extensive interaction at expert clinical level was recorded in the released clinical notes.

Readers can get a quick overview of the whole risk management debate at Wikipedia, but the tragedies that have been managed for plaintiffs over the years in our law practice have barely elicited a personal rebuke for any individual because the defendant organisation concedes, or is found to have, systemic management deficiencies. This assists individuals to evade personal responsibility. Large sums are awarded, plaintiffs and defendants try to recover some of their losses, but the individuals who contributed to the systemic failures go to work the next day.

In his recent report, Mr Haddon Cave QC named a number of senior military officials and civil servants as personally responsible for the loss of 14 lives in an RAF Nimrod over Afghanistan (http://www.nimrod-review.org.uk/). The UK Government is considering action. Is this the beginning of a new era of moving risk management from being a buzz word to a personal duty of care? I say the sooner the better.

Bernard Collaery is a senior partner at Collaery Lawyers

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