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Review the Commission of Inquiry into the collapse of of a viewing platform at Cave Creek near Punakaiki on the West Coast.

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Judge Noble's report has been divided into four sections:

- Preliminary information and contents (PDF, 185K)
- Part one (PDF, 778K)
- Part two (PDF, 471K)
- Witness list (PDF, 182K)

Key points of the report

Summary from the epilogue

"What caused this catastrophe to happen? Standing back and viewing the evidence objectively I am left with the overwhelming impression that the many people affected - victims and their families, departmental employees and their families and others closely associated with the disaster - were all let down by faults in the process of government departmental reforms.

"No government department can do its job without adequate resourcing. In my opinion, it is up to governments to ensure that departments charged with carrying out statutory functions for the benefit of the community are provided with sufficient resources to enable them to do so. Here, the evidence is clear that the Department of Conservation lacked, and continues to lack those resources. For future safety that must change." Noble report.

Dominant cause of collapse

"From the engineering evidence it is clear that the proximate or dominant cause of the collapse was that the platform was not constructed in accordance with sound building practice. This resulted in a total and catastrophic failure." Noble report.

Secondary Cause 1 - Failure to provide qualified engineering input into design and approval of the project.

(i) When the department was created an appropriate framework for management of design and construction of structures was never laid down and given to conservancies and then to field centres.

(ii) Officers at both regional conservancy and field centre levels were inadequately instructed regarding the management of design and construction of structures.

Secondary Cause 2 - Failure adequately to manage the construction.

(i) The expert evidence is that adequate working drawings and specifications ought to have been prepared under certification by a qualified registered engineer. They were not.

(ii) Such plans ought to have been strictly followed in construction. No plans were followed.

(iii) Construction ought to have been carried out by suitably skilled tradespeople under the supervision of a qualified and suitably skilled carpenter. It was not.

(iv) The building project ought to have been appropriately planned, sequenced and managed. It was not.

Secondary Cause 3 - Failure to comply with Statutory Requirements.

Doesn't list any conclusions but covers the Building Act and the department's failure to comply with it in terms of a consent for the platform (DOC did try and get a retrospective consent but was declined); the Resource Management Act (RMA) and the Health and Safety in Employment Act (HSE).

Secondary Cause 4 - Lack of inspections.

"It is common ground that the platform was never the subject of any formal inspections, either during or after construction … I conclude that there were no formal inspections of the platform following construction, and even if there had been, it is unlikely that the fundamental design and construction details would have been revealed." (This is because inspecting it would have required the platform to have been substantially dismantled).

Secondary Cause 5 - Lack of warning signs.

"In general terms the engineering evidence is against the use of loading restriction signs, except in specific back country circumstances. The emphasis is directed towards design and construction that, in terms of platforms, allows the structure to carry the maximum possible load which could crowd onto a platform within appropriate safety margins. So on the face of it, no warning signs were necessary at Cave Creek, although, in human terms a loading restriction sign might have had a cautionary effect."

However a sign limiting numbers to 5 had been ordered and delivered to the Punakaiki field centre in January 1995.The relevant officer was on leave, the signs were tidied away and when the officer returned, the pressure of work, including acting as Field Centre manager meant he overlooked the sign. "If the 'maximum

5' sign had been in place and observed by those present on 28 April, a tragedy of this scale would have been prevented. It is conjectural whether, under a maximum load of five people, the platform would have failed then, but on the engineering evidence it would probably have failed under that loading at some time."

Secondary Cause 6 - Systemic failure.

Judge Noble concluded that substantial systemic failure was the pre-eminent secondary cause of the collapse. He noted the following points in which the relevant evidence demonstrates that:

(i) "No proper and adequate project management system was either inherited or formulated by the department upon its inception."

(ii) "Despite Dr Edmond's claim that systems existed on the West Coast to ensure that a suitable structure was built at Cave Creek, no evidence was presented by any of the head office staff to show the existence of a proper, regularised department-wide system of project management appropriate to each of the 14 conservancies and the 66 field centres, or the existence of one pertinent to the West Coast Conservancy. No evidence suggested that anyone in the organisation had been given the responsibility of preparing such a system ... I conclude that there were no effective systems of management, inspection and control."

Root causes of the collapse

"The root causes of the collapse lie in a combined systemic failure against the background of an underfunded and underresourced department employing (at least at grassroots level) a band of enthusiasts prepared to turn their hands to any task, but who were subject to pressures not only from the overzealous conservationist element but also from altered priorities.

"They were doing their best to meet public demand and (in this case) building structures where no proper or appropriate system of control had ever been designed at head office level, and properly put in place and monitored at regional conservancy and thence at field centre level, to ensure that the procedures were followed. With regret I reach the inevitable conclusion that against that background, a tragedy such as Cave Creek was almost bound to happen.

The Cave Creek platform was not a priority project. If funds were not available it could have been deferred (as it had been the previous year). No reduction in funding was imposed so no economies should have been made in design and construction. Nevertheless I find it was conceived and built within a culture designed to do more with less."

DOC acceptance of responsibility

An important point to note is that, as the judge commented: "the department very quickly and properly acknowledged its responsibility." As Mr Rennie (counsel for the department) said:

"A series of errors combined to produce a dangerous and in the end disastrous situation. The Department of Conservation has already publicly accepted that it is responsible for those errors and their disastrous result. It has also sought and supported the present Inquiry so that these matters are investigated independently of the department. The aim is to ensure that such an accident could never happen again."

Recommendations (not an exhaustive list but the ones most relevant)

- The crown's exemptions from the Building Act and the Health and Safety in Employment Act should both be removed. It also recommended consideration be given to amending S80 of the Building Act so as to make it an offence to use any structure for public use for which a building consent has been issued until a code compliance certificate is issued; and for which a building consent is required but for which no consent is held.
- That the department promote the HSE Act with diligence and thoroughness within the West Coast conservancy and ensure its implementation and application by proper training.
- The department, with priority, completes and implements the project management system, incorporating all necessary steps from initial conception of a project to post-completion inspection and checking; and adequately trains and continuously supports staff.
- The government adequately resources the department so that it may provide adequate and properly qualified staff to ensure the continuous correct implementation of the project management system.
- That the department implement and proactively monitor a complaints reporting system.

All these recommendations were implemented and the HSE promotion is throughout the country and not confined to the West Coast.

The other more general recommendations were to institute a combined regional disaster and trauma plan for the West Coast.

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Contact

The Department of Internal Affairs
Te Tari Taiwhenua
PO Box 805
Wellington
New Zealand

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