CORONERS FINDINGS AND CONCLUSIONS

CORONER'S FINDINGS (SECTION 56 *CORONERS ACT 1956*)

1. Katie Bender died instantly at about 1.30pm on Sunday, 13th July 1997 on the foreshore of Lake Burley Griffin in the vicinity of Lennox Gardens Canberra whilst watching the demolition by implosion of Royal Canberra Hospital on Acton Peninsula with her family. Katie Bender died as a result of being struck in the head by a fragment of steel expelled from the Main Tower Block during the demolition process. I find that Rodney Douglas McCracken and Anthony Bruce Fenwick contributed to her death. Cameron Dwyer and Gordon Ashley also contributed to her death.

RODNEY DOUGLAS MCCRACKEN – MANSLAUGHTER BY GROSS NEGLIGENCE

2. Rodney Douglas McCracken will be committed for trial for the indictable offence of manslaughter by gross negligence. Anthony Bruce Fenwick will be committed for trial for being knowingly concerned in the commission of that offence by Rodney McCracken.
3. The elements required to establish the offence of manslaughter by gross negligence are set out in the decision of R v Adomako (1995) 1AC171 at 187. Lord Mackay with whom the other Law Lords agree said: -

> "The ordinary principles of the law of negligence apply to ascertain whether or not the defendant has been in breach of a duty of care towards the victim who has died. If such a breach of duty is established the next question is whether that breach of duty caused the death of the victim. If so, the jury must go on to consider whether that breach of duty should be characterised as gross negligence and therefore as a crime. This will depend on the seriousness of the breach of duty committed by the defendant in all the circumstances in which the defendant was placed when it occurred".

4. A breach of the relevant duty is constituted by either an act, an omission or both. The NSW Court of Criminal Appeal, has said: -

> "D(efendant) may also incur liability for an offence which is defined in terms of the doing of a positive act, by virtue of an omission to act, where the common law or a statute expressed or by implication imposed upon the defendant a duty to act. Thus, although manslaughter is usually defined in terms of the doing of an act causing death, and indeed, it is usually committed by a person so acting, it can be committed by an omission to act".
>
> See R v Taktak (1988) 14NSWLR 226 at 237.

5. The requisite intent required to establish the offence is set out in the decision of Nydam v The Queen (1977) VR430 at 444 where the Full Court of the Supreme Court of Victoria said: -

> "The requisite mens rea is, rather, an intent to do the act which, in fact, caused the death of a victim, but to do that act in circumstances with a doing involves a great falling short of the standard of care required of a reasonable man in the circumstances and a high degree of risk or likelihood of the occurrence of death or serious bodily harm if that standard of care was not observed, that is to say, such a falling short and such a risk as to warrant punishment under the criminal law".
>
> The High Court of Australia endorses these remarks in Wilson v The Queen (1991 – 1992) 174 CLR313 at 333.

6. There is in my view a strong basis for finding that Mr. McCracken and Mr. Fenwick owed a duty of care towards Katie Bender. The duty arises in a number of ways under the common law and/or the *OH&S Act*, the various Standards and Codes referred to in this Report and under the various contracts negotiated by CBS and CCD. Mr. McCracken and Mr. Fenwick were well aware of the presence and location of the crowd of spectators. Under the *OH&S Act* there are duties to ensure that workplaces are safe and without risk to health or harm to people. The duties are imposed on employers and any person who has any form of control of the workplace. PCAPL under its contract appointed Mr. Dwyer to act on its behalf and as such had a duty pursuant to Clause 2F and Paragraph 6.5.3 of the Project Management Manual where it states "to take all reasonably practical steps to ensure that persons at or near a workplace under the Project Managers control, including those who are not employed on the site, are not exposed to risk to their health or safety arising from the conduct of the Project Managers responsibilities". Mr. Fenwick in signing his contract between CCD and the Territory had a similar duty of care imposed upon him.

7. The acts and omissions amounting to gross negligence on the part of Mr. McCracken contributing to the death of Katie Bender were: -

a. The amount of explosives (480 to 500kg) used on 13th July 1997 compared to what he indicated he would use only days earlier (note, as a comparison, the amount of explosives used the 1998 car bombing in Omagh, Nothern Ireland was 600kg),
b. The failure to take prudent steps to ensure that the cutting charge methodology as set out in his workplan was in fact used,
c. Never having used Riogel before,
d. Mr. McCracken had never used backing plates in this manner on any prior demolition,

e. Mr. McCracken never tested the backing plates before testing them,
f. Mr. McCracken's failure to properly advise Mr. Ashley that the method of demolition was implosion in order to ensure the pre – weakening was appropriate for that method,
g. Mr. McCracken's failure to obtain any independent expert advice of an engineering nature or a demolition explosives expert to confirm that his final method was in fact safe, given all the changes he had made to his methodology and the fact that he had never before imploded steel framed buildings of this kind,
h. His failure never to calculate and set a precise exclusion zone which took into account the significant changes he made from time to time to his methodology,
i. Mr. McCracken's failure to properly inform Mr. Fenwick, PCAPL, WorkCover and TCL of the changes to his methodology by either amending his workplan or the Appendix K response to fully detail and explain the consequences of these changes.
j. The failure to ensure that in accordance with his own methodology all explosive charges at the lower level of each column were placed above the half moon cut, despite stating it was his responsibility to conduct the final checking,
k. Apparent duplicity in providing information on explosive quantities and cutting charges at times when he was well aware these figures were not accurate and that he had abandoned any intention to use cutting charges,
l. Mr. McCracken was fully cognisant of the possibility of flying debris being produced as a result of:-

    i. His admissions to police that when using explosives on steel there was a possibility of steel fragments being ejected,
    ii. His possession of the Du Pont Blasters handbook 15th Edition that specifically warned or the "very definite danger" from flying fragments of metal when blasting iron or steel. The handbook warned that pieces could be expected to travel several hundred feet with the chance of severe injury to people. For that reason the handbook stressed the need to provide ample protection against that hazard. It further warned that the charges should be located in such a way as to blow the fragments away from people,

iii. His statement that the outside columns and the upper floors were loaded more lightly because of the possibility of fly,

iv. His statement to Mr. Dwyer on 9th July 1997 that "minimal fragments go that way (towards the Hospice), more fragments go that way (towards the lake),

v. His comments to Mr. Messenger on 10th July 1997 that he expected the columns to shatter,

vi. His use of the backing plates specifically because of his belief that the charges might otherwise blow through the web,

vii. Mr. McCracken conceded the possibility in Section K4(e) that fly may not be able to be confined within the building for directions other than the Hospice,

viii. His concession during the video walk around that he would expect that fly material around the site and perhaps as far as 200 metres,

ix. The test blast he conducted under different conditions to those ultimately employed resulted in some fly,

x. The fact that he used cartridge explosives on steel

instead of specially designed shaped charges whether or not for the purposes of cutting despite being contra indicated in the *Demolition Code of Practice*, and

xi. The comments made to Mr. Mazzer on 11th July 1997 that the charges had been placed on the inside of the columns "so it blows the columns forward away from the hospital…so that if there is a bit of shrapnel it will fly in the same direction to where no one is standing".

8. Mr. McCracken had 30 years experience in the use of explosives and his understanding of their effect on steel so therefore he must have been or ought to have been aware of what Mr. Loizeaux describes as the "ever present real probability, not possibility, that (throwing projectiles) is one of the ways that excess energy will be dissipated under any detonation". Mr. McCracken's own promotional video graphically demonstrates this proposition.
9. Mr. McCracken despite all indications of the risk of flying debris reconfigured the blast in such a way that it was to his knowledge in the direction of the crowd. He failed to take any steps to ensure that adequate protective measures were in place between the explosives, the column

web and the crowd. The only measure that he could possibly be described as being protective on the lake side of the building facing Katie Bender was the bund wall that was too low to capture any debris coming from the ground floor, was too low to catch all material from the lower ground floor and in any event had a gap in the vicinity of column C30 and did not even extend across C74. The photographs show the absence of any protective measures along the face of the building. The photographer was taking these photographs standing in a position directly between the unprotected columns and where Katie Bender was standing when struck by the fatal fragment of the web on 13th July 1997.

10. The methodology used on Sunday, 13th July 1997 was a disaster in waiting for these reasons: -

    a. The evidence was that the steel was mild steel of the kind generally used in the construction of buildings of this type,
    b. The use of this type and amount of explosives against steel in this fashion resulted in fragmentation entirely consistent with what would be expected,
    c. The method of cutting the columns (the half moon cuts) combined with the gearing effect of oxy - acetylene cuts and the weight of the building meant that the columns could never have kicked out as intended,
    d.
    e. The quantities used were clearly excessive,
    f. The protective measures were virtually non existent, and
    g. The blast was in the direction of the crowd across the lake and the possibility of flying fragments being produced was well known to Mr. McCracken.

11. Section 59 of the *Coroners Act 1956* provides if the Coroner is of the opinion that the evidence is capable of satisfying a jury beyond reasonable doubt that a person has committed an indictable offence the Coroner shall proceed in accordance with the *Magistrates Court Act 1930* and commit the person for trial in the Supreme Court. I am satisfied that Mr. Rodney Douglas McCracken should be committed to stand his trial in the Supreme Court of the Australian Capital Territory for the offence of manslaughter of Katie Bender as provided for in Section 15 of the *Crimes Act 1900.*

<u>ANTHONY BRUCE FENWICK – KNOWINGLY CONCERNED IN MANSLAUGHTER BY GROSS NEGLIGENCE</u>

12. The evidence is such as to satisfy me that Mr. Fenwick was knowingly concerned in the manslaughter of Katie Bender by Mr. Rod McCracken by reason of: -

    a. his knowledge that a large crowd of spectators would be present to witness the demolition,

b. the failure to ensure that his subcontractor was properly experienced and competent to undertake the demolition when such enquiries would have revealed that his subcontractor had no previously imploded a multi – storey steel framed building of any type before,
c. the absence of any real or effective supervision of his subcontractor Mr. McCracken in the following material respects:-

i. Permitting his subcontractor to commence work without having prepared a workplan,
ii. The failure to ensure that the subcontractors proposed method of demolition had been approved by a qualified structural engineer prior to the commencement of work as required by Specification 18 of the contracts or at any time thereafter,
iii. The failure to ensure that the subcontractors workplan complied with the *Demolition Code of Practice,*
iv. The failure to ensure that the subcontractor either used specially designed shaped charges to cut the steel as proposed in his workplan or alternatively to ensure that any method used in substitution for

collapsing the steel columns had been competently assessed as safe,

v. After becoming aware of the Hospice meeting on 2nd July 1997 that his subcontractor then proposed to use 130kg of explosives in total for both buildings he failed to take any steps either to ensure that the subcontractor did not exceed that quantity or alternatively that any proposal to increase that quantity of cartridge explosives had been competently assessed as safe,
vi. The drawings indicated an amount of explosives significantly greater than 130kg being used and as such he failed to ensure that this additional quantity had been competently assessed as safe,
vii. Mr. Fenwick's absence from the worksite from the morning of Friday 11th July 1997 until 10.30am on Sunday 13th July 1997 during a critical stage of the implosion process in which time the subcontractor

was loading increased quantities of cartridge explosives against the steel columns,

viii. The failure to ensure that the method of cutting and

pre – weakening the steel columns was consistent with the proposed method of demolition and safe,

a. The failure to ensure that his subcontractor provided considered advice as to the appropriate exclusion zone to ensure the safety of the crowd and his further failure to comply with the direction of Mr. Dwyer to advise him of the "safe viewing distance",
b. The failure to ensure that the method finally used by his subcontractor to collapse the steel columns had either been tested or otherwise competently assessed as safe prior to detonation including the use of backing plates, prepared by Mr. Fenwick's own workmen to strengthen the columns,
c. Given such test blasting as had been performed by Mr. McCracken had resulted in steel fragments being projected, Mr. Fenwick then failed to ensure that the method finally adopted had sufficient protective measures in place to prevent any debris emitted by the demolition escaping the site,
d. Given that the blast had been reconfigured by the subcontractor in the direction of the crowd Mr. Fenwick failed to ensure that sufficient protective measures were in place to prevent any debris being emitted by the demolition escaping the site, and
e. Having regard to the Appendix K response he conceded the possibility of debris flying in directions other than towards the Hospice, Mr. Fenwick failed to ensure that sufficient protective measures were in place to prevent any such debris escaping the site.

13. Mr. Fenwick owed a duty of care to Katie Bender as a member of the crowd of spectators on the other side of Lake Burley Griffin. The matters set out above demonstrate a large number of omissions rather than positive acts on Mr. Fenwick's part. These acts and omissions contributed to the death of Katie Bender.
14. The High Court of Australia sets out the principles dealing with accessorial liability in the decision of Giorgianni v The Queen (1985) 156CLR 473 and accordingly it must be stated that Mr. Fenwick knew: -

a. A large crowd was present as spectators in the vicinity of the implosion,

b. The blast had be reconfigured away from the Hospice and towards the crowd,
c. There was a possibility of fly material being expelled by the implosion in the direction of the crowd,
d. There was no adequate protective measures in place to prevent any such fly material from leaving the implosion site, and
e. Mr. Fenwick knew the final implosion methodology employed by Mr. McCracken had changed significantly in the early days of July 1997 and had not been tested prior to the implosion itself.

15. It should be noted that I have disregarded Mr. Fenwick's ROI with the Australian Federal Police as I have some reservations as to its admissibility. That is a consideration for the Director of Public Prosecutions. Section 59 of *Coroners Act* again applies. Anthony Bruce Fenwick will be committed to stand his trial in the Supreme Court of the Australian Capital Territory for the offence of being knowingly concerned in the offence of the manslaughter of Katie Bender on 13th July 1997.

CAMERON DWYER

16. Mr. Cameron Dwyer is in a totally unrelated set of circumstances to those of Mr. McCracken and Mr. Fenwick. Mr. Dwyer presents a number of complex legal issues primarily as to his state of knowledge. There are a number of significant failures by Mr. Dwyer during the life of the project. The failures were in the nature of omissions rather than positive acts. The Project Management Agreement imposed upon Mr. Dwyer and PCAPL supervisory functions and responsibilities over the demolition contractor Mr. Fenwick and the implosion subcontractor Mr. McCracken. These responsibilities existed notwithstanding the position adopted by Mr. Dwyer and his company during the Inquest.

17. Mr. Dwyer's evidence on many occasions throughout the Inquest was far from satisfactory. One gained the impression from Mr. Dwyer's demeanour during his evidence that he had no appreciation of the significance of what was occurring or what he was being told about the site which would warrant some assertive action on his part. Mr. Dwyer frequently stood by and did nothing or very little to examine the various circumstances that arose from time to time directly applicable to his functions. Mr. Dwyer seemed blind to the real issues facing the project. He failed to respond to the constantly changing situations on the site being created by the contractor and subcontractor on a daily basis. There were times in his evidence that the only inference one could draw about Mr. Dwyer's lack of management of the project was that he was incompetent. I have previously stated that it was really more a lack of skill and capacity to handle Messrs. Fenwick and McCracken and to follow through on his own initial actions to produce positive outcomes.
18. The additional problem which should no longer delay the presentation of these findings of this Inquest concerns the claims of privilege made on the grounds of self incrimination not only during the Inquest but subsequently

submitted to me in Chambers during the course of the deliberation of this decision. Counsel for PCAPL in a separate presentation to their general submissions made on the evidence tendered on 23rd April 1999 no less than 163 submissions seeking privilege. Accordingly that material will be considered after the publication of these findings. The claims have not yet been taken into account.

19. The inadequacies of Mr. Dwyer's management of the project are reflected in various chapters of this Report but in particular I should itemise some of the more poignant facts: -

    a. Mr. Dwyer's decision to recommend City and Country Demolition as the successful tenderer in circumstances where there was simply no inquiry made about the experience and capability of the proposed implosion subcontractor. The tender documents by CCD did no more than mention a name nor was nothing known about the actual method proposed to be used,
    b. Mr. Dwyer permitted work to commence and continue notwithstanding his own direction of 21st April 1997 and the contractual requirements that no work should occur until Specifications 11 and 18 had been complied with,
    c. Mr. Dwyer well knew by early June 1997 that a large crowd of spectators would be present to witness the implosion,
    d. After Mr. Hugill ceased his involvement and Mr. Dwyer required the substitution of a structural engineer with implosion experience he failed to ensure that Mr. Gordon Ashley had the requisite experience nor did he fully supervise the cutting of columns and the failure to ensure the method of cutting and pre – weakening the steel columns was consistent with the proposed method of demolition being safe,
    e. Mr. Dwyer failed to ensure that every time Mr. McCracken changed his methodology he made no enquiry, directly or indirectly, personally or by any other agency, to ensure that the changes were competent and safe, (I refer in particular to the change in type and quantity of explosive, the reconfiguration of the blast and the failure to employ the protective measures in the nature of bund walls and wire meshing fence in addition to the cladding to the columns).

19 (a) Mr. Dwyer fully acknowledged as did his Counsel that he was to act as a conduit between the demolition contractors, the people organising the public event and the general co – ordination of meetings knowing full well that people would rely on his advice particularly having regard to his own direction of 2nd June 1997 requiring Mr. Fenwick to comply with advice as to the safe viewing distance,

    a. Mr. Dwyer was present when Mr. McCracken told the Hospice meeting on 2nd July 1997 that he might reconfigure the blast. This was a classic

circumstance where Mr. Dwyer should have maintained constant pressure upon Mr. McCracken to ascertain in what way the blast was to be reconfigured and if it was to be reconfigured was it then safe to proceed with the demolition on Sunday 13th July 1997. The end result of all this was Mr. Dwyer took an active role in drafting the Appendix K response which went out under his name and in particular specific mention is made in that document to the possibility that flying debris would not be able to be contained within the buildings except in the direction of the Hospice.

17. On 9th July 1997 Mr. McCracken told Mr. Dwyer that flying debris would be generated from the implosion some of which would go in the direction of the lake. Mr. Dwyer had viewed the promotional video of Mr. McCracken upon the demolition of the Ryde (Sydney) convent where there was an exclusion zone of 500 metres. An examination of that video depicts a large amount of brick and debri being thrown large distances at great speed. There were other demolitions depicted on the video e.g. wheat silos where there were no protective measures taken and debris was observed flying from the demolished buildings. Mr. Dwyer, despite this knowledge, failed to ensure that sufficient protective measures were in place to prevent any such debris escaping the site.

21.

a. Mr. Dwyer directed that no test blasting should take place without his prior written approval. Mr. McCracken simply did not comply with this direction. Mr. McCracken went ahead in total defiance of Mr. Dwyer's very proper demands. Yet Mr. Dwyer failed to take any action on this conduct. Mr. Dywer noted after the implosion that Mr. McCracken had advised him orally prior to the occurrence of each test blast. The test blast performed by Mr. McCracken had resulted in steel fragments being projected. It must be said that Mr. Dwyer failed to ensure the method finally adopted had sufficient protective measures in place to prevent any debris being omitted and escaping from the demolition site.
b. There was a failure by Mr. Dwyer to ensure the method used by Mr. McCracken including the use of backing plates had been either tested or otherwise competently assessed as safe prior to the detonation.

22. Many of these failures reflect a lack of knowledge of the *Demolition Code of Practice.* Some of these failures would not have occurred if the code had been strictly enforced by Mr. Dwyer.

23. Mr. Dwyer owed a duty of care to Katie Bender as one of the members of the crowd of spectators. These few examples demonstrate the acts of omission on his part. The real concern is not only his state of knowledge but the extent of the admissibility of the matters of which are set out above. Strictly those are not issues for the Coroner but rather a jury and the Director of Public Prosecutions.

24. Despite my reservations about Mr. Dwyer's state of knowledge I am satisfied that his knowledge did extend to the following areas: -

a. A large crowd was present as spectators in the vicinity of the implosion,
b. The blast had been reconfigured away from the Hospice across the lake towards the crowd,
c. The possibility of fly material being expelled by the implosion in the direction of the crowd,
d. There was no adequate protective measures in place to prevent any such fly material from leaving the implosion site, and
e. Generally he knew that Mr. McCracken had significantly altered the implosion methodology.

25. The evidence does not satisfy me at the prima facie level for the purposes of Section 59 of the *Coroners Act 1956* or Section 91 of the *Magistrates Court Act* as being capable of satisfying a jury beyond reasonable doubt that Mr. Dwyer has committed an indictable offence of being knowingly concerned in the offence of manslaughter. The Director of Public Prosecutions, on a further view of the admissible evidence, may reach a contrary view. It is open to the Director of Public Prosecutions to commence criminal proceedings against Mr. Dwyer by an ex officio indictment. Accordingly, I am not prepared to commit Mr. Dwyer for trial in respect of any criminal offence arising under the *Crimes Act 1900.*
26. The evidence does satisfy me to the prima facie level that there is a case against Mr. Dwyer for breaches of the *Occupational Health and Safety Act 1989.* It is recommended that the Director of Public Prosecutions consider the institution of proceedings against Mr. Dwyer in respect of breaches of the Part III of the Act.
27. The *Occupational Health and Safety (Amendment) Act 1999* (No 24 of 1999) and the *Dangerous Goods (Amendment) Act 1999* (No 25 of 1999) commenced on the 6th May 1999. The publication of this legislation appeared in the ACT Gazette S22. This amending legislation which occurred during the course of the Inquest amidst some considerable controversy would permit prosecutions being commenced after Coronial findings have been handed down or an Inquest or an Inquiry is concluded. The position with such prosecutions prior to these Amendments was that Section 31 of the *Magistrates Court Act 1930* required the prosecutions be commenced within 1 year after the commission of an offence. The *Occupational Health and Safety Act* had no specific provision and was bound by the 1 year limitation period. Amending legislation now allows a prosecution to be commenced in the Magistrates Court within 1 year after the day in which a Coronial Report is made or a Coronial Inquest or Inquiry is concluded.

WARWICK LAVERS

28. The evidence does not support in my assessment the institution of proceedings against Mr. Warwick Lavers. The evidence does not satisfy me to the requisite degree at a prima facie case level that Mr. Lavers has committed any breaches of the *Occupational Health and Safety Act*. Mr. Lavers was the representative of the Project Director TCL and did not maintain or control a workplace in the same sense as Mr. Dwyer nor did he have the requisite technical experience to be providing sound and reliable advice. The Report addresses in detail the fact that Mr. Lavers was designated as a supposed expert and was under significant pressure from certain Government officials to provide advice particularly as to the viability of the implosion being staged as a public event. Although Mr. Lavers could in all the circumstances have exercised a greater degree of supervision and authority in relation to Mr. Dwyer I do not consider on the evidence or the public interest that a prosecution is warranted against this official.

TOTALCARE INDUSTRIES LTD AND PROJECT COORDINATION (AUSTRALIA PTY LTD)

29. The question must inevitable arise by reason of these conclusions as to whether the evidence supports charges against the two companies acting in the positions as Project Director and Project Manager. Mr. Dwyer of PCAPL and Mr. Lavers of TCL were employees of those corporations. Neither person could be described as being in the controlling mind of the company (see DPP, Victoria Reference No 1 of 1996 (1997), 96 Australian Criminal Reports 513). Both men had certain reporting responsibilities to their organisations. It seems to me that neither company had any substantive knowledge as to the activities of Mr. Fenwick or Mr. McCracken. I am inclined to the view advanced by Counsel for both companies that the evidence is insufficient nor does it warrant in the public interest any further consideration of whether the companies should be prosecuted.
30. It is my recommendation that neither corporation should be liable to prosecution for any criminal offence. I am not prepared to advance any views as to whether the actions of either corporation would warrant a finding of negligence on the civil standard of proof as it is my view that the question needs to be determined at another time and place in a different tribunal and jurisdiction.

GORDON ASHLEY

31. The comments made at Paragraph 130 of this Report in the topic headed Engineers should be considered.

WORKCOVER INSPECTORS

32. The comments made under the Role of Regulatory Agencies should be considered.

Dated this day of 1999

Shane G. Madden

Coroner