

Cave Creek: a national tragedy (A)

On Friday 28 April 1995, Department of Conservation (DOC) Chief Executive Bill Mansfield took an urgent phone call. It told him that one of the department's viewing platforms on the West Coast of the South Island had collapsed. Details were unclear, but there had been injuries and probably deaths. Rescue efforts, reliant on helicopters at the remote site, were already underway. By the end of the day, Mansfield was on the Coast, ready to inspect the scene, and the first questions were being asked, why this tragedy had occurred.

The Department of Conservation

Bill Mansfield took over the leadership of DOC in 1990. He would be the third chief executive in three years, picking up after lengthy spells with an acting CE; he would be working to the third minister since the department was established in 1987.

For most of his career a lawyer with the Ministry of Foreign Affairs, Mansfield had returned from New York in 1986 to become a deputy secretary of Justice, one of the largest public sector departments at that time, with management responsibility for around 2000 staff and a budget of approximately \$NZ200 million.¹ He had worked at Justice through the introduction of the State Sector and Public Finance Acts in 1988 and 1989.²

This case was written by Janet Tyson with supervision by Professor John Alford and Dr Richard Norman, ANZSOG. It has been prepared as a basis for class discussion rather than to illustrate either effective or ineffective handling of a managerial situation. The assistance of Keith Johnston, Keith Lewis, Hugh Logan, Bill Mansfield and Kerry McDonald is gratefully acknowledged.

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¹ In 1995 one \$NZ equalled \$US0.66.

² The two major pieces of legislation that reshaped the New Zealand Public Service, removing centralised control and introducing a number of private sector processes such as accrual accounting.

DOC was a new department. It had been created just prior to the State Sector Act as a consequence of the environmental reforms to consolidate the conservation functions of government in one operational agency, and the related decisions to place the commercial activities of government (including farming and forestry) into new state-owned enterprise structures. The State Sector Act was designed, among other things, to clarify the roles and responsibilities of ministers and departmental chief executives. The new Act devolved most human resources and accounting decisions to departments, encouraging CEs to act autonomously.

DOC's functions were drawn from six former agencies, including the Wildlife and Forest Services, and the Department of Lands and Survey. Established under the Conservation Act 1987, the long list of legislation it was required to administer included the National Parks Act 1980, Reserves Act 1977, Wildlife Act 1953, Marine Reserves Act 1971, Marine Mammals Protection Act 1978 and the Wild Animals Control Act 1977.

Under the previous organisational arrangements, like those in many other countries, decisions regarding forest management or recreational opportunities could be taken by the relevant organisation, without proper consideration of the effects on the habitats of species that were the responsibility of a different organisation.

In contrast DOC, charged with managing areas for conservation purposes in an integrated way, was a model much admired by conservationists in other countries and by high-profile international conservationists like David Bellamy and David Attenborough.³ Within New Zealand, however, the concept was not universally supported. In particular, elements within the private sector were concerned that DOC's priority on conservation would lead to reduced opportunities for tourism developments or other commercial activities on the conservation estate.

Funding and restructuring

Funding had been an issue since the DOC concept was proposed, with successive CEs putting the case, without success, for a lift in funding to match increased departmental responsibilities such as the new advocacy role under the Resource Management Act 1991. In real terms, funding had decreased by 18% overall between the 1987–88 and the 1995–1996 financial years. (*Exhibit 1*).

Budget management concerns had been largely behind the decision of the then Minister of Conservation to call in consultants Coopers and Lybrand in 1988. Following their recommendations, the former district management office tier was removed, leaving DOC with a three-tier structure: field offices, regional conservancies, and Head Office. As CE, Bill Mansfield had 24 direct reports. (*Exhibit 2*)

This was the second restructure staff had been through, and on each occasion the number of permanent positions had been reduced, with some associated redundancies and redeployments. The destabilising impact of this was evident in morale and productivity.

³ British-based conservationists widely known through their television programmes, and both frequent visitors to New Zealand.

On accepting the CE appointment, Bill Mansfield assured DOC's staff that in the interests of stability he would work within the new structure. Before he had been at DOC for a year, Mansfield would be working to another new minister. With the election of the centre-right National Government in November 1990, Denis Marshall became the fourth Minister of Conservation.

Distinct operational styles

DOC's founding CE, Ken Piddington, had sought to create a new culture for the Department distinct from the very different cultures of its predecessors. To that end he encouraged each conservancy to develop its own operational style. In some conservancies, the individual approach extended to developing new standard operating procedures in place of inherited ones.

The Coopers and Lybrand Report, produced at a time when decentralisation was a very favoured approach, recommended a clearer split between policy and operations, with the Head Office focussing primarily on developing strategic policies, and the management function and responsibility for providing specialist advice being at the regional conservancy level.

In practice, it turned out that some operational matters had to be dealt with nationally, while less formal links between conservancies and key head office personnel were devised to "get things done".

In his first three years as CE, Bill Mansfield travelled throughout New Zealand and visited all 71 field centres.

He would later recall how he was impressed by the "extraordinary commitment" of DOC's staff.

"Not only were the staff committed to their work, but, in my view, they compared very favourably, level for level, with those in other organisations at which I had experience. In particular I was impressed with the calibre of senior managers in the department, including senior conservators ...

"DOC staff ... believe in what they do, want to do jobs to a high standard and come under pressure from local communities when the organisation's ranking in priorities is not universally shared. However, taken too far, this can become a situation where too many tasks are taken on, workloads become too great, and mistakes are made. It has always been difficult to limit this enthusiasm and commitment of staff, which of course in many ways is commendable."⁴

As well, during the field visits, Mansfield identified problems with planning and prioritising, including what was then a public service-wide problem of making a big budget spend before the end of the financial year. He also found some ad hoc approaches to operating procedures.

⁴ Noble, G.S. (1995) Report of the Commission of Inquiry into the Collapse of a Viewing Platform at Cave Creek near Punakaiki on the West Coast, Wellington, Department of Internal Affairs, p 28. Referred to as COI in following footnotes.

Strategic direction

In 1992 Bill Mansfield had the opportunity to attend a course at the Ashridge Management School, in Britain, a private sector training establishment. While there he devoted time to developing Atawhai Ruamano (literally Conservation 2000), the strategic intent process intended, among other things, to introduce the coherence he identified as lacking in the department, and to establish clearer priorities for its work.

Six streams for development were identified during the Atawhai Ruamano process, including external relations with communities and interest groups, and a “People Plan” to help staff manage their career structures better, and develop management skills. Another, acknowledging the growing importance of tourism, was Visitor Services.⁵

Extensive internal and external consultation took place over Atawhai Ruamano in 1992 and 1993 including in each case an assessment of the Department’s strengths and weaknesses.

The West Coast conservancy

The DOC conservancy that managed the largest area of land was the West Coast (*Exhibit 3*). It was a strip of land stretching for 600 km (the distance from Auckland to Wellington or Melbourne to Mildura), between the Southern Alps and the sea, and accounting for 23 percent of the total national conservation estate. West Coast Conservator Bruce Watson had nine percent of the \$NZ120 million national budget, and a staff ceiling of 112.

The Coast carried the burden of many conflicting political expectations. Tourism was the new hope for the economy of a long-depressed region. DOC had to manage the balance between preserving the conservation assets to attract tourists, and minimising impact on jobs in the traditional extractive industries of mining and forestry.

A cause for optimism was the growing number of students enrolled at the Greymouth-based Tai Poutini⁶ Polytechnic. One of the most popular courses was Outdoor Education, which often made use of the newly opened Paparoa National Park. The park encompassed most of the spectacular landforms of the West Coast’s karst (limestone) country with its caves, canyons, and underground streams.

The new park had further boosted rapidly growing tourist numbers. The Punakaiki Visitor Centre, the second busiest in the country, had 167,000 visitors in 1994. But when the park had been established in 1987, the conservancy, like the rest of DOC, was working to a reduced budget, and was yet to see any of the funding promised to upgrade park facilities.⁷

The Cave Creek complex, with its spectacular karst formations, was just outside the new park. One of the projects approved in the West Coast business plan for 1992–93

⁵ Conservation 2000: Atawhai Ruamano proposed changes in three core areas of conservation results (Biological Diversity, Historic Heritage and Visitor Services) and three areas to change the way the department worked (staff management – the People Plan), External Relations, and relations with Maori.

⁶ Tai Poutini is the Maori name for the West Coast.

⁷ COI, p30.

was to develop and construct an interpretive walk for the area. The idea had come jointly from the West Coast Northern Operations Manager, Kevan Wilde, and Trevor Worthy, a contractor. Both were experienced in managing and interpreting karst landscapes. The concept included a viewing platform to give visitors a safer view of the spectacular, 30-metre deep Cave Creek chasm.

The project prescription⁸

The prescription for the project was prepared after the route was walked by Craig Murdoch, the Punakaiki Field Centre Manager, Kevan Wilde (Murdoch's immediate superior), and Les Van Dijk, then acting Conservation Officer, Recreation and Ecological Management, at Punakaiki.

Craig Murdoch delegated preparation of the prescription to Les Van Dijk. Van Dijk, a qualified motor mechanic for 15 years and subsequently a park assistant with the Lands and Survey department, had moved to DOC to work on various activities based at the Punakaiki Field Centre in 1987 and had been promoted to conservation officer in 1994.

He prepared detailed plans of the proposed high-level viewing platform. He had drawn these using a rough sketch Murdoch had given him, and with reference to "the green book", a department manual containing example drawings of boardwalks, stairs and portions of track formation. He thought, mistakenly, that they were suitable for use as construction plans. Kevan Wilde approved the prescription on 5 November 1992, and a week later Van Dijk ordered materials, including a 7m length of steel to be used in connecting the platform to a concrete step counterweight, to be delivered to Punakaiki.

On 30 April 1992, the conservancy had applied for a Head Office grant for \$NZ10,600, the estimated cost of materials for the whole project (i.e. track formation, boardwalk and stairs construction, construction of lower and upper viewing platforms and other related works.) \$NZ11,000 was approved on or before 27 June 1992. That meant that the moneys should be expended on the project before 30 June 1993. Neither the bid nor the funding approval referred to allowances for resource management and/or building consent application fees.

The Building Act, which for Crown agencies came into force in January 1993, required a permit for any structure from which a person might fall a metre or more. Head Office's policy people had not yet issued definitive advice on how the Building Act might apply to DOC constructions.

Preparation for construction⁹

Over the next months, work proceeded on various parts of the Cave Creek project. At Punakaiki, Les Van Dijk built a timber deck, referring to the plans he had drawn up, and this was delivered by helicopter to the site along with other materials, including a bag of bolts, but not including the steel. To be cantilevered over the sheer drop, the platform would improve the view while protecting the spongy land fringing the chasm.

⁸ COI, pp36–7.

⁹ COI, p40 and following.

As was later explained, Craig Murdoch, concerned that as much of the project work as possible was carried out before the end of the financial year, readily adopted an idea that the conservancy should promote a work programme, seeking volunteers from within the staff. On Thursday and Friday 23 and 24 April 1993 some 18 staff members turned up and were arranged into groups of four or five. Murdoch was assigned to the track upgrade group, but, as Field Centre Manager, moved between groups to “make sure people were happy with what they were doing and didn’t require a change.”

Four department employees set in the piles and bearers and assembled the platform on them. The Van Dijk plans were not at the site. There were no plans at the site.

On-site construction¹⁰

Les Van Dijk was not assigned to the platform project but worked with the track upgrade group. The four who worked on the platform were, in alphabetical order, Mark Davis (who had no particular building experience); Colin Mulqueen (a self-described jack of all trades with some building and carpentry experience); Graeme Quinn, who had “done a little jobbing carpentry in the way of small maintenance jobs, but nothing major”; and Kevan Wilde, the Northern Operations Manager.

At the site, according to Mark Davis, “not much was discussed about the way the platform was to be built. We had with us a post pile driver and a chainsaw. I do not think we measured out accurately where the posts were to go.” Colin Mulqueen explained that the pile-driving task depended on the nature of the ground, and adjustments in pile location had to be made to take account of the presence of roots and rocks. The front of the area was an overhang, and Davis recalled that one pile “went right through the earth and came out the other side.” For those reasons the pile lines were not straight, and packers had to be used when attaching bearers.

No plan of precise pile location was ever prepared, and no grid was ever laid out on the ground. Following driving in of the piles and nailing of bearers, the pile tops were trimmed to an even height. The piling took most of the first day; thereafter the platform (effectively a kitset) was erected on top.

The work done, the builders had their photo taken on the platform, over the chasm.

The platform in use¹¹

It would be a year before any further work would be done on the platform. In April 1994, Colin Mulqueen came back to pour concrete at the base of the platform, creating a set of steps. He had no instructions to use steel to attach the concrete to the platform, to provide the strong counterweight required for a cantilevered construction. (By this time, the steel had disappeared from the Punakaiki store.)

Some months later the new structure was shown off to the local Conservation Board, with Conservator Bruce Watson, Kevan Wilde and Craig Murdoch present. Board chairman Bruce Hamilton asked if the platform had a permit or license, prompting

¹⁰ COI, pp45–7.

¹¹ COI, pp56–7.

Watson to ask Wilde and Murdoch to see if necessary consents had been obtained. Subsequent approaches to various staff to retrospectively submit the platform plans for approval were not effectively followed up. It would later be found that “the obtaining of building consent was regarded as an administrative exercise” and that safety issues were not considered.

A further request arising from the Conservation Board visit was to prepare signs giving an (unspecified) loading limit. Rodney Chambers, a relatively new staff member, was asked to organise this. Working on calculations in a general directive from Head Office, he at first proposed a maximum of 10 people but decided that a limit of five would make for better viewing. The completed sign arrived as Chambers was on holiday and was “tidied away” into the workshop where it would remain.

Safety concerns¹²

Chambers had had safety concerns about the platform, having taken his children on it, but the focus of his concern was the handrails. Taking this further with Senior Conservation Officer John Bainbridge, he was asked to provide working drawings and, finding the van Dijk plans, which did not match the reality, arranged for drawings to be done “as built”. The resultant drawings, prepared by a German exchange student, showed possible seating on the platform. Bainbridge, treating them as “as built” plans, referred to them in an ultimately abortive attempt to get a retrospective building permit from the Buller District Council (the local territorial authority).

On 27 April 1995, the day before the tragedy occurred, Conservation Officer Shirley Slatter observed that the platform flexed as a group of Outdoor Education students from Tai Poutini Polytechnic students stood on it during a scheduled field trip. She thought this unusual. She reported her concerns to Stephen O’Dea, the newly appointed field centre manager, and persuaded him to come with her to look at it the next day.

The following day, O’Dea was in front of the second group of field trip students from Tai Poutini who crowded on to the Cave Creek viewing platform. When the platform tore from its nailed supports, he and 17 others fell for 30 metres into the chasm. As Mansfield would learn by the time he reached the Coast, four were seriously injured, and 14, including Stephen O’Dea, died at the scene.

The immediate aftermath

Conservation Minister Denis Marshall was in Australia, but his staff advised him immediately of the collapse, as well as the Acting Minister Simon Upton and Prime Minister, Jim Bolger.

To get to the Coast that Friday night Bill Mansfield eventually had to charter a plane, accompanied by Keith Johnston, DOC’s Executive Manager Strategic Development.

While DOC’s West Coast journalist Steve Attwood fielded calls from around the country, Public Awareness Manager Joris de Bres co-ordinated the department’s response, despatching a journalist to help Tai Poutini Polytechnic manage the “massive

¹² COI pp70–1.

volume of media interest”. As Mansfield and Johnston travelled south, Deputy Director-General Alan Edmonds fronted the peak-hour *Holmes* TV programme, committing the Department to deal with the issues openly and honestly.

Mansfield and Johnston stayed with a devastated Regional Conservator Bruce Watson, and his wife. Early the next morning Simon Upton flew in and they walked to the site together. For Bill Mansfield, seeing the smashed and bloodstained timbers was one of the worst aspects of an experience that still haunts him. Walking out, he acknowledged the department’s responsibility to the waiting television cameras.

There were intense and emotional meetings with the staff at Punakaiki. That weekend Mansfield also spoke by telephone to the State Services Commissioner and the Solicitor-General and raised the question whether he should resign immediately to publicly accept departmental responsibility for the tragedy.

A series of urgent actions were also initiated that weekend on Mansfield’s instructions including a nationwide check on DOC’s built structures – it was unclear how many there were in total – to ensure no others posed a danger, and that no design flaws were being replicated.

A full public inquiry

It was clear that there would need to be a full public inquiry, and the CE had already determined any inquiry could not be conducted by the department alone.

On Radio New Zealand’s *Morning Report* the next Monday Mansfield was asked if he would resign or make some similar gesture. He said that a full public inquiry was needed and it was his job to lead the department through the investigation process and ensure full co-operation.

Public opinion at this stage was largely in support of the department; prominent broadcaster Paul Holmes awarded the department a “bouquet of the week” for its open acceptance of responsibility.

In the coming months, Bill Mansfield would visit each family, to express his sorrow and personally apologise for the Department’s failure.

Preparing for the Inquiry

Hugh Logan, head of the neighbouring Nelson Conservancy, was brought in to manage West Coast operations day to day, as Bruce Watson assisted with preparations for the Commission of Inquiry. The department made a conscious decision to provide staff directly involved with legal advice and other support.

As DOC prepared itself for the Commission, cataloguing all material that might possibly be needed, Bill Mansfield, aware that morale had been shaken nationwide, also travelled around the country speaking to staff.

As the extent of the task of inspecting all DOC’s built assets became apparent, with teams of engineers at work around the country, he realised a comprehensive review of

the department's quality and safety systems was called for. He set up a team, led by Keith Johnston, to implement what would become Quality Conservation Management (QCM).

The internal review

In September, the CE also wrote to the West Coast Conservancy,¹³ acknowledging the burden and stresses of the past months. He pointed out that the Commission of Inquiry, yet to report, had already “identified some matters for change, and some ideas as to how we could do things better in the future” and that, while some would apply to the department as a whole, the terms of reference singled out the Coast.

He said that, with the endorsement of Bruce Watson and other senior staff, to provide an opportunity to implement identified options for improvement, he had asked a small team to report on efficiency and effectiveness matters that could be implemented. “I believe that by doing this we can hold on to what has been achieved and maintain a robust operation.” Hugh Logan led the four-person review team.

The Commission of Inquiry (the Noble Commission)¹⁴

The terms of reference confined the scope of the Commission of Inquiry to the “cause and circumstances of the collapse, and matters incidental thereto.” A later extension covered the rescue effort. Matters relating to the collapse included the suitability of the design and construction of the platform, whether any applicable statutes were complied with, the competence of those involved, and the adequacy of any inspection.

The Commission was also asked to find whether any government department or its staff, or any other responsible body, had exercised those responsibilities competently; and to examine the adequacy of relevant laws and if necessary recommend changes.

The Commission of Inquiry was conducted by a district court judge, Graeme Noble, assisted by counsel. DOC was represented by QC, Hugh Rennie. The families were also represented by counsel. Forty-two witnesses were heard during the first part, which dealt with the collapse. Ten oral and 26 written submissions were presented.

In his evidence, Bill Mansfield rejected the view that under-funding had anything to do with this particular collapse, although in March he had told the Planning and Development Select Committee that DOC was “as lean and efficient as it can get.”¹⁵ Other witnesses, however, emphasised the financial problems faced by the conservancy, and the resultant culture of “doing more for less”, working long hours, and the failure to fill key vacancies.

¹³ Logan, H. (1995), ‘West Coast Efficiency and Effectiveness Review’, report to the Director-General of Conservation. Appendix. (Referred to from here as WER).

¹⁴ COI, ppxi-xiii.

¹⁵ COI p34.

The platform construction working party¹⁶

During a detailed examination of the platform construction, the judge asked members of the working party who was in charge. “Perceptions of this vary”, he would find. “Craig Murdoch said that Colin Mulqueen was the nominated supervisor but could not point to any document or conversation confirming this. Mulqueen himself said ‘I did not see myself as being in charge in the sense that I was there to order everyone what to do.’ He was conscious of Mr Wilde being in the party – ‘obviously he was much more senior in status to myself ...’ Mr Wilde accepted he was the most senior department employee present but for the day was working as a labourer under the direction (he thought) of Mr Mulqueen.”

Judge Noble found

“the probabilities all point the one way. ... Whether or not Mr Mulqueen accepted it, he was assumed by Mr Murdoch to be in charge, and, despite the consensus operating within the party, he was clearly in charge of it.

“So there it is. The evidence is ambivalent. The logical person ... to be in charge on the day did not accept that responsibility. Whether he was suitably qualified to be in charge is another issue. ... I conclude that, even if the issue of who was in charge had been properly established, the platform would probably have been built no differently. The failure to do so, was not, in itself, a secondary cause of the collapse. Rather, the failure firmly to place a suitably qualified and experienced person in charge demonstrates the systemic failure to which I shall later refer.”

“Total and catastrophic failure”

Despite terms of reference that would seem to have excluded the possibility, Judge Noble’s findings blamed the Government. Highlighting what he saw as a failure to transfer good systems from predecessor departments, he said, “I believe the department was malformed at birth.”¹⁷

In his report on 10 November 1995, Noble found that the “proximate or dominant” cause of the collapse was that the platform was not constructed by the department in accordance with sound building practice, resulting in “total and catastrophic failure.”¹⁸ Six “secondary causes” contributing to this were DOC’s failure to provide qualified engineering input into the design and approval of the platform; adequately manage its construction; comply with the Building Act; or provide loading restriction signs, an adequate inspection system, and a proper project management system for employees.

“It follows that the platform was not designed or constructed to appropriate standards, was completely unsuitable for the use for which it was designed and constructed, and was unsafe for any use,” Judge Noble commented.

Elsewhere, he said, “The department acted unlawfully, but the named individuals did not ... The department did not act in a competent and appropriate manner. Nor did its

¹⁶ COI p43.

¹⁷ COI p26.

¹⁸ COI p22.

nominated staff members, but ... they were working within a system that was fatally flawed.”¹⁹

Institutional and inevitable

Judge Noble found

“It would be quite inappropriate to point the finger of blame at any one of the individuals. It is uniquely an institutional failure. The striking feature of the inquiry is that not one of the individuals concerned was ever aware of the appropriate standards to be met, simply because no such set of standards was in place.”²⁰

Further:

“The root causes of the collapse lie in a combined systemic failure against the background of an under-funded and under-resourced department employing (at least at grass-roots level) a band of enthusiasts prepared to turn their hands to any task ... 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.

“With regret I reach the inevitable conclusion that, against that background, a tragedy such as Cave Creek was almost bound to happen.”²¹

Of Mansfield and the DOC team, the judge said

“I was left with the impression that these very capable people from the top levels of the department’s hierarchy simply did not seem to appreciate the concept of accountability in personal terms as it applies, for example, to the private sector. Knowing one is accountable requires consciously acting in a manner that takes account of all known potential pitfalls ... for the future, it needs to be clearly understood that failure to be accountable will result in some real and tangible sanction.”²²

The review team findings

In early December, the report of the West Coast Conservancy Efficiency and Effectiveness Review was presented to Bill Mansfield. Praising the conservancy for its “positive achievements for conservation”²³ within “a community that is often less than supportive”, the review also identified a number of problem issues, including the fact that managers were based close to the conservator rather than out in the field.

For instance

“the allocation of ... major project responsibilities has often ignored the functional responsibility lines ... This was a deliberate policy aimed at spreading workloads, targeting particular skills and ensuring the Regional Conservator has personal contact.

¹⁹ COI p86.

²⁰ COI p86.

²¹ COI, p74.

²² COI, p75.

²³ WER, p2.

“The effect of this was to allocate work to managers who are not normally involved with that work, and therefore are not always aware of procedures or established processes. In particular, the two Operations Managers had been used as special project managers with a consequent reduction in time for oversight and supervision.”²⁴

Communication over key issues was “limited or patchy and in some instances lacking”. These and other issues led the team to conclude that, in combination, “they indicate a state of poor organisational health in the Conservancy.”²⁵

The State Services Commission review

By the time the internal review appeared, a further inquiry into the Department was well under way. It had been announced – accompanied by a directive to DOC to make no comment at this stage – as the public were still absorbing the implications of the Commission’s findings. Some commentators were calling for heads to roll – Mansfield’s, and the Minister’s. Many people seemed baffled by the fact that no-one was being punished. No-one had been sacked, or would be. (Some of those most closely involved, the most senior of them being Conservator Bruce Watson, resigned shortly after the inquiry concluded, while others had already left DOC).

The new inquiry, led by private sector businessman Michael Morris, was asked to “carry out a review of the performance of the department and its Chief Executive”²⁶ following the Commission of Inquiry findings. The report, completed in 14 days, looked into every aspect of the department’s responsibilities, structures and systems.

Like the Noble Report, what became known as the Morris Report did not apportion blame to individuals. Commenting that the question of funding was outside its terms of reference, the report said “if it is accepted that the department was under-funded on establishment ... the impact of these fiscal restraints is likely to have been greater” on DOC than on most other departments.²⁷

Accountabilities not clear

The Morris Report also said

“For Public Service managers, there is a tension between the implicit requirements of the State Sector Act 1988 and the Public Finance Act 1989 ... the former leads Chief Executives to do as much as they possibly can with available resources; the latter leads, in times of fiscal constraint, to prioritising and a reduction in outputs produced. Where there is a heavy load of non-discretionary functions this could lead to a reduction in standards and quality of service delivery. Accountabilities in this situation are not clear.”²⁸

The Morris Report praised Bill Mansfield for his performance as CE, saying that over the last five years he had either exceeded or met the expectations of an able and competent public service chief executive. “This assessment has taken into account the significant improvements to the department’s management systems which have taken

²⁴ WER, p6.

²⁵ WER p14.

²⁶ State Services Commission Review (SSR) Appendix 1.

²⁷ SSR p15.

²⁸ SSR p5.

place in an environment of continuous change. It has also reflected the strong leadership provided by the Chief Executive ...”²⁹

The Report endorsed the West Coast Review Team’s finding of poor organisational health, and said that it “does not reflect so much on the performance of the Department and its Chief Executive as on the state of the Department in that Conservancy.”³⁰ Noting there were proposals for further reorganisation, it said it “does not believe these would be in the best interests of the department.”

Though the Department could have been more proactive in developing monitoring and management systems, this did not, however, “relieve the Regional Conservators of their delegated and statutory responsibilities.”³¹

A repeat of the tragedy was judged to be unlikely. “If not for a tragic combination of circumstances, misunderstandings and breakdowns in procedures and communications, such events, in our view, would have been unlikely to occur, in the West Coast or elsewhere, had the then available systems and departmental procedures been used as intended.” Considering the environment in which DOC had to operate, its management and systems did not compare unfavourably with those of other departments.³²

Recommendations and decisions

The Morris Report’s recommendations³³ to the department included developing a systematic organisational risk assessment process, and analysing its recruitment and staff development needs, as well as reviewing Head Office policy for communication directions on operations and sharing good practice across the organisation. To the State Services Commissioner, Don Hunn, it asked that “you clarify Public Sector accountabilities in relation to the requirements of the State Sector Act and the Public Finance Act.”

As the Morris report was being prepared Bill Mansfield was also weighing up whether, if his own performance was cleared, he should nonetheless resign. He was aware that, whatever decision he took, many would disagree. He also knew the decision was likely to have implications for the position of the Minister.

For Mansfield the balance was primarily between the sense of public closure, closure for the families, and the personal relief that his resignation might help to bring, on the one hand, and on the other the implications of the resignation at that point for the change process and the Department as a whole.

The personal endorsement of his performance as CE in the Morris Report, did nothing to clarify the direction he should take.

²⁹ SSR p22.

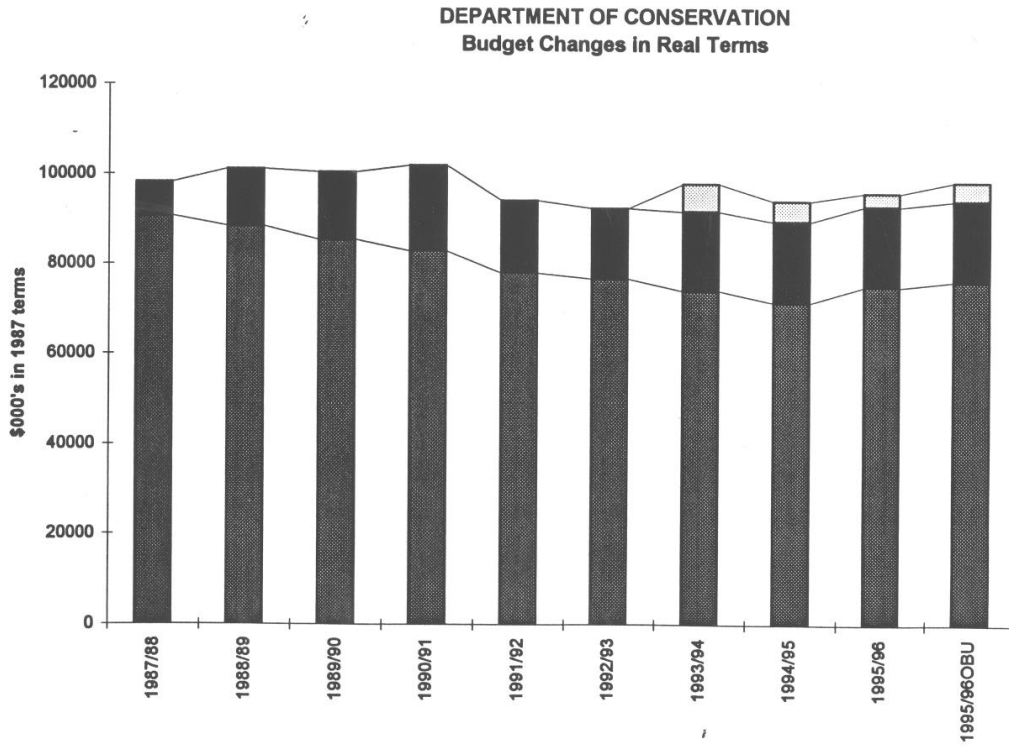
³⁰ SSR p27.

³¹ SSR p29.

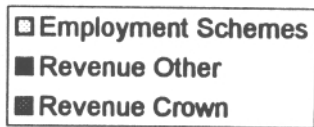
³² SSR p36.

³³ SSR p34-5

Exhibit 1



BUDDOC.XLS



Source: SSC Review of Department of Conservation, November 1995
Background Material Volume I History and Context

**Part A – Exhibit 2
Department of Conservation Structure, 1995**

Source: Bach Consulting

Note
* Total number of reports both direct and indirect
†18 of these positions still on the organisation chart have remained unfilled for long periods

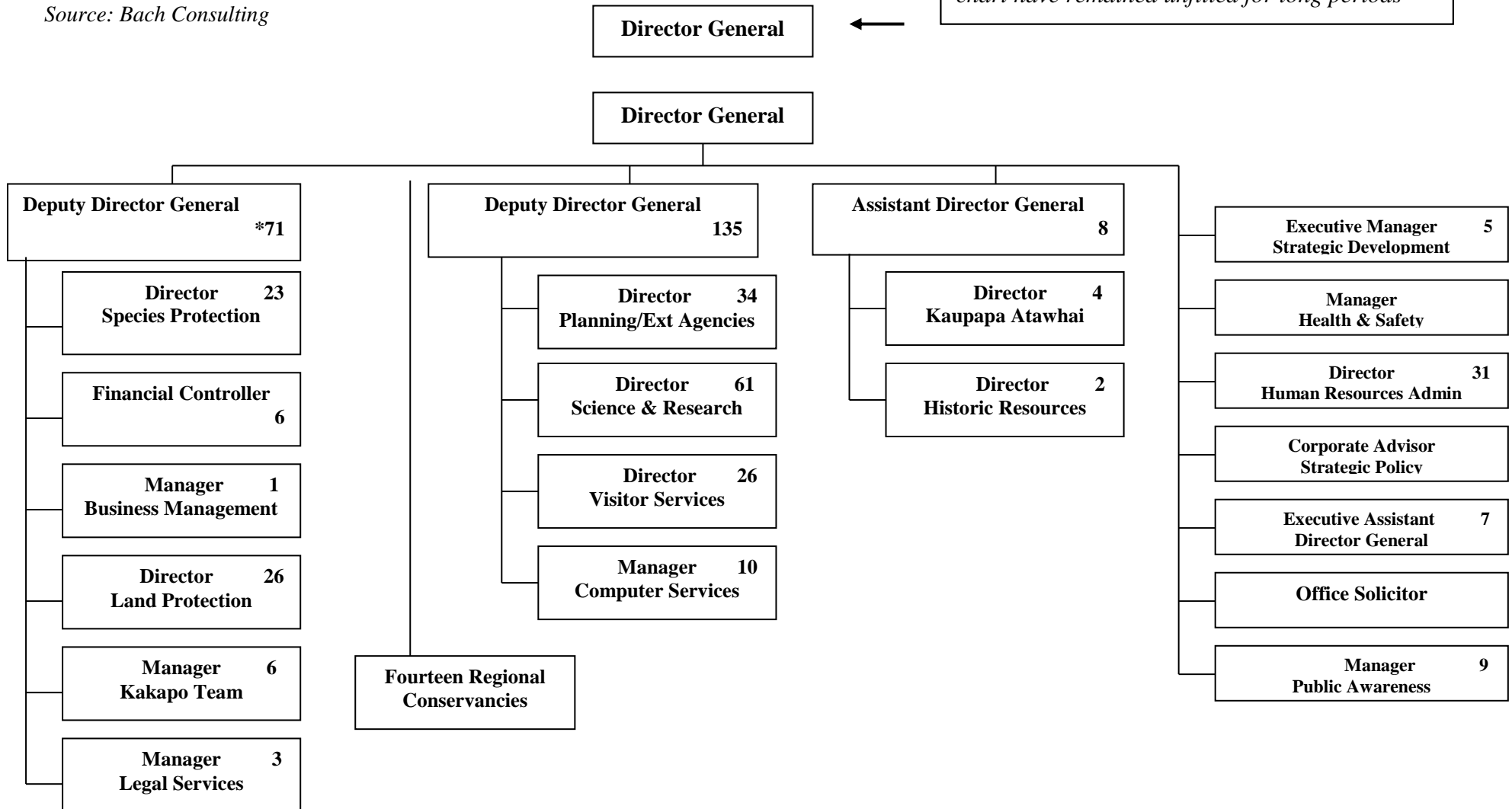
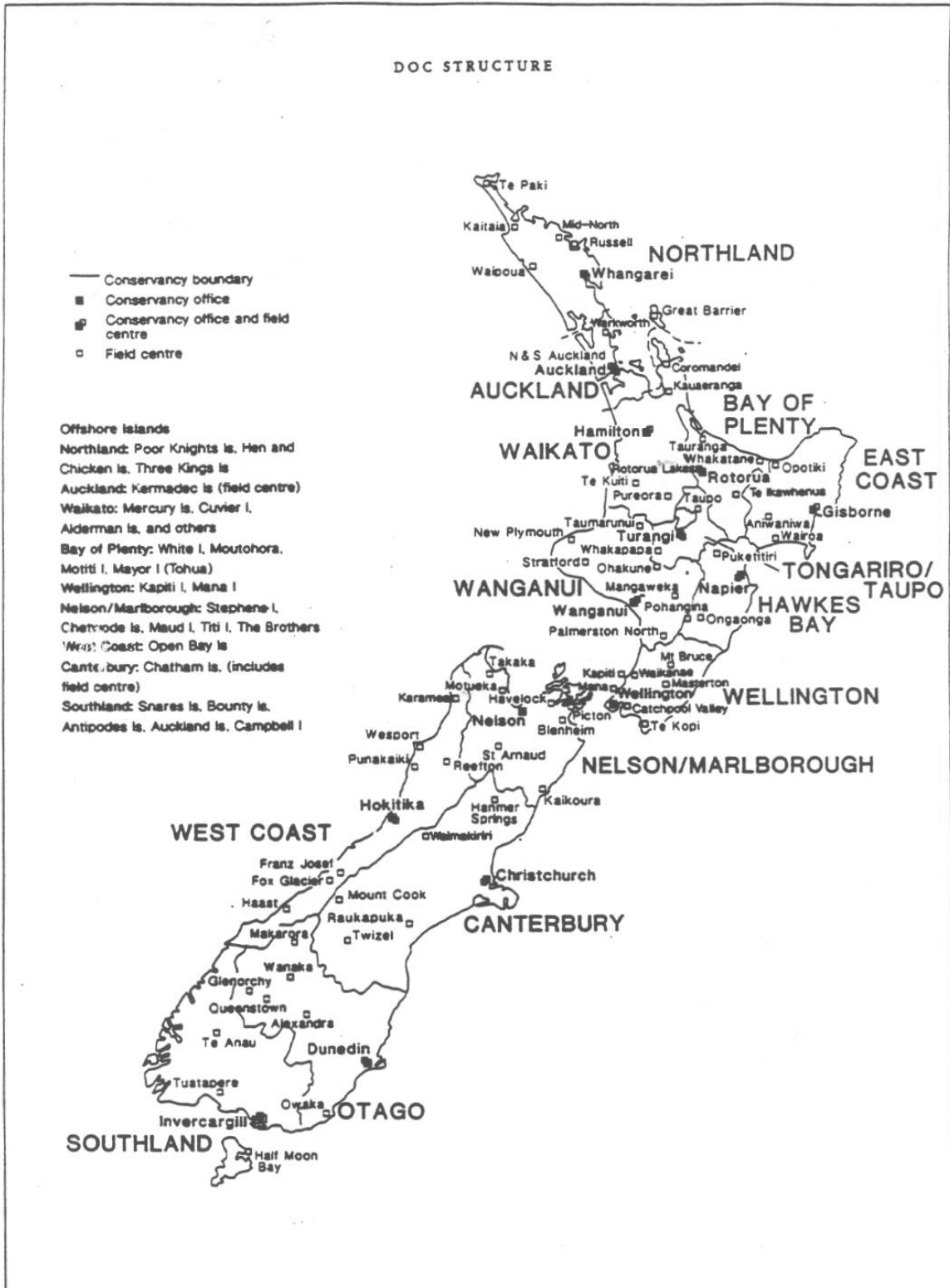


Exhibit 3: Conservancy boundaries



Source: SSC Review of Department of Conservation, November 1995
Background Material Volume I History and Context