ROADS AND TRAFFIC AUTHORITY OF NEW SOUTH WALES V DEDERER: 20/20 HINDSIGHT OR AN ACCIDENT WAITING TO HAPPEN? A TIMELY OPPORTUNITY TO REVISIT AND REAPPRAISE *SHIRT*

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I SYNOPSIS

> *'It's always best on these occasions to do what the mob do.' 'But suppose there are two mobs?' suggested Mr Snodgrass. 'Shout with the largest,' replied Mr Pickwick.*[1]

In August 2007, the High Court of Australia handed down its decision in *Roads and Traffic Authority* (RTA) *of New South Wales v Dederer.*[2] The High Court, by a 3-2 majority (the majority comprising Gummow, Callinan and Heydon JJ, and the minority being Gleeson CJ and Kirby J), allowed the appeal by the RTA. It held that a duty of care imposes an obligation to exercise reasonable care, not a duty to prevent potentially harmful conduct. The leading judgment for the majority was given by Gummow J and the principal judgment in dissent was given by Kirby J. Both judgments took as their 'texts' the classic passage from the judgment of Mason J in *Wyong Shire Council v Shirt.*[3]

This article will focus on the different reasoning between these two judgments, contending that the judgment of Kirby J, who essentially supported the reasons of the majority in the NSW Court of Appeal, is to be preferred. As will be developed in the article, this conclusion follows because the NSW Court of Appeal adopted a dynamic as

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1 Charles Dickens, *Pickwick Papers*, Chapter 13 (1836), cited in The Penguin Dictionary of Quotations, JM and MJ Cohen, Penguin Books, 1977, 138.

2 [2007] HCA 42 (*Dederer*).

3 (1980) 146 CLR 40 (*Shirt*), 47-48.

opposed to a static analysis of the risks associated with activity on the Wollamba bridge. An explanation is undertaken by utilizing diagrams in the context of the Australian and New Zealand Risk Management Standard[4] AS/NZS 4360[5] which incorporates a matrix of likelihood and consequences in calculating a risk ranking.

This article will also attempt a reappraisal of the two part test in *Shirt* for statutory authorities,[6] and, given the passage of the Civil Liability Acts (or their equivalent) in most States, a new section entitled General Principles for Statutory Authorities is proposed.[7]

The central thesis of this article is that statutory authorities be required to follow the Australian and New Zealand Risk Management Standard AS/NZS 4360. The essence of the standard is to define a process of continual improvement, commencing with the identification and analysis of the risks faced by the organisation. The risks are then evaluated through a process of ranking and prioritising. The next stage deals with the treatment of the risks involving appropriate precautions. Finally, monitoring and review procedures are put in place to ensure continuous improvement.

For present purposes, the focus is on the part of AS/NZS 4360 which covers the process of ascribing a calculated risk ranking to a particular

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4 Standards Australia was established in 1922 and is recognised through a Memorandum of Understanding with the Commonwealth government as the peak non-government standards development body in Australia. Standards Australia develops and maintains around 7000 Australian Standards. http://www.standards.org.au/cat.asp?catid=21 at 9 March 2008.

5 AS/NZS 4360: 2004 Risk Management, SAI Global. http://www.saiglobal.com/shop/Script/Details.asp?docn=AS0733759041AT at 15 February 2008.

6 The focus is upon statutory authorities as *Shirt* (1980) 146 CLR 40, *Dederer* (2007) HCA 42 and *New South Wales v Fahy* [2007] HCA 20 ('*Fahy*') all involved statutory authorities. In *Fahy* [2007] HCA 20 the High Court reaffirmed the so-called *Shirt* negligence calculus.

7 This new section would be located immediately after the relevant section covering the statutory equivalent of the *Shirt* test in the respective State Civil Liability or Wrongs Act. See *Civil Liability Act* 2003 (Qld), s9(2); *Civil Liability Act* 2002 (NSW), s5B(2); *Civil Liability Act* 1936 (SA), s32(2); *Civil Law (Wrongs) Act* 2002 ACT, s43(2); *Civil Liability Act* 2002 (WA), s5B(2); *Civil Liability Act* 2002 (Tas), s11(2).

outcome. The standard methodology is to adopt an operation matrix with two elements: likelihood (for which read probability) and consequences (for which read seriousness). The final step is to allocate a risk ranking to the outcome in question (for example, serious injury from jumping/diving from a particular bridge) from low to moderate to high to extreme.

The adoption under Civil Liability legislation of AS/NZS 4360 would have the effect for the first part of the test in *Shirt* of a risk being foreseeable if a statutory authority following AS/NZS 4360 considered or ought to have considered the risk, that the risk was a significant practical risk, and in the circumstances a statutory authority following AS/NZS 4360 would have taken the precautions.

The effect of requiring AS/NZS 4360 to be followed on the second part of the test in *Shirt* would be a dynamic negligence calculus where there is an ongoing regularly reviewed likelihood that the harm would occur if care were not taken, whether the adopted risk ranking under AS/NZS 4360 was appropriate, and what precautions were taken as a result of that risk ranking.

While confining the new test to statutory authorities, it is recognised that these authorities do have special qualities, such as being given wide discretion as to how they perform their statutory functions with limited resources under powers confined by statute, but their activities primarily interact with the public, and therefore a greater appreciation of risk should be expected from such bodies. Therefore, if AS/NZS 4360 is to be called up in legislation,[8] it is appropriate to commence with statutory authorities who, if committed to continuous improvement, should already be using this risk management standard.

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[8] Australian Standards are called up by legislation where a section requires compliance with that particular Australian Standard. For example, *The Work Health (Occupational Health and Safety) Regulations* 1992 (NT), s84(1) covers design of plant and reads: 'Plant shall be designed according to the requirements of these Regulations and, where applicable, the relevant standards specified in Schedule 10.' Schedule 10 then lists a raft of standards from AS 1200 Pressure Equipment and AS 1418 Cranes to AS 1576 Scaffolding and AS 1735 Lifts.

II Facts of the Case

'Now, what I want is Facts… Facts alone are wanted in life.'[9]

In December 1998, Mr Dederer, who was 14 years old at the time, dived from the Wollamba bridge, struck a submerged sandbank and suffered a severe spinal injury. Pictorial signs prohibited diving. Mr Dederer had seen a 'no diving' sign but did not believe the activity was dangerous. Mr Dederer was familiar with the area from family holidays, and from boating experience was aware of the sandbar and that the water varied in depth.

On the day before the accident, Mr Dederer jumped twice from the bridge and his feet did not touch the bottom. On the day of the accident, Mr Dederer's evidence was that he changed his mind and decided to dive rather than jump once he got up onto the bridge. Mr Dederer had often seen people jumping and sometimes diving off the bridge.

Attempts by Great Lakes Shire Council officers and police to prevent diving from the bridge had been unsuccessful. Council concerns that the signage was inadequate had been drawn to the attention of the RTA. Mr Dederer's accident was the first reported accident since the bridge, which is 632 metres in length, was built in 1959.

III The Tortuous Trail to the High Court

'Do you spell it with a "V" or a "W"?' inquired the judge. 'That depends upon the taste and fancy of the speller, my Lord,' replied Sam.[10]

In the NSW Supreme Court, Dunford J found for Mr Dederer against both the RTA and the Council in the ratio of 80/20. Damages were awarded in the sum of $840,000 which had been reduced by 25% for Mr Dederer's contributory negligence.

Dunford J found the RTA negligent for three reasons:

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9 Charles Dickens, *Hard Times*, Book 1, Chapter 1 (1854), cited in The Penguin Dictionary of Quotations, JM and MJ Cohen, Penguin Books, 1977, 135.

10 Charles Dickens, *Pickwick Papers*, Chapter 34 (1836), cited in The Penguin Dictionary of Quotations, JM and MJ Cohen, Penguin Books, 1977, 138.

1. In failing to erect signs warning of the danger of shifting sands and variable depth.
2. In failing to replace horizontal railings with vertical pool-style fencing.
3. In failing to change the flat top of the handrail to a triangular shape that would be difficult to stand on.

The Court of Appeal held that the NSW *Civil Liability Act* meant that the Council was not liable[11] but that the Act did not apply to the action against the RTA. In a 2:1 majority decision, the Court of Appeal dismissed the appeal by the RTA, but the Court did increase the proportion of Mr Dederer's contributory negligence from 25% to 50%. The RTA appealed to the High Court.

IV A Tale of Two Shirts

A *The Gospel According to Gummow J*

> *'Your dexterity seems a happy compound of the smartness of an attorney's clerk and the intrigue of a Greek of the lower empire.'*[12]

It must be both unnerving and galling for an eminent judge such as Ipp JA to be handed a failing grade in the tort of negligence, but the withering attack by Gummow J on the majority in the Court of Appeal permits no other conclusion. No one can accuse His Honour of being 'willing to wound, and yet afraid to strike'[13] and a recent article by the President of the NSW Court of Appeal makes the point that 'studied criticism in a reserved and published judgment by a senior court bears an institutional sting, if only because of the intended likelihood of its republication'.[14]

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11 The Council was not liable because Mr Dederer's injuries were 'a result of the materialisation of an obvious risk of a dangerous recreational activity' within the meaning of section 51 of the *Civil Liability Act 2002* (NSW).

12 A G Noorani, 'Invective in Politics' (2005), Volume 22, *Frontline*, Issue 12 (quoting Benjamin Disraeli).

13 Alexander Pope, *An Epistle to Dr. Arbuthnot*, Prologue to the Satires, line 203, Pope Poetical Works, Edited by Herbert Davis, Oxford University Press, 1966, 333.

14 President Justice Keith Mason, *Throwing Stones: A Cost/Benefit Analysis of Judges Being Offensive to Each Other*, 1, (Paper presented at Judicial Conference of Australia, Sydney, 6 October 2007).

His Honour's judgment is peppered with barbed missiles of which the following are some telling examples.

> The errors of which the appellant rightly complains … did not turn on factual matters upon which reasonable minds might differ. Rather, they concerned the misapplication of basic and settled matters of legal principle.[15]

> Rather, the errors on the part of the majority of the Court of Appeal lay in fundamental matters of law: matters against which concurrent findings of fact are no insulation.[16]

> The trial judge and the majority in the Court of Appeal impermissibly reasoned that if a warning is given, and if the conduct against which that warning is directed continues notwithstanding the warning, then the party who gave the warning is shown to have been negligent by reason of the warning having failed. Quite apart from its inconsistency with the scope of the RTA's duty of care, this reasoning erroneously short-circuits the inquiry into breach of duty that is required by *Shirt*…[17]

To understand the force of the criticisms, it is necessary to examine the conceptual reasoning process adopted by Gummow J.[18] His Honour commences his analysis by making two points in relation to the scope of the RTA's duty of care. Firstly, duties of care are obligations of a particular scope which varies depending on the relationship in question.[19] Secondly, whatever their scope, 'all duties of care are to be discharged by the exercise of reasonable care'.[20]

However, it is contended here that the particular scope, and therefore the obligation to exercise reasonable care, can change over time as more knowledge and information come to hand, so that the obligation to exercise reasonable care becomes more onerous.[21] This point will be developed later in the section reappraising *Shirt*.

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15 *Dederer* [2007] HCA 42, [18].

16 Ibid [42].

17 Ibid [55].

18 Heydon J agreed with the reasons of Gummow J. *Dederer* [2007] HCA 42 [283].

19 *Sullivan v Moody* (2001) 207 CLR 562, 579-580 [50] (Gleeson CJ, Gaudron, McHugh, Hayne and Callinan JJ).

20 *Dederer* [2007] HCA 42 [43].

21 In *Vairy v Wyong Shire Council* (2005) 223 CLR 422, 454 [94] Gummow

Relying on *Brodie v Singleton Shire Council*, Gummow J affirms a road authority, such as the RTA, is obliged to exercise reasonable care such that roads are safe 'for users exercising reasonable care for their own safety'.[22]

In applying this test, Gummow J said that:

> the RTA did not owe a more stringent obligation towards careless road users as compared with careful ones. In each case, the same obligation of reasonable care was owed, and the extent of that obligation was to be measured against a duty whose scope took into account the exercise of reasonable care by road users themselves.[23]

It is contended here that whilst the RTA did not owe a more stringent obligation towards careless users, the obligation should be assessed against the relevant risk ranking given by the RTA to a fatality or serious injury resulting from diving off the bridge under the risk management standard AS/NZS 4360. If no risk ranking was attempted by a statutory authority for a significant practical risk, it begs the question whether a rebuttable presumption of negligence arises rather than moving to address the undemanding test of a foreseeable risk not being 'far-fetched or fanciful' as per the first limb of the *Shirt* test or the 'not insignificant' test in the Civil Liability Acts. This rebuttable presumption will be further developed in the proposed s5BA(3) of the Civil Liability Acts in the context of a statutory authority failing to utilise the widely followed risk management standard AS/NZS 4360.[24]

His Honour then proceeds to contrast an obligation to exercise reasonable care with an obligation to prevent harm occurring to others, pointing out that the former and not the latter is the law. His Honour held that the majority in the Court of Appeal, by being fixated on the failure of the 'no diving' pictograms and 'no climbing' signs to prevent large numbers

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J stated: 'The scope of that duty must be assessed, not by exclusive reference to the risk which resulted in Mr Vairy's accident, but against the background of the whole multitude of risks that may crystallise over the length of shoreline, the care, control and management of which is the responsibility of the Council.'

22 *Brodie v Singleton Shire Council* (2001) 206 CLR 512, 581 [163].

23 *Dederer* [2007] HCA 42 [47].

24 providing generic guidance for every enterprise, large or small, public or private. http://www.riskmanagement.com.au/ at 9 March 2008.

of young people from endangering themselves, and by categorising the RTA's ignoring of such unabated practice as unreasonable, fell into error.

> 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. If the contrary were true, then defendants would be liable in any case in which a plaintiff ignored a warning or prohibition sign and engaged in the conduct the subject of the warning.[25]

With respect, His Honour has overlooked that a dynamic, as opposed to a static, risk ranking which takes into account ongoing information as to the adequacy or otherwise of the pictorial 'no diving signs' calls not for total prevention but for the correlation between the exercise of reasonable care against the ongoing calculated risk ranking.

Gummow J concludes the section of his judgment entitled 'Reasonable care, not prevention' by reiterating that 'the question is always the reasonableness of the warning, not its failure'[26] and that any finding of negligence by reason of the warning having failed is not only inconsistent with the scope of the RTA's duty of care but also short-circuits the negligence inquiry into breach of duty.[27]

His Honour then turns his attention to the proper identification of the risk, noting that even if the Court of Appeal had assessed the RTA's duty as the exercise of reasonable care, error could still result from incorrect identification of the risk.[28] By characterising the risk as a serious spinal injury from diving off the bridge erected by the RTA, Gummow J held that the Court of Appeal had

> obscured the true source of potential injury. This arose not from the state of the bridge itself, but rather from the risk of impact upon jumping into the potentially shallow water and shifting sands of the estuary. This mischaracterisation of the risk led to two consequent errors. First, the majority were distracted from a proper evaluation of the probability of that

25 *Dederer* [2007] HCA 42 [54]..
26 Ibid [56].
27 Ibid [55].
28 Ibid [59].

> risk occurring. Secondly, they erroneously attributed to the RTA a greater control over the risk than it possessed.[29]

Thus, according to Gummow J, the characterisation sin committed by the Court of Appeal was to focus

> on the frequency of an antecedent course of conduct, namely jumping and diving, and not on the probability of the risk of injury occurring as a result of that conduct, namely impact in shallow water.[30]

Essentially, with respect, His Honour has identified a distinction without a difference, which becomes apparent once a proper risk management appraisal is adopted.

Having dealt with the relevant risk and moved on to consider the proper assessment of breach, Gummow J then chides the Court of Appeal for falling into the particular trap warned against by Hayne J in *Vairy*.[31]

> [T]heir Honours erred by focusing in retrospect on the failure of the RTA to *prevent* Mr Dederer's dive, as opposed to asking what, in prospect, the exercise of reasonable care would require in response to a foreseeable risk of injury. The use of phrases such as 'an accident waiting to happen' was redolent of a retrospective, not prospective, approach to the matter.[32]

His Honour, in exasperated tones reminiscent of a barrister berating a wayward pupil, states that it is necessary to 'set out yet again'[33] the relevant passage from the judgment of Mason J in *Shirt*,[34] emphatically stating that:

> [w]hat *Shirt* requires is a contextual and balanced assessment of the reasonable response to a foreseeable risk. Ultimately,

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29 Ibid [60]. On the issue of control, Gummow J said 'whatever its role in creating the bridge, the RTA did not control Mr Dederer's voluntary action in diving, and nor did it create or control the natural variations in the depth of the estuary beneath the bridge' [62].

30 Ibid [61].

31 *Vairy v Wyong Shire Council* (2005) 223 CLR 422, 462 [128].

32 *Dederer* [2007] HCA 42 [66].

33 Ibid [68].

34 *Shirt* (1980) 146 CLR 40, 47- 48.

> the criterion is reasonableness, not some more stringent requirement of prevention.[35]

Gummow J then applies the two part test in *Shirt*, finding for the first part that 'the risk of injury consequent upon jumping or diving from the bridge into water of variable depth was reasonably foreseeable' and, given the risk was obvious to a 14 year old boy, that 'it beggars belief that the RTA could not foresee the very conduct against which its signage warned'.[36]

Given the answer to the first part of the *Shirt* test is in the affirmative, Gummow J then concludes by assessing the RTA's response to that risk or the so-called *Shirt* calculus.[37]

> [I]t becomes apparent that the RTA did not breach its duty of care. Though grave, the risk faced by Mr Dederer was of a very low probability, and a reasonable response to that risk did not demand the measures suggested by him … This was not a case in which the defendant had done nothing in response to a foreseeable risk. To the contrary, the RTA had erected signs warning of, and prohibiting, the very conduct engaged in by Mr Dederer … In the circumstances, that was a reasonable response, and the law demands no more and no less. [38]

Essentially, His Honour's criticisms of the reasoning of the majority in the Court of Appeal reduce to two points. Firstly, that the majority set the 'bar' for the duty of care too high by purportedly seeking to prevent potentially harmful conduct. Secondly, that the majority impermissibly focused attention on the levels of activity by jumping and diving off the bridge, rather than the actual outcome in the form of the number of recorded accidents in the water below. It will be submitted that, with respect, Gummow J is incorrect on both counts because the prospective

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35 *Dederer* [2007] HCA 42 [69].

36 Ibid [70].

37 The four factors comprising the negligence calculus have now been incorporated into statute in most States following the Ipp report. For example, the *Civil Liability Act* 2002 (WA), s5B(1) & (2). The four factors are: the probability of the harm occurring; the likely seriousness of the harm; the burden of taking precautions; and the social utility of the conduct that created the risk.

38 *Dederer* [2007] HCA 42 [78]-[79].

application of the two part test in *Shirt*, if applied in a static rather than a dynamic analysis, leads to a misapplication of the proper process of a calculated risk ranking.

It will be further argued that what is really required is a reappraisal of *Shirt* and a new test. This is because the first part of the test in *Shirt*, reasonable foreseeability, is so low whether one adopts 'not far-fetched or fanciful' or 'not insignificant'[39] as to be virtually meaningless, and the second part, the so-called negligence calculus needs to be conducted from a more rigorous analytical platform in keeping with an assessment of the calculated risk ranking and the statutory authority's response to that risk ranking.

B *The Gospel According to Callinan J*

> *'Rather a tough customer in argeyment, Joe, if anyone was to try and tackle him.'*[40]

Callinan J was a member of the majority in company with Gummow and Heydon JJ, and His Honour essentially supported the reasoning and conclusions of Handley JA the dissenting judge in the NSW Court of Appeal.[41] As will be discussed in the next section, while Kirby J was calling in aid new bridge design codes and domestic pool fencing to lend strength to the conclusion of the majority in the Court of Appeal, Callinan J was also reflecting on conducting the balancing exercise in *Shirt* in a sufficient and proper manner.

> Also to be balanced, are the interests of the community in being able to walk across the bridge, to enjoy the view, and to pause and lean in comfort on a flat surface of a top rail as they do so. Only an extremely high unscaleable fence, with perhaps shards of glass embedded in its top, or barbed, or electric, or razor wire, might, on the evidence, have deterred determined and adventurous youths from climbing and jumping.[42]

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39 Following the recommendations of the Ipp report, most States have adopted as a general principle that a person is not negligent in failing to take precautions against a risk of harm unless *inter alia* the risk was not insignificant. See for example, *Civil Liability Act* 2002 (NSW), s5B(1)(b).

40 Charles Dickens, *Barnaby Rudge*, Chapter 1 (1841), cited in The Penguin Dictionary of Quotations, JM and MJ Cohen, Penguin Books, 1977, 133.

41 *Dederer* [2007] HCA 42 [264].

42 Ibid [275].

His Honour, echoing Gummow J's analysis, discussed the bridge as an allurement to a youth intent on the thrill of making a high dive which he knew to be banned.

> To say … that the bridge was therefore an allurement which the defendants should, on that account, have rectified, is to cease the inquiry at, or to treat as effectively decisive, the state of affairs antecedent to the first respondent's entirely voluntary, and premeditated, prohibited act of diving.[43]

Callinan J also observed that 'a defendant is not an insurer'[44] in concluding that the RTA 'in responding to a risk that had not been realised for 40 years, by erecting the pictograph signs, acted reasonably and adequately'.[45]

C *The Gospel According to Kirby J*

> *'Be sure that you go to the author to get as his meaning, not to find yours.'*[46]

There may be some measure of comfort for the majority of the Court of Appeal to know that Kirby J held[47] that they had correctly applied *Shirt*.

> There is no indication in the majority reasons in the Court of Appeal that Ipp JA or Tobias JA overlooked any of the strictures against mechanistic reasoning or hindsight analysis contained in *Fahy* and in the other cases to which reference is made in their Honours' reasons.[48]

It is contended here that, with respect, the common sense application by the majority in the Court of Appeal of the probability of a serious or fatal accident in the water being a function of the quantum of activity taking place off the bridge itself, is the correct approach from a risk management perspective.

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43 Ibid [277].

44 Ibid [278].

45 Ibid.

46 John Ruskin, *Sesame and Lil*ies, Of Kings' Treasuries, Ruskin, Sesame and Lilies, Everyman's Library, Dent, London 1974, 10.

47 Gleeson CJ agreed with the reasons of Kirby J, subject to some additional observations as to the nature of the exercise involved. *Dederer* [2007] HCA 42 [15].

48 *Dederer* [2007] HCA 42 [139].

Kirby J argued that given the RTA was aware of the continuing practice of young people jumping and diving from the bridge, 'Ipp JA analysed, prospectively, what, armed with such knowledge, the RTA ought reasonably to have done'.[49] His Honour continued by approving Ipp JA's assessment that the RTA realised their signs were useless and the rejection of 'the suggestion that the RTA was excused from action simply because no significant injury had previously occurred'.[50]

Kirby J agreed with Ipp JA that the RTA was required to respond to its knowledge of the risk by taking measures beyond mere reliance on signs, namely, the introduction of a triangular surface for the upper railing of the bridge (which his Honour categorized as 'inexpensive'[51]), and the installation of vertical pool-type fencing. At the very least, the addition to the no diving pictogram of the specific warning 'shallow water' placed close to the most popular entry point to the water 'would have been a reasonable response, in terms of signage. Questions of resources would scarcely come into such a modification'.[52]

Kirby J goes on to note that three other developments which came out in the evidence strengthened Ipp JA's conclusion on the need for vertical pool-type railings.

> The first was the introduction of the new Bridge Design Code in 1992, of which the RTA was aware. The second was the opportunity provided in 1993 by the replacement of wire in the area of the horizontal railings which afforded such ease of access to the flat upper railing. The third was the growing familiarity of the Australian community with the special need to protect young people in the vicinity of water.[53]

His Honour concluded by finding that the majority in the Court of Appeal had made no error on breach and supported their finding that:

> [t]he RTA did not give any, or any reasonable, consideration to the fact that because of its position, construction and configuration in relation to the water below, the bridge presented special dangers, particularly to children and young persons.[54]

49 Ibid [141].
50 Ibid [144].
51 Ibid [149].
52 Ibid [146].
53 Ibid [151].
54 Ibid [152].

Interestingly, Kirby J observed that the formula in *Shirt* 'is not mathematical in its application'[55] and this is most noticeable when applying the last factor in the negligence calculus, namely, 'any other conflicting responsibilities which the defendant may have'.[56]

V *Shirt* Revisited

> *'Look here. Upon my soul you mustn't come into the place saying you want to know, you know.'*[57]

It is contended in this paper that, with respect, the real issue is the inadequacy of the two step process in *Shirt* for statutory authorities. Under the common law[58] and statute,[59] statutory authorities enjoy particular protection as a species of defendant in relation to their wide discretion as to how to perform their statutory functions with limited resources, and with powers confined to those that are conferred by statute, as compared with the application of Risk Management Standard AS/NZS 4360: 2004.

This in turn leads to the need for a new test, at this stage confined to statutory authorities who should be expected to adopt AS/NZS 4360: 2004, to replace the test in *Shirt*. The two part test in *Shirt* was recently reaffirmed by the High Court in *Fahy*[60] and remains essentially intact in the Civil Liability Acts, notwithstanding the new Ipp Report inspired substitution of 'the risk was not insignificant'[61] for the first limb of *Shirt.*

Gleeson CJ in *Fahy* considered the nature of the 'calculus'.

> This has since been referred to, somewhat unfortunately, as a 'calculus'. What is involved is a judgment about reasonableness, and reasonableness is not amenable to

55 Ibid [135].

56 *Shirt* (1980) 146 CLR 40, 47- 48.

57 Charles Dickens, *Little Dorrit*, Book 1, Chapter 10 (1857), cited in The Penguin Dictionary of Quotations, JM and MJ Cohen, Penguin Books, 1977, 135.

58 See for example *Sutherland Shire Council v Heyman* (1985) 157 CLR 424; *Pyrenees Shire Council v Day* (1998) 192 CLR 330; *Graham Barclay Oysters Pty Ltd v Ryan* [2002] HCA 54.

59 See for example *Civil Liability Act* 2002 (NSW) ss41-46.

60 *Fahy* [2007] HCA 20.

61 See for example *Civil Liability Act* 2002 (NSW) s5B(1)(b).

> exact calculation. The metaphor of balancing, or weighing competing considerations, is commonly and appropriately used to describe a process of judgment, but the things that are being weighed are not always commensurate. As was pointed out in *Mulligan v Coffs Harbour City Council*, there are cases in which an unduly mathematical approach to the exercise can lead to an unreasonable result.[62]

His Honour's reference to the calculus not being amenable to exact calculation may be compared with the 'more elaborate inquiry' view of Gummow and Hayne JJ.

> This approach to questions of breach of duty has come to be known as the '*Shirt* calculus'. The description may be convenient, but it may mislead. Reference to 'calculus', 'a certain way of performing mathematical investigations and resolutions', may wrongly be understood as requiring no more than a comparison between what it would have cost to avoid the particular injury that happened and the consequences of that injury. *Shirt* requires a more elaborate inquiry that does not focus only upon how the particular injury happened. It requires looking forward to identify what a reasonable person *would* have done, not backward to identify what would have avoided the injury.[63]

Kirby J was also supportive of the test in *Shirt* stating that the re-expression of *Shirt* should be rejected and the problem lies in the misapplication of the test.

> It follows that it is quite wrong for critics to portray *Shirt* as providing an 'open sesame' to liability by removing the requirement of reasonableness inherent in Lord Atkin's approach in *Donoghue v Stevenson*. The law has not lost the moorings of that fundamental requirement. On the contrary, the *Shirt* formulation, in a highly practical way, directs specific attention to a series of considerations that are typically such as to moderate the imposition of legal liability where that would not be reasonable.[64]

With respect to this distinguished quartet of judges on the High Court, it is submitted that there lies within each of the above trio of passages a

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62 *Fahy* [2007] HCA 20 [6].

63 Ibid [57].

64 Ibid [121].

misunderstanding of risk management. In the case of the Chief Justice, it is the focus upon a judgment about reasonableness which His Honour states is not amenable to exact calculation. Whilst eschewing 'an unduly mathematical approach', leaving wide open the weightings of the four factors (probability, seriousness, burden and social utility) that make up the negligence calculus now enshrined in legislation,[65] is far too subjective an exercise and is open to individual judicial idiosyncrasies.

Similarly, it is quite possible to place the inquiry upon a far higher plane of objective analysis than the subjective weighting of the calculus as personified in Callinan J's reference to shards of glass or razor wire in *Dederer*, where His Honour appears to weight social utility very highly while minimizing probability because no one had been injured in 40 years.[66]

With regard to Gummow and Hayne JJ's injunction that the *Shirt* inquiry take place prospectively rather than retrospectively, reference has already been made to the error of conducting even a prospective approach within a static framework. Kirby J's observation of *Shirt* being 'highly practical' overlooks His Honour's own criticisms of the majority's approach in *Dederer*.

In contrast to the majority of the High Court who reaffirmed *Shirt*, Callinan and Heydon JJ believe '[t]he case for a reconsideration of *Shirt* is very strong'.[67]

> In the law of tort, of negligence particularly, absolute rigidity of principle in practice turns out to be impracticable. When it is sought to be imposed, it so often proves incapable of sensible application. Accordingly, a flexible and realistic test should be substituted for a test of foreseeability of fancifulness or otherwise. The test that commends itself to us is the one stated by Walsh J at first instance in *The Wagon Mound [No 2]*, that what should be foreseen is a risk that is 'significant enough in a practical sense'.[68]

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65 See *Civil Liability Act* 2003 (Qld), s9(2); *Civil Liability Act* 2002 (NSW), s5B(2); *Civil Liability Act* 1936 (SA), s32(2); *Civil Law (Wrongs) Act* 2002 ACT, s43(2); *Civil Liability Act* 2002 (WA), s5B(2); *Civil Liability Act* 2002 (Tas), s11(2).

66 *Dederer* [2007] HCA 42 [274]-[275].

67 *Fahy* [2007] HCA 20 [224].

68 Ibid [226].

The strength of the first part of the test being proposed by Callinan and Heydon JJ lies in the focus on a significant practical risk. This is in line with risk management under AS/NZS 4360 and the calculation of a risk ranking using likelihood and consequence. The risk ranking itself provides a quantifiable and objective platform from which to launch a new second part of the old *Shirt* test, namely, the inquiry as to what precautions were taken as a result of the ongoing risk ranking, which is again more objective than the so-called negligence calculus. Objectivity can be distinguished from 'an unduly mathematical approach' and *a priori* is to be preferred to a subjective calculus where judicial weightings can resemble 'nonsense on stilts'.[69]

VI Risk Management Standard AS/NZS 4360: 2004

'Childhood's a risk we all take.'[70]

Underpinning the general principles of negligence is a risk analysis. Following the Civil Liability Acts,[71] a person is not negligent in failing to take precautions against a risk of harm unless the risk was foreseeable, was not insignificant, and in the circumstances a reasonable person in the person's position would have taken those precautions. In determining the latter question, the court is to consider *inter alia* the familiar four factors of probability, seriousness, burden and social utility in the negligence calculus.

So if the person takes a decision to cut down a large tree next to his neighbour's fence on a windy day without ropes when his neighbour is holding a children's birthday party, that person is conducting a risk analysis in the same way as people do when running a red light, cutting grass in bare feet or climbing a long ladder without assistance.

Similarly, businesses and public bodies conduct risk analyses of the risks they face in operating their activities. A risk management standard

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69 Bentham J, 'Anarchical Fallacies: Being an Examination of the Declaration of Rights Issued During the French Revolution' in Bowing J (ed) , *The Works of Jeremy Bentham* (Russell & Russell, New York, 1962) Vol 2, 489.

70 David Hughes, *The Pork Butcher* (1984), 114, cited in the Penguin Dictionary of Twentieth-Century Quotations, JM and MJ Cohen, Penguin Books, 1995, 181.

71 For example, *Civil Liability Act* 2002 (NSW), s5B(1) & (2).

meets a need for practical assistance in applying risk management in public and private sector organisations.

Risk Management Standard AS/NZS 4360: 2004 provides a generic guide for managing risk, and may be applied to a very wide range of activities, decisions or operations of any public, private or community enterprise, group or individual. AS/NZS 4360 does not have any legal status in the sense of being called up[72] in legislation, but all organisations who aspire to be certified under such standards as AS/NZS ISO 14001 Environmental Management Systems or AS/NZS 4801 Occupational Health and Safety Management Systems would be expected to adopt this risk management standard.[73]

The risk management process offers systematic monitoring, assessing, communicating, and treating of identified risks. This ensures continuing improvement of risk management strategies. The main elements of the risk management process can be clearly shown diagrammatically.[74]

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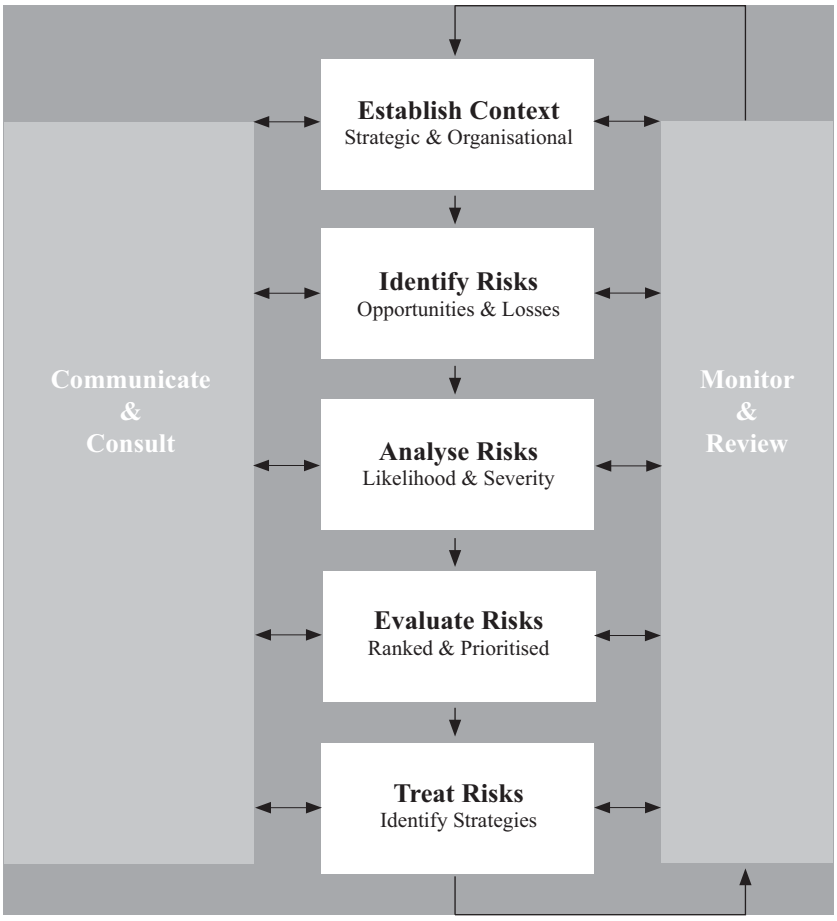
[72] See n8 for explanation of Australian Standards being called up under legislation.

[73] In order to secure certification in ISO 14001 Environment Management Systems and AS/NZS 4801 Occupational Health and Safety Management Systems, it is a requirement of those standards that risks be appropriately managed, and certifying bodies would expect close attention to be paid to the risk management standard AS/NZS 4360.
For example, in AS/NZS 4801 Occupational Health and Safety Management Systems, Section 4.4.6 is entitled Hazard Identification, Hazard Risk Assessment and Control of Hazards/Risks. Section 4.3.1 is entitled Planning Identification of Hazards, Hazard/Risk Assessment and Control of Hazards/Risks. This latter section requires a documented procedure for managing risk, a risk matrix and a risk register.
ISO 14001 Environment Management Systems uses the same numbering system as AS/NZS 4801 above, but slightly different language. So Section 4.4.6 is entitled Operational Control and Section 4.3.1 is entitled Environmental Aspects. An aspect is a situation that could cause harm and equates to hazard in AS/NZS 4801, and an impact is a change in the environment and equates to risk in AS/NZS 4801.

[74] Monash University, *Risk Management*, < http://www.adm.monash.edu.au/audit/risk/riskmanagement-process.html> at 17 February 2008. Source: AS/NZS 4360:2004.



Each step is discussed in further detail below:[75]

1. Communicate and consult
   Communicate and consult with internal and external stakeholders about the process as a whole and at each stage of the risk management process.

2. Establish the context
   Establish the external, internal and risk management context in which the rest of the process will take place. Establish the criteria against which risk will be evaluated. Define the structure of the analysis.

[75] Ibid.

3. Identify risks
   Identify where, when, why, and how events could prevent, minimise, delay, or improve the achievement of the objectives.

4. Analyse risks
   Identify and evaluate existing controls. Determine the likelihood, severity, and the resulting level of risk.

5. Evaluate risks
   Rank and prioritise the risks to assist decision-making regarding the extent and nature of treatments required.

6. Treat risks
   Develop and implement appropriate risk treatment strategies to address the risks.

7. Monitor and review
   Monitor the effectiveness of all steps in the risk management process to ensure continuous improvement.

So how widespread is the use of AS/NZS 4360? The answer is extensive,[76] and this can be demonstrated very readily by examining annual reports[77] and published material. Given that *New South Wales v Fahy*[78] involved the New South Wales Police Department, it is instructive

[76] Australian Standard *AS 4360 Risk management* is the international leader in providing generic guidance for every enterprise, large or small, public or private. http://www.riskmanagement.com.au/ at 9 March 2008.
See for example Power and Water Corporation (NT) Statement of Corporate Intent, 12: 'Key risks are also examined and subject to external audit in relation to the certification activities for ISO 9001 (Quality Management Systems), ISO 14001 (Environmental Management Systems) and AS 4801 (Occupational Health and Safety Management).' http://www.powerwater.com.au/powerwater/docs/publications/2007_2008_sci.pdf at 11 March 2008.

[77] See for example Power and Water Corporation (NT) Annual Report 2007, 22: 'We have been recognised nationally as being proactive in critical infrastructure protection. This includes an all hazards approach in line with the principles outlined in the Australian/New Zealand Standard for Risk Management (AS/NZS 4360).' http://www.powerwater.com.au/powerwater/docs/annrep/2007/Main%20Report_lr.pdf at 11 March 2008.

[78] *Fahy* [2007] HCA 20.

to examine the NSW Police Annual Report for 2005-06. Under 'Year at a Glance' the Commissioner states: 'There was a significant focus on professional standards and the development and implementation of risk management practices.'[79] Later in the Annual Report there is a further reference to the importance of risk management within NSW Police.

> All commands within NSW Police identify and manage local risks using the Command Management Framework (CMF), which is a risk based, self assessment process focusing on compliance. The CMF is based on the Australian Business Excellence Framework and the Australian/New Zealand Risk Management Standard AS/NZS 4360: 2004.[80]

Utilising the risk management process and the seven steps identified above, how would this translate in practical terms for a statutory authority like the Roads Traffic Authority of NSW?[81] The first step is to communicate and consult with stakeholders, and having established the context, then identify the risks. One of the risks identified given the nature of the RTA's activities would plainly be the state of its bridges and any dangers associated with them. This would come under a variety of headings from maintenance and traffic hazards, to activities taking place on and from the bridges. In the specific case of the Wollamba bridge, the Great Lakes Council, as part of the consultation process, would have alerted the RTA to the Council's concerns with the level of jumping and diving from this particular long bridge over a tidal river (as of course actually happened).

Following the risk management standard, the RTA would then have analysed, evaluated and treated all the identified risks. The treatment

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79 New South Wales Police Department, Annual Report 2005-06, 6.

80 Ibid, 16.

81 An examination of the RTA's 2007 Annual Report reveals numerous references to risk management such as the following under strategic and operational risk on page 18: 'The RTA has a process for identification, assessment, management and monitoring of the major risks facing each area of its operation.'
Road Traffic Authority of New South Wales, Annual Report 2007, 18. http://www.rta.nsw.gov.au/publicationsstatisticsforms/downloads/2007_annual_report_dl1.html at 11 March 2008.
An examination of the Great Lakes Council Annual Report 2006/2007 also reveals numerous references to risk management, particularly in Section 3 Principal Activities. http://www.greatlakes.nsw.gov.au/Annual06_07.htm at 11 March 2008.

that actually eventuated for the Wollamba bridge was the erection of the pictorial 'no diving' signs in 1995. The final step, and one of the most important, is to monitor and review the effectiveness of all steps in the risk management process in order to achieve continuous improvement. This crucial step makes the process dynamic and is the reason, with respect, why the majority in the NSW Court of Appeal correctly identified the appropriate risk management approach.

In contrast to this risk management process under AS/NZS 4360 which would have yielded a list of all the RTA's bridges ranked and prioritised to assist RTA management decision-making regarding the extent and nature of treatments required (including the review of the effectiveness of measures taken), Kirby J observed that the trial judge found that 'the RTA has no policy or programme for dealing with this type of issue [the failure of the signs to prevent activity from the bridge], and there is no funding allocated for such an issue'.[82]

Writing extra judicially, Ipp J was considering the resources defence of statutory authorities under s 42 of the *Civil Liability Act* (NSW),[83] which provides that the general allocation by the authority of financial and other resources that are reasonably available to it for the purposes of exercising its functions is not open to challenge.[84] Ipp J noted that one of the reasons the defence has not proved to be very successful was that defendants have generally not called witnesses who are in a position to support the reliance by the authority on an absence of resources, instead relying on the production of accounts or explanatory evidence of a minor official.[85]

> In *RTA v Dederer*, for example, the NSW Court of Appeal was substantially influenced by the fact that the witness called by the authority was not a person who had the power to authorise the expenditure of funds to carry out the remedial measures for which the plaintiff contended.[86]

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82 *Dederer* [2007] HCA 42 [108].

83 *Civil Liability Act* 2002 (NSW).

84 The Hon Justice DA Ipp, *The Metamorphosis of Slip and Fall* [31]. (Presented at NSW State Conference of the Australian Lawyers Alliance, 30 March 2007.)

85 Ibid [35].

86 Ibid.

An appreciation of the above standard ensures that, rather like an iceberg being nine tenths submerged, the rare fatality or crippling injury (probability of the harm occurring in the negligence calculus) does not distract attention from the far more numerous minor injuries or 'near hits' lurking below the observable surface. By putting in place measures to deal with the 'near hits', the size of the iceberg is reduced and the consequential likelihood of a fatal accident reduced. A fatal accident can be likened to the reverse of winning the lottery: all the wrong outcomes conspire to occur at the same time.

A proper risk management approach adopts an operational risk matrix based on the likelihood and consequences.[87] The following is an example[88] of a typical table which, for health and safety, asks what is the credible worst case consequence utilising a 1 to 5 consequence ranking.

1	2	3	4	5
Minor costs under $5,000 with first aid required only and no referral to a medical practitioner needed.	Costs between $10,000 and $100,000 with a medical practitioner required but no rehabilitation needed for a full recovery.	Costs between $100,000 to $500,000 with a lost time injury, a short term hospital stay and short term rehabilitation results in a full recovery.	Costs between $500,000 to $1 million with a long term hospital stay, extended lost time injury and incident recordable by legislation.	Costs exceed $1 million with a severe injury or illness resulting in a fatality or 85% impairment under the American Medical Association Guides to the Evaluation of Permanent Impairment.

[87] The use of such an operational risk matrix based on likelihood and consequences (for which read probability and seriousness in the negligence calculus) is followed in AS/NZS 4360. Some risk management texts advocate the use of other practical tools to effectively quantify, rank, and track risks, but the effect is the same. Tracking risk, of course, is part of the review of the precautions put in place and involves a dynamic process of readjustment if the precautions are not working or the risk ranking has risen.

[88] Risk Management Guidelines, HB 436:2004, Companion to AS/NZS

Then, a likelihood index is utilised with E being rare (occurs in exceptional cases only), D being unlikely (could occur at some time), C being moderate (might occur at some time), B being likely (will probably occur in most cases) and A being almost certain (expected to occur in most cases).[89] In the matrix below, the likelihood index of A to E is shown on the vertical axis on the left hand side of the matrix, while the 1 to 5 consequence ranking is shown at the top of the matrix.

The final step is to allocate a calculated risk ranking to the outcome in question from low to moderate to high to extreme. The table below is similar to Table 6.6 in the guidelines to the risk management standard and which the guidelines describe as illustrating 'the process and descriptors that may be used to combine the level of consequences with the level of likelihood to determine a level of risk'.[90] Thus, the RTA should have ranked the outcome of diving off the Wollamba bridge based on the above operational risk matrix. For a consequence of 5 (the outcome for Mr Dederer), a rare likelihood yields a 'high' risk ranking and an unlikely likelihood yields an 'extreme' risk ranking.

Likelihood		1	2	3	4	5
Almost certain	**A**	High	High	Extreme	Extreme	Extreme
Likely	**B**	Moderate	High	High	Extreme	Extreme
Moderate	**C**	Low	Moderate	High	Extreme	Extreme
Unlikely	**D**	Low	Low	Moderate	High	Extreme
Rare	**E**	Low	Low	Moderate	High	High

This process of risk ranking is not static and should be regularly updated as more relevant information is gathered that might call for a reappraisal of the calculated risk ranking. Thus, known information as to rising levels of the activity (diving) antecedent to the risk likelihood being assessed for a consequence of 5 (fatality/crippling injury) is highly relevant to the risk ranking.

4360:2004, Table 6.2, page 53, Standards Australia.

89 Risk Management Guidelines, HB 436:2004, Companion to AS/NZS 4360:2004, Table 6.4, page 54, Standards Australia.

90 Risk Management Guidelines, HB 436:2004, Companion to AS/NZS

On the evidence, it was quite open for the Court of Appeal to find that between 1995 to 1998 the RTA, were it applying a prospective risk management approach, to have re-appraised the likelihood of diving from the Wollamba bridge from E (rare) to D (unlikely), thereby shifting the risk ranking from 'high' to 'extreme'.

The first diagram below depicts Time on the horizontal axis from the date the Wollamba bridge was built in 1959 to the date of Mr Dederer's accident in 1998. The vertical axis depicts the Scope of the Duty which can change as more information or knowledge becomes available, thereby making the obligation to exercise reasonable care more onerous. Neither axis is to scale and the diagram is for illustrative purposes only. As more knowledge and information come to hand, it is quite feasible that the obligation to exercise reasonable care can rise.

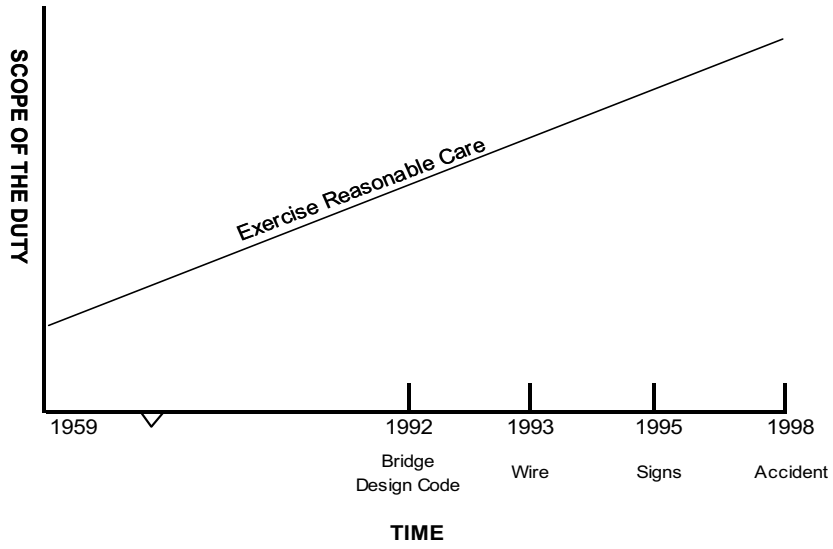
Clearly, knowledge by the RTA that existing preventative measures were not working and the likelihood of a serious accident was rising (thereby leading to an increase in the calculated risk ranking), would ratchet up the objective standard of the exercise of reasonable care. The revised upward risk ranking would mandate an additional response which translates to the precautions a reasonable person would have taken in the circumstances becoming more onerous. This is not the prevention of potentially harmful conduct, but the exercise of reasonable care in response to known information.

The line depicting the exercise of reasonable care is drawn as smoothly rising. In reality it could be very stepped depending on the ongoing process of tracking. For example, had the pictorial no diving signs proved to have been successful for a period of time, then the exercise of reasonable care line would plateau until new evidence suggested this was no longer the case and it would then recommence its upward path until a new set of precautions were put in place commensurate with the new risk ranking. This is commonly referred to as process of continual improvement and if successfully implemented would fully discharge the obligation to exercise reasonable care, because, while the exercise of reasonable care would be rising, so too would the precautions taken against a risk of harm.

Recent relevant developments that came out in the evidence are depicted on the horizontal axis as the introduction of the new Bridge Design

Code in 1992, the replacement of wire in the area of the horizontal railings in 1993, and the introduction of the pictorial 'no diving' signs in 1995.

Diagram 1



For the purpose of analysis, it will be assumed in favour of the RTA that its response to the known risk of diving off the bridge of erecting the pictorial 'no diving' signs fully discharged its obligation to exercise reasonable care in 1995. Thus, had Mr Dederer dived off the bridge in 1995, shortly after the signs first went up, then the RTA would not have been in breach of its duty of care.

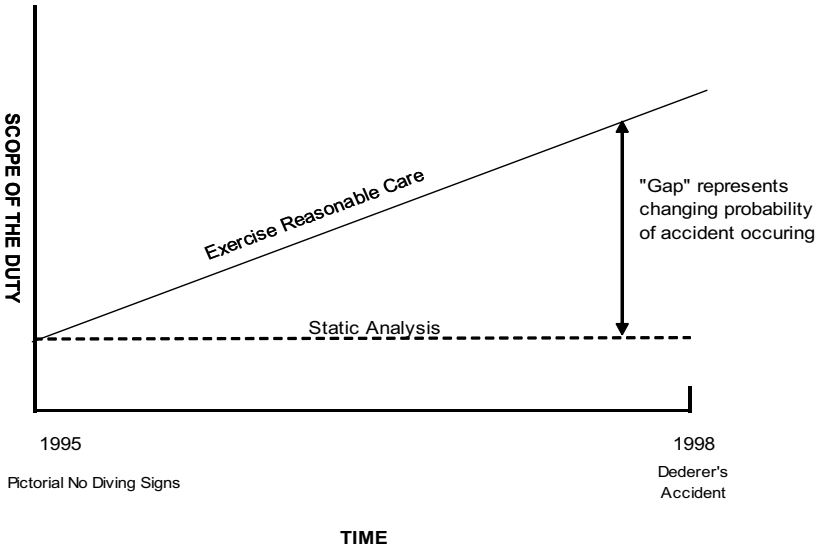
This discharge of the RTA's obligation is depicted in the second diagram below, which only covers the period 1995 to 1998, with the confluence of the broken and unbroken lines in 1995.

Gummow J's position is depicted by the broken line entitled static analysis as His Honour held that the signs were enough because there was no accident between 1995 and 1998.

The majority in the Court of Appeal's position is depicted by the rising solid line which posits that the probability of an accident was rising due to known rising levels of activity off the bridge and that therefore

potentially a gap was emerging between the exercise of reasonable care and the actions of the RTA in going no further than the erection of the 'no diving' signs. It is argued, with respect, that the Court of Appeal's dynamic analysis is to be preferred because it is in keeping with AS/NZS 4360.

Diagram 2



So how would the new first part of the *Shirt* test of significant practical risk being proposed by Callinan and Heydon JJ in *Fahy* and the adoption of AS/NZS 4360 translate into the Civil Liability Acts while being confined at this stage to statutory authorities? For illustrative purposes, a new proposed s5BA[91] General Principles for Statutory Authorities is given below.

> **5BA General principles for Statutory Authorities**
>
> (1) A statutory authority is not negligent in failing to take precautions against a risk of harm unless:

[91] This would be the appropriate numbering for New South Wales and Western Australia, but would alter for other jurisdictions. See n7 above.

> (a) the risk was foreseeable (that is, it is a risk of which the statutory authority following Risk Management Standard AS/NZS 4360 considered or ought to have considered), and
> (b) the risk was a significant practical risk, and
> (c) in the circumstances, a statutory authority following Risk Management Standard AS/NZS 4360 would have taken those precautions.
>
> (2) In determining whether a statutory authority should have taken precautions against a risk of harm, the court is to consider the following (amongst other relevant things):
>
> (a) the ongoing regularly reviewed likelihood that the harm would occur if care were not taken and whether the adopted risk ranking was appropriate,
> (b) the consequences of the harm,
> (c) the precautions taken as a result of the risk ranking in (2)(a) above,
> (d) the burden of taking precautions in (2)(c) above to avoid the risk of harm provided evidence is given from a senior officer of the authority who had the power to authorize the funds for which the person who has suffered the harm contends,
> (e) the social utility of the activity that creates the risk of harm.
>
> (3) In the event that a statutory authority does not adopt and follow Risk Management Standard AS/NZS 4360, with particular emphasis being placed upon the ongoing risk ranking of the harm, then a rebuttable presumption of negligence arises against the statutory authority.

It is proposed that AS/NZS 4360 be called up[92] in the legislation as a mandatory requirement for statutory authorities, and that failure to properly implement this risk management standard will lead to the rebuttable presumption of negligence as per 5BA(3) above.

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[92] See n8 for explanation of Australian Standards being called up under legislation. An operational risk matrix utilising likelihood/consequences is not mandated under the standard and other tools are available to quantify, rank and track risks, but the effect is the same.

VII Conclusion

> *'New opinions are always suspected, and usually opposed, without any other reason but because they are not already common.'*[93]

This paper contends that the reasoning of the majority in the Court of Appeal in *Dederer* is to be preferred to the reasoning of the majority in the High Court. This follows by virtue of the Court of Appeal's dynamic as opposed to static analysis of the relevant information on activity levels that impact on the probability of the harm occurring. The actual outcome of recorded incidents is directly related to this antecedent activity and, with respect, Gummow J is 'looking through the wrong end of the telescope' in deflecting attention from the levels of activity on the bridge to the impact in shallow water. The example of an iceberg being nine tenths submerged illustrates where His Honour falls into error by concentrating on the 'above the surface' observation that up until 1998 there had been no serious accidents, rather than the 'below the surface' level of activity in the form of 'near hits'.

A further contention is that this conflation of reasoning would be avoided if the two part test in *Shirt* was abandoned in the case of statutory authorities, and replaced by a more demanding and objective two part test.

This new test, which at this stage is confined to statutory authorities, is incorporated into a proposed s5BA of the Civil Liability Acts and calls up the risk management standard AS/NZS 4360: 2004. The new test comprises, firstly, the calculated risk ranking of a significant practical risk and, secondly, the statutory authority's ongoing response to a risk ranking that may well change depending on circumstances. It is fundamental, both to AS/NZS 4360 and the new test, that relevant information either collected by or drawn to the attention of the statutory authority may change the risk ranking and therefore the appropriate response to the exercise of reasonable care. It is hoped that with the adoption of a more objective and quantifiable test for breach of duty of care, a more consistent and predictable set of outcomes will emerge in the future, with governments less inclined to treat their statutory authorities as a form of legally endangered species.

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93 John Locke, *Essay on the Human Understanding*, Dedication, cited in The Penguin Dictionary of Quotations, JM and MJ Cohen, Penguin Books, 1977, 235.