GENERAL CHRONOLOGY AND OVERVIEW

Royal Canberra Hospital situated on the Acton Peninsula closed on 27th November 1991. On Sunday 13th July 1997 a large crowd estimated to be in excess of 100,000 people gathered in sunny conditions in the area of Commonwealth Avenue, Flynn Drive and Lennox Gardens adjacent to the south western foreshores of Lake Burley Griffin to witness the final stages of the demolition of certain of the Royal Canberra Hospital buildings.

The buildings to be demolished were the Main Tower Block (stage 1) and Sylvia Curley House (stage 4). The demolition of Bennett House and the Maternity Unit (stages 2 and 3) did not occur on this day and is not the subject of any inquiry by this Inquest.

The demolition which was scheduled to commence at 1.00pm was to be achieved by implosion. The buildings were to collapse inward on themselves (on their own footprint) after the detonation of an amount of explosives. A fireworks display was to precede the implosion event. A delay of about thirty minutes occurred. The delay was caused by falling debris from the pyrotechnic display on the roof of the tower block severing the electronic firing circuit. The explosives were ultimately detonated at 1.30pm.

Tragically Katie Bender was struck in the head by a fragment of steel killing her instantly. The fragment weighed 999 grams. It travelled a distance of 430 metres at a sub sonic speed in about 3.1 seconds after the blast first occurred. The fragment of steel was expelled from one or other of the corner columns (C30 or C74) on the outside row on the face of the East Wing of the Main Tower Block. There were a number of persons in her immediate proximity that witnessed this tragedy. A number of other spectators were injured by flying metal and debris. There was also damage to some motor vehicles.

The fragments of debris were propelled distances of up to 1km from the site of the demolition in the direction in which Katie. Bender was located and further round to and beyond the area of the Canberra Yacht Club. Items of debris were located in the area of the southern end of Commonwealth Avenue bridge, the lake foreshore, the National Library of Australia, the Treasury car park, the Hyatt Hotel, Lennox Gardens and the area towards and beyond the Canberra Yacht Club. An item of steel weighing about 16 kilograms was later retrieved from Lake Burley Griffin on the south western foreshore adjacent to the Yacht Club. It is trite to say that many hundreds of Canberra citizens drawn to this spectacle were at grave risk. A diagram and photographs of the significant items subsequently located and apparently ejected from the building is found in exhibit 10A and re-produced in this Report.

The true sequence in reality was that at 1.30pm the Main Tower Block was first detonated. I am satisfied that Katie. Bender died in this first procedure. Thereafter, within a short space of time, the fireworks were discharged and almost immediately Sylvia Curley House was detonated. I shall refer further to these procedures in the segment of the Report relating to the Manner and Cause of Katie Bender's death.

The Coroner attended the scene of the death within an hour of the detonation at the request of the Australian Federal Police. An investigation into the young girl's death was commenced immediately. Katie Bender was born in Canberra on the 18th September 1984. She was aged 12 years at the time of her death.

In April 1995 the Keating Government agreed in principle with the Australian Capital Territory Government to exchange certain sites of land within the Australian Capital Territory to facilitate the building of the National Museum of Australia. The ACT relinquished the Acton Peninsula site where the Royal Canberra Hospital was situated to the Commonwealth of Australia. The Australian Capital Territory Government received in return the foreshore area near the suburb of Kingston. The Chief Minister Mrs. Kate Carnell MLA announced the land exchange agreement on the 11th April 1995. In July 1995 a feasibility study was undertaken by Richard Glenn and Associates for the demolition and clearance of the buildings on Acton Peninsula. On the 4th August 1995 Cabinet approved a submission that the implosion method of demolition was recommended. It was estimated that the demolition time, if implosion was an option, would be reduced by a month. At this stage the suggested completion date for the demolition was the 3rd May 1996. The estimated cost of the demolition was assessed at $8.125 million dollars.

Although the chronology of significant dates relevant to the demolition of the Royal Canberra Hospital site (reproduced in this Report) would suggest that between August 1995 and December 1996 various studies and reports were being commissioned and prepared in relation to the site, in effect, the period from February 1996 to December 1996 was one of relative inactivity. In October 1996 the Keating Labor Government was defeated at the election by the Honourable Mr. John Howard. On 9th December 1996 the Acton Peninsula project was re-enlivened in an ACT Government Cabinet decision.

On Friday 13th December 1996 the Prime Minister, the Honourable Mr. John Howard announced the design work on Acton Peninsula would begin immediately. An amount of $750,000.00 was to be provided for the design work. On the same day as the announcement by the Prime Minister Project Coordination Australia Pty Ltd., by what is known as a single select method, was engaged as the project manager for the site. The next day, 14th December 1996 a fence was erected around the site. The Canberra Times attributes the Prime Minister as giving a direction "get on with it". The appointment of Project Coordination Australia Pty Ltd. as the project manager for the Acton site, pursuant to the single select method, was not formally approved in writing until six days after the oral appointment was announced. It should be noted that PCAPL had a wealth of experience as a project manager on various sites in the ACT but not specifically in a field of demolition by implosion. Such a method of demolition had never previously been undertaken in the Territory.

The ACT Hospice is located on the northern foreshore of Lake Burley Griffin. The Hospice was within 78 metres of SCH. The Hospice was opened in February 1995 and occupies the land on a licence. It is operated by the Little Company of Mary on behalf of Calvary Hospital, Bruce with a capacity of 17 beds for the terminally ill. There are two other groups sharing the Hospice facilities, the Home Based Palliative Care Nurses and the Hospice Palliative Care Society who are a volunteer organisation raising funds for the Home Based Palliative Care Nurses. It is of

significant relevance that the Hospice continued to operate during the demolition process but in particular remained occupied on Sunday, 13th July 1997 when the implosion was to occur.

The chronology of events set out within this report reflects the course of various actions undertaken by various persons and organisations throughout the course of the demolition project. Those events are discussed in detail in the report.

Mr. W Stoll, Assistant Commissioner of the Australian Federal Police, with a number of other senior officers commissioned a team of investigators led by Detective Sergeant Greg Ranse and Detective Constable Mark Johnsen to immediately conduct an investigation into the circumstances of Miss. Katie Bender's death and the demolition of the hospital building. Some 16 persons constituted the investigation team. The team received overwhelming support from the ACT community in the donation of videos and photographs of the events of that afternoon. The Australian Federal Police also arranged over a period of a number of days counselling for those spectators traumatised and suffering emotional effects as a consequence of the day's events. The investigation, as the subsequent evidence revealed during the Inquest, was broad based and thorough in the areas that were examined by the investigating team of police officers. A team of police divers searched Lake Burley Griffin to locate, plot and retrieve debris from the implosion. Members of the Bomb Response team were called on to provide assistance with interviews and with recovery of explosives.

The Inquest opened at a Directions hearing on the 5th September 1997 in accordance with the *Coroners Act 1956*. The *Coroners Act 1956* was the applicable legislation at the date of death of Miss. Bender on Sunday, 13th July 1997. It was replaced on the 9th October 1997 by the *Coroners Act 1997*.

The transitional provisions in Section 106 of the *Coroners Act 1997* provided that the earlier legislation (*Coroners Act 1956*) continued to apply to an Inquest into a death occurring prior to 9th October 1997 and which had not concluded before that time. It was common ground amongst all parties represented at the Inquest that the *Coroners Act 1956* was the applicable legislation.

A further four Directions hearings were convened before the Inquest formally opened on Tuesday 17th March 1998 for the reception of evidence. Thereafter the Inquest sat for 118 days. The formal evidence concluded on Wednesday 11th November 1998. A further 3 Directions hearings were held.

Counsel Assisting the Inquest Mr. I W R Nash and Mr. S Whybrow submitted the initial set of submissions on the 12th March 1999. The submissions made by the various interested parties were lodged on 23rd April 1999 and replies were received by 21st May 1999 save in one case where the submission was not received until Wednesday, 9th June 1999.

There were no less than 18 separate legal representatives involved in the Inquest at various times representing many diversified interests in the demolition project. Ms. Susan Leis of Koffels, Solicitors of Sydney for Mr. Gordon Ashley, a structural engineer from Leichhardt (Sydney) withdrew after appearing for a number of days in

the proceedings. Mr. J Kershaw and Mr. N Haberechet of the Canberra Community Action on Acton Inc. were granted leave in accordance with section 53 of the *Coroners Act 1956* to appear as they demonstrated sufficient community interest having urged Government, both Commonwealth and Territory, for a number of years earlier not to pursue the Acton demolition project. In fact CCAA had petitioned Mr. T. Kaine MLA and Minister for Urban Services to halt the project as late as Friday, 11th July 1997. The leave granted to CCAA was only for a limited interest.

The Inquest heard evidence from 47 witnesses and received 753 exhibits with an additional 82 documents being marked for identification. The transcript totalled almost 9900 pages.

The Inquest had a significant impact on all those engaged in the inquiry process, particularly Mr. Gary Hotham of Totalcare Industries Limited who on the sixth day of giving evidence was unable to continue for medical reasons. After about a month's recuperation Mr. Hotham was able to resume his evidence to its completion. The Inquest recognises that the death of Katie Bender had a significant impact on Mr. Hotham. It is to his credit that he was able to assist the inquiry by the completion of his evidence. The Inquest also recognises the assistance provided to it by the Totalcare Industries legal team to facilitate his evidence being completed without further detriment being rendered to Mr. Hotham's health. Mr. Tony Fenwick of City and Country Demolition (CCD) appeared during the first week of the Inquest and was represented from time to time by legal counsel but was also unable to attend the Inquest due to illness.

On the 30th July 1998 Mr. F. J. Purnell SC of Counsel for Totalcare Industries Limited instructed by Deacons Graham and James brought an application in the Supreme Court of the Australian Capital Territory seeking inter alia to review the conduct of the Coroner and in particular the failure of the Coroner to direct Counsel Assisting and the Director of Public Prosecutions to identify whether any of its officers servants or agents would or were likely to be charged with a criminal offence or subject to any other proceedings. The application was refused.

Another significant legal issue emerged during the latter stages of the Inquest in relation to the privilege against self-incrimination. It was claimed by witnesses called by Totalcare Industries Limited and Project Coordination Australia Pty Ltd. Mr. Rod McCracken of Controlled Blasting Services declined to give evidence to the Inquest, as did Mr. Tony Fenwick of CCD on the basis of self-incrimination. Counsel for PCAPL submitted no less than 163 applications for privilege on the basis of self – incrimination.

The Inquest hearing took longer than anticipated due to the large amount of material adduced, the number of witnesses, the technical and professional expertise that those witnesses brought to the proceedings. In November 1998 it was urged upon me to reopen the Inquest and call additional evidence in respect of certain demolitions conducted by Mr. J Mark Loizeaux of CCD in the central business district of Perth in 1992. It was alleged that a substantial amount of fly debris was emitted at those demolition projects. The request to reopen the Inquest was declined. The methodology employed by Mr. J Mark Loizeaux was never in any way substantially challenged. It was always recognised that debris can be emitted in any demolition

process whether it was done by the conventional means or by the implosion technique. The emission of fly material, debris and other items was clearly evident on the various video films of other demolitions admitted into evidence. In the end it was necessary to strike a balance between the degree of fine detail sought and a practical conclusion to the Inquest. It was necessary to conclude the Inquest otherwise to permit it to continue would have no longer served any useful purpose.

The Jurisdiction of the Coroner is threefold in its function: -

(a) To make certain findings as to the manner and cause of death (Section 56(1) of the *Coroners Act 1956*),

(b) To make comment on any matter connected with the death including issues of public safety (Section 56(4) of the *Coroners Act 1956*), and

a. To make recommendations to the Attorney General on any matter connected with the Inquest including matters relating to public safety (Section 58(2) of the *Coroners Act*).

I have examined these functions in some detail in the first segment of this Report. It is very necessary to state these principles at the outset and to develop these concepts for fear there is some misunderstanding of the Coronial process which is inquisitorial in its function, non – adversarial and not necessarily strictly reliant on the laws of evidence.

The rules of natural justice apply equally to the Coronial function. Accordingly, in the absence of specific statutory provisions the principles reflected in the High Court of Australia decision of Annetts v McCann (1990) 170 C. L. R. 596 are relevant to a Coronial hearing. The *Coroners Act 1997* has now incorporated those principles in the statute.

The approach that I have adopted in the preparation of this Report is to examine the process from the time there was the announcement of the in principle agreement by both the Commonwealth and Territory Governments of the Acton – Kingston land exchange on 10th April 1995 to the actual demolition on Sunday, 13th July 1997. The report attempts to examine in a logical progressive way the major significant events that occurred on the site in a chronological manner as the project evolved. The Report does not adopt the approach of working backwards in an endeavour to discover or pin point every piece of evidence that might suggest the process was fundamentally flawed. It is to be remembered at all material times the Acton Peninsula project was a commercial industrial site which over a number of months was in various stages of development. There has been no attempt to retrace the demolition project with a view to making some identification of any or every potential mistake in the project. The Coronial function is one of fact finding.

It is to be hoped that the scope of the Inquest and the detail developed will be reflected in the learning that may be derived from the death of Katie Bender. There

has been a substantial amount of work already contributed to learning from this tragedy. The efforts put into place already by ACT WorkCover to adopt better work practices is a classic example of the identification of problems. The protocol being developed will lead to a better application of the *Occupational Health and Safety* legislation.

There are some issues of a minor or of a peripheral nature that were considered by the Inquest. Those issues do not have any significant impact or direct relevance to the cause of death, my findings, comments or recommendations. The fact that the Report only makes a brief mention of that material should not detract from their importance. Those fields of interests generated by the Inquest can be addressed in the appropriate forum of government or private commercial enterprise. Two examples covered in this area are: -

a. The status of the land on Acton Peninsula as to whether it belongs to the Commonwealth or the Territory, and
b. Whether the Building Controller of the Australian Capital Territory has any relevance to a project being undertaken on land where it is controlled, operated or supervised by the Commonwealth of Australia.

Although it was an unusual step to take in the coronial process, I decided at an early stage that in view of the large number of interested parties in the proceedings and the fact that the ACT Government had convened a parallel inquiry pursuant to the *Inquiries Act 1991* that it was necessary to issue search warrants in accordance with Division 2 of the *Coroners Act 1956*. About 18 search warrants were issued on various government departments, corporations, other institutions and individuals. This course facilitated the preservation of various documentation particularly in relation to the tendering and contractual process and enabled the investigation team to focus on certain areas of inquiry. It should be recognised that there was full co – operation in this process by Government and all affected parties but it was a process issued as a matter of precaution.

There was in the early days after the tragedy the creation of the Tanzer and then the Smethurst Inquiry. It is appropriate to acknowledge the co – operation provided to myself and the Chief Magistrate, Mr. R. J. Cahill, OAM, by Major General Smethurst, AO, MBE particularly when it was clear that the *Inquiries Act 1991* had the potential to create problems with the Coronial function especially with the provisions contained in Section 19 of the *Inquiries Act 1991* relating to the admissibility of evidence. These difficulties were overcome in due course in a spirit of mutual agreement between the respective Inquiries. I acknowledge with appreciation the role-played by Major General Smethurst AO, MBE in resolving these problems. There was a real risk that the judicial process of the Coronial Inquiry would be hampered by the administrative arrangements under the *Inquiries Act.*

The Bender Inquest received an extensive volume of evidence in its 118 sitting days. It is only now upon reflection, having reviewed the evidence and the submissions lodged by the interested parties, that its duration could have been shorter. The circumstances of Katie Bender's death warranted a detailed investigation and review of the events leading to and culminating in the blast on Sunday, 13th July 1997.

The demolition by the implosion technique had never been implemented in the Australian Capital Territory and was relatively novel in Australia. The implosion method of demolition by its very nature would excite the interests of the public as a spectacle. The attraction of a large spectator group was an automatic consequence of such a demolition. The simple curiosity of human nature is such as to be sufficient to generate an interest in this method of demolition.

The Royal Canberra Hospital played a significant role in the lives of many Canberrans over a long period of time as the city and the Territory emerged from the status of a country town. There are now many areas that I consider quite properly could have been examined by the Smethurst Inquiry. A logical commencement point for the Coronial process may well have been from the period after the demolition site commenced operation in the period of April/May 1997 rather than as remote in time as the Cabinet decision of August 1995 when the first Glenn feasibility study was being considered. It is out of extreme caution that a wide ranging Inquiry was undertaken to ensure that no issue was missed and therefore it seems to me on review that there is no necessity now to reconvene the Smethurst Inquiry or any other Inquiry.

The Coronial Inquest has sufficiently recorded all the significant steps since the announcement was made by the Chief Minister Mrs. Kate Carnell MLA on the 11th April 1995 of the inprinciple land exchange agreement. There is no doubt that the Inquest traversed and reviewed many matters outside the normal parameters of the Coronial function. The evidence received, whether it constitutes any part of my findings, recommendations or comments, is open to public scrutiny and examination by not only Government, its agencies or instrumentalities but for the broader benefit of the community to analyse, accept or reject in the terms of adopting or implementing any of the suggestions or recommendations.

The Inquest had become extremely broad in its fact-finding role. The duration of the Inquest raised a real potential for an expansive result and therefore a serious risk of falling into jurisdictional error. The comments made by Nathan J in Harmsworth v the State Coroner of Victoria (1989) Victorian Reports 989 at 995 and 996 are particularly apposite. I quote, omitting various statutory references, "the Coroners source of power of investigation arises from the particular death or fire. A Coroner does not have general powers of inquiry or detection. The enquiry must be relevant, in the legal sense to the death or fire. This brings into focus the concept of "remoteness". Of course the prisoners would not have died, if they had not been in prison. The sociological factors which related to the causes of their imprisonment could not be remotely relevant. This can be tested by considering how wide, prolix and indeterminate the Inquest might be if each of the many facets of the individual personalities of all those involved were to be considered. The Coroner would be confronted with a need to inquire into the personal peculiarities of all of the prisoners who barricaded themselves in. Both those who relented and those who did not. Whether for example, one group or person suborned others and if so why and how. The personalities of all the prisoner officers who interacted with all of the prisoners could also be investigated".

"The power to comment arises as a consequence of the obligation to make findings. It is not free ranging. It must be comment "on any matter connected with the death".

"The powers to comment and also to make representations are inextricably connected with, but not independent of the power to inquire into a death or fire for the purposes of making findings. They are not separate or distinct sources of power enabling a Coroner to inquire for the sole or dominant reason of making comment or recommendation. It arises as a consequence of the exercise of a Coroners prime function, that is to make "findings"".

Needless to say having embarked on such a wide ranging Inquiry out of extreme caution to ensure no issue was overlooked there is now no need in my view to again convene the Smethurst Inquiry. It would be simply a duplication of the process with little or no cost efficiency.

I note the positive help of the various parties and the considerable assistance of Counsel and their Solicitors throughout the Inquest process. I am confident that at all times Counsel were endeavouring to assist the Inquest in their presentation of the evidence and their approach to their examination of witnesses. The Court had the benefit for the first time of high quality information technology from the outset of the Inquest, which substantially assisted the parties in the smooth running of the inquiry once the technical difficulties were overcome. The transcripts and exhibits were scanned into the system so that the legal representatives and the witnesses had available to them on the screen the actual document of relevance to their evidence.

The Court has had the benefit of Counsel’s substantial written submissions and replies along with much material provided during the Inquest.

OVERVIEW OF TECHNOLOGY USED IN THE BENDER INQUEST

It was clear early on that the weight of Exhibits in the Bender Inquest would be a considerable burden if presented in the traditional hard copy format. Thus in an attempt to deal with this situation a solution was sought which would enable the timely presentation of materials to all parties in the proceedings. A solution from Auscript was selected. The Auscript team performed two major tasks. Scanning the Exhibits and photographs, supplying and setting up some of the hardware.

The court room used for the Inquest was a typical court with insufficient infrastructure to handle to multimedia presentation that would be used. However, as the court room would revert to a normal court after the Inquest there was a trade off as to the nature of the changes, permanent or temporary.

Televisions were attached to the walls for public viewing, five 21 inch computer screens were placed strategically around the court to be utilised by the Coroner, the Counsel Assisting, and the members of the profession.

Over 30,000 pages of Exhibits and 2000 photographs were scanned and loaded onto the computer. The Counsel Assisting the Coroner had control and was able to display, on every device, any of these items at any time. Counsel also had the ability to play videos with the picture being broadcast to every device in the court.

Transcripts were provided daily and loaded onto the PC as well. The software ISYS was used to successfully search and retrieve pertinent information from previous days.

At the completion of sitting the equipment was dismantled and the court was back to normal within a few hours.

This was the first serious attempt within the Magistrates Court to apply modern technology to a lengthy and complex case. The venture was successful. The fact that this first attempt was on such a large and high profile case added certain dimensions of pressure. The parties involved in supporting this endeavour provided an excellent service. Mr. Luke Magee, the Courts Senior Technology Officer deserves special mention in achieving the success. The Court extends its thanks to him for his efforts. A schedule of costings is attached for general information.

ACKNOWLEDGEMENTS

Many individuals and their agencies invested a considerable amount of work and effort to assist in the investigation and Inquest. Their efforts are appreciated. I extend my thanks to Counsel and their Solicitors for their valuable assistance. The Police Investigation team are recognised elsewhere in this Report.

I would like to extend my thanks and appreciation to Counsel Assisting the Coroner, Mr. I. W. R. Nash of Counsel and Mr. S. Whybrow of the Office of the ACT Director of Public Prosecutions for their dedication and commitment to a difficult and complex proceeding. Both Counsel have worked under substantial pressure not only during the actual hearing but also in the preliminary period prior to the Inquest commencing and then later in the presentation of their comprehensive submissions.

It is also appropriate to recognise the patience and dedication of my two Associates during the period of the Inquest. Ms. Tina Stephenson acted as my Associate from January 1998 to April 1999 when she moved on to advance her legal career. Mrs. Linda Bundic has been my Associate since April 1999. She has conscientiously committed herself to the presentation of this Report. I extend my gratitude to them both for their support and assistance discharged in a professional manner. It is sincerely appreciated.

THE BENDER FAMILY

Mr. and Mrs. Bender and the family attended the Inquest almost on a daily basis, particularly Anna who provided substantial assistance to their legal Counsel. The dignified attendance on a daily basis has been noted. Their regular attendance underscores the importance of learning from this tragic incident.

I extend to the Bender family as the Coroner and on behalf of the Canberra community our sincere sympathy on the tragic death of their daughter and sister, Katie.

The contents of this Report may give them some understanding as to why Katie died on Sunday, 13th July 1997. The memories of Katie will always be cherished by her

family. It is to be hoped in the interests of public safety for all Canberrans an incident of this type is never permitted to occur again.

Dated this day of 1999

Shane G. Madden

Coroner