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Cultivating Excellence in Employment to Support Primary Industries

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Governance lessons from the Davison KC Mauao review

The Davison KC review into the fatal landslide at Mauao has lessons for anyone sitting around a board or committee table. Six people lost their lives. We owe it to those affected to take the findings seriously and consider what they mean for the organisations we govern. (Davison KC review report and related papers see https://www.tauranga.govt.nz/council/external-review-into-mount-beachside-holiday-park-landslide)

The review found that Tauranga City Council knew about the landslide risk. Expert advice had recommended a plan to manage it. That plan had not been implemented. Nobody had been allocated ownership of the risk, responsibility had not been clearly transferred, recommendations were not tracked to completion and the matter was not escalated.

There is a lot for all of us to think about there and it is applicable to every organisation.

We can have a constitution, policies, a risk register and regular board meetings. We can receive reports and record decisions in the minutes. But we still need to make sure someone acts and that the action does what we intended.

That applies to a business, an industry organisation, a charity or the local sports club. For me, the first question is who owns the issue. Saying "management is dealing with it" is too loose. Which person? Do they have the authority and resources? When will they report back? What happens if the work stalls?

The second question is what happens to expert advice. A report arriving in someone's inbox is only the start. Its recommendations need a decision. If we accept them, who will implement them? If we defer them, what risk are we carrying while we wait?

Important information must also reach the people responsible for deciding. The Council's response identifies the danger of significant issues being buried in attachments and reports disappearing when meetings are cancelled. Those are very ordinary administrative problems with potentially serious consequences.

Every board should look at how its own information is managed. Can staff raise an urgent concern between meetings? Does the board paper make the problem clear? Are we hearing from the people who understand what is happening on the ground?

Then there is the question of evidence. The Council's response proposes testing critical controls, checking management and contractor assurances, undertaking site visits and examining significant risks in depth. That is useful advice for any governing body.
If someone tells us there is a safety procedure, ask how it works. Have the staff been trained? Has it been tested? If we rely on financial controls, check an actual payment. If we oversee a facility or service, go and see it operating.

Governors need enough information to exercise judgement. Calling something operational does not make it irrelevant to the board.

People leaving is another point where things can go wrong. Volunteers retire. Managers change jobs. Committees turn over. Open risks, contracts and unfinished actions need a deliberate handover, with the new person understanding what they have taken on.

Our governing documents matter too. Before making a significant decision, we should know what we are authorised to do, who can decide and what process is required. The minutes should explain the decision and identify who will act. Keeping unresolved matters on the agenda until there is a clear decision and someone responsible for delivery.

None of this requires a huge organisation or an expensive governance system. A small board can ask these questions, keep clear records and follow up. Where the issue exceeds our knowledge, we need proper advice.

At your next meeting, choose one significant risk or unfinished decision. Ask who owns it, what has happened and what evidence shows the response is working. Then keep asking until you are satisfied. That is the practical governance lesson I take from this review.