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DISCUSSION PAPER LEARNING FOR EMERGENCY SERVICES

Looking for a new approach

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Cover: A destroyed house at Kinglake from the Black Saturday bushfire. Photo by the Bushfire and Natural Hazards CRC



TABLE OF CONTENTS

ABSTRACT	4
DISCUSSION PAPER	5
INTRODUCTION	6
I. THE MOTIVATIONS FOR CALLING POST-EVENT INQUIRIES	7
The desire to assign responsibility or blame	11
II. INQUIRIES AS A POST DISASTER LEARNING TOOL	19
Methodology	19
Results	3
Discussion	5
III. CORONERS - A TALE OF TWO INQUESTS	10
The death of Alison Hume	11
The death of Michael Wilson	13
IV. THE VALUE OF RECOMMENDATIONS	20
Lessons identified or lessons learned?	25
V. THE NEED TO BE HEARD AND TO TELL THE STORY	27
VI. THE CURRENT POSITION	30
VII. ALTERNATIVE MODELS	33
Civil Aviation 'no blame' investigations	33
WHAT MIGHT POST-DISASTER INQUIRES LOOK LIKE WHEN MODELLED ON AVIATION SAFETY INVESTIGATION?	39
The medical profession and 'open disclosure'	40
WHAT MIGHT POST-DISASTER INQUIRES LOOK LIKE WHEN MODELLED ON 'OPEN DISCLOSURE'?	46
Inquiries based on principles of restorative justice	49
SHARING RESPONSIBILITY	60
THE USE OF RESTORATIVE JUSTICE BEYOND CRIMINAL LAW IS NOT UNIQUE AND IS GROWING	63
WHAT MIGHT POST-DISASTER INQUIRES LOOK LIKE WHEN MODELLED ON 'RESTORATIVE JUSTICE'?	65
VIII. COMPENSATION	68



IX.	A STANDING BODY TO CONDUCT FUTURE INQUIRIES?	73
	THE INSPECTOR GENERAL FOR/OF EMERGENCY MANAGEMENT?	73
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	A Fire and Emergency Safety Bureau?	74
	A STANDING INSTITUTION TO CONDUCT INQUIRIES	75
	A STANDING SECRETARIAT	79
	A CENTRE TO SHARE LESSONS LEARNED	81
	MOVING FORWARD	83
<hr/>		
X.	CONCLUSION AND RECOMMENDATIONS	85
	Appendix 1: Inquiries included in this review (by year).	87

DRAFT - FOR DISCUSSION

ABSTRACT

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This paper reviews the processes used in inquiries following significant natural hazard events, and in particular bushfires. It is argued that the coroner/Royal Commissioner model has not proved effective in identifying learning that will help communities to rebuild relationships after an event, or develop resilience in anticipation of the next event.

After identifying shortcomings with current practices the paper argues that restructuring post event inquiries. Restorative justice is a concept established in the area of criminal law but it is argued that guidance from the restorative justice community could assist in formulating enquiries that would assist all the parties to come together to resolve collectively how to deal with the aftermath of the disaster and deal with its implications for the future.

The paper also argues that a standing Fire and Emergency Safety Bureau should be considered to conduct some enquiries and to act as a standing secretariat for inquiries in the nature of a Royal Commission.

Issues of compensation for those affected by natural disasters are touched upon.

DRAFT - FOR DISCUSSION

DISCUSSION PAPER

This is a discussion paper circulated for feedback and comment. The authors welcome your thoughts in response to the following questions, as well as any other thoughts, criticisms, concerns or ideas you would like to share.

Specific questions:

1. What do you think the community should expect from post-event reviews?
2. Are we well served by current post-event review processes?
3. Are the criticisms of current post-event reviews justified?
4. Is there value in current post-event reviews that the authors have not identified or given due weight to?
5. Do you agree with the suggestions for the move to restorative justice practices? Why or why not?
6. Do you have other suggestions on how post event reviews may be improved and made more meaningful?
7. How could we improve this report to make it more relevant, meaningful and helpful?
8. Are there any other thoughts, criticisms, concerns or ideas you would like to share?

DRAFT - FOR DISCUSSION

INTRODUCTION

Each day fire, ambulance and other emergency services respond to events that are dangerous and often fatal. These events are out of the ordinary experience of most people and, occasionally, beyond the 'knowledge, skills, experience and imagination'¹ of the emergency responders. A review of the response to an incident may identify ways in which the response could have been different and perhaps more effective. These reviews can range from internal agency reviews, operational reviews,² special inquiries³ and Royal Commissions.⁴ Coroners provide another source of review.⁵

This paper will review examples of these processes, as well as the experiences of those involved. It is argued that none of the review process are fully effective in identifying lessons from the response to emergencies and disasters. It is proposed that a new approach, more suited to the purposes of constructively generating lessons for future policy and practice and supporting to goal of shared responsibility, is required.

¹ Mark Crossweller, 'How a change in thinking might change the inevitability in disasters' (2015) 30(3) *Australian Journal of Emergency Management* 48-55, 50.

² See for example, Ron McLeod, *Inquiry into the Operational Response to the January 2003 Bushfires in the ACT* (Australian Capital Territory, 2003).

³ See for example M.J. Keelty, *A Shared Responsibility: The Report of the Perth Hills Bushfire February 2011 Review* (Western Australia, 2011).

⁴ Victoria, 2009 Victorian Bushfires Royal Commission, *Final Report* (2013).

⁵ See, for example, Maria Doogan, *The Canberra Firestorm: Inquests and Inquiry into Four Deaths and Four Fires between 8 and 18 January 2003* (ACT Coroners Court, 2013).

I. THE MOTIVATIONS FOR CALLING POST-EVENT INQUIRIES

Following a major bushfire or natural disaster:

The public demands an investigation... The motivations for calling such investigations are many, but the strongest one ought to be to determine what we can learn from the examination and what we need to do to prevent or mitigate another like event.⁶

The policy literature take a critical stance on post-disaster inquiries. With respect to royal commissions, Prasser says:

... public inquiries (and royal commissions) can be established for politically expedient reasons such as to show concern about an issue, give an illusion of action, show responsiveness to a problem, co-opt critics, reduce opposition, delay decision-making and reassert control of the policy agenda. These 'covert' goals are never explicitly stated by the initiating government as this would undermine the veracity of the public inquiry instrument as a tool of investigation and, of course, in meeting a government's political goals.⁷

Others have identified a similar list of relevant considerations. Sulitzeanu-Kenan's analysis shows that it is not the 'inherent severity of an ... event' but rather 'the interplay of the politics of blame, public agenda ... and government popularity [that] determines the choice of whether to establish a commission of inquiry'.⁸

Brown argues that the crisis is not the damage done by an event, but the loss of confidence in government. Public inquiries are the tool 'through which legitimacy crises are repaired'.⁹ They play an important role 'in mitigating public anxieties, and elaborating fantasies of omnipotence and control'.¹⁰ Regehr et al say inquiries '... are a

⁶ Allan Holmes, 'A Reflection on the Bushfire Royal Commission – Blame, Accountability and Responsibility' (2010) 69(4) *Australian Journal of Public Administration* 387, 389.

⁷ Scott Prasser, 'Royal Commissions in Australia: When Should Governments Appoint Them?' (2006) 65(3) *Australian Journal of Public Administration* 28-47, 34

⁸ Raanan Sulitzeanu-Kenan, 'Reflection in the Shadow of Blame: When Do Politicians Appoint Commissions of Inquiry' (2010) 40 *British Journal of Political Science* 613–634, 632.

⁹ Andrew D. Brown, 'Authoritative Sensemaking in a Public Inquiry Report' (2004) 25 *Organization Studies* 95-112, 96.

¹⁰ Ibid 107.

means for government to demonstrate concern for an issue and to appease the public...'¹¹

Prasser argues that an inquiry can give a government time to think by delaying policy decisions and diverting attention from the government to the inquiry,¹² D'Ombrain agrees:

... most investigative commissions are set up very quickly, usually in response to intolerable political pressure to be seen to do something and to find ways to provide the ministers most involved with relief from daily barrages in Question Period and from the media.¹³

Sedley argues that inquiries 'are designed in part to absorb and still controversy': that is, the inquiry stops the media and others hounding government for a response.¹⁴ In the same vein, Sulitzeanu-Kenan says:

... the appointment of an inquiry can be attractive to office holders as it facilitates non-engagement on their part, even in the face of great public attention. It is widely accepted as legitimate to refrain from addressing the issue while these ad hoc institutions are investigating. This enables ministers to regroup, conduct consultations, learn the situation and consider alternative options – all of which require time, and a relative pause in the pace of events... We may therefore understand the appointment of inquiries as a venue alteration exercise – replacing one volatile critical audience (the media, the opposition and the public) with a much slower-moving and predictable audience – the inquiry commission.¹⁵

This discussion can be considered in the context of the 'black Saturday' bushfires and the decision to establish the 2009 Victorian Bushfires Royal Commission. On 7 February 2009 fires burned into several Victorian communities, claiming 173 lives and over 2000 homes. This was the biggest death toll from a single natural hazard event, excluding heat waves, in Australian history. (The heat wave that preceded these fires caused '374 excess deaths in Victoria for the week of 26 January to 1 February 2009'¹⁶ but these

¹¹ Cheryl Regehr, John Hill, Gerald Goldberg and Judy Hughes, 'Postmortem Inquiries and Trauma Responses in Paramedics and Firefighters' (2003) 18 *Journal of Interpersonal Violence* 607-622, 607.

¹² Prasser, above n 7, 42.

¹³ Nicholas D'Ombrain, 'Public Inquiries in Canada' (1997) 40(1) *Canadian Public Administration / Administration Publique Du Canada* 86-107, 93.

¹⁴ Stephen Sedley, 'Public Inquiries: A Cure or a Disease?' (1989) 52 *Modern Law Review* 469-479, 478 16.'

¹⁵ Sulitzeanu-Kenan, above n 8, 617.

¹⁶ Department of Human Services, *January 2009 Heatwave in Victoria: An Assessment of Health Impacts* (Government of Victoria, 2009) 15.

deaths or the response to the heat wave were not subject to investigation by the Royal Commission.) On 9 February the Victorian government announced that a royal commission would be established. The letters patent, establishing the commission, were issued on 16 February and three Commissioners were appointed to investigate the fires and the circumstances of the deaths.¹⁷ As noted by Prasser, “covert’ goals are never explicitly stated’¹⁸ so any conclusion as to whether political considerations were a factor in the decision to appoint the commission must, at best, be speculation but even so some speculation may be warranted.

In announcing the commission, the then Premier, John Brumby, was quoted as saying:

... no stone will be left unturned.

"We want to make sure that every single issue, every single factor, everything in relation to the horrific weekend, to the horrific fires on Saturday is investigated and uncovered," he said.

Mr Brumby says the Commission will review every aspect of the state's fire strategy.

"Whatever aspect of government policy, whatever aspect of people's own practice in terms of their fire plans, whatever recommendations are needed, to be put in place in the future to be sure that this disaster will never ever occur again," he said.¹⁹

The government's stated objective, as would be expected, was to discover the truth and gain information rather than to deal with the political issues or 'covert goals'.²⁰ Even so the decision to appoint the royal commission may have been influenced by the factors identified in the literature and discussed above. Given the tragic death toll and the impact on the community the government needed to signal to the community that it was taking the situation seriously and therefore calling for the inquiry with the highest prestige.²¹ Calling the inquiry so early, with a clear mandate to investigate government policy, could deflect any criticism of government inaction over the event or any

¹⁷ Victoria, above n 4, *Final Report Vol III: Establishment and Operation of the Commission*, viii.

¹⁸ Prasser, above n 7.

¹⁹ 'Brumby announces bushfires Royal Commission' *ABC News* (Online), 9 February 2009 <<http://www.abc.net.au/news/2009-02-09/brumby-announces-bushfires-royal-commission/289196>> (accessed 29 January 2015).

²⁰ Prasser, above n 7, 34.

²¹ *Ibid* 34.

allegation of a desire to hide.²² At that point, the fires having just occurred, there was no list of complaints but they may have been expected. Given the death toll there was no way a government could 'deny or ... seek to minimise the seriousness of a problem' or 'deny that there is any basis at all for the complaints' that could have been foreseen.²³ In the circumstances it may have been considered that it would be 'more damaging to resist having a royal commission than to appoint one'.²⁴

There was no suggestion that a royal commission was required because of:

- The need to use coercive powers;²⁵
- A lack of confidence in the public institutions;²⁶ or
- The need to protect witnesses²⁷ or allow cross-examination.²⁸

With respect to the use of coercive powers, Prasser said:

Most public inquiries do not need such powers of investigation, relying instead upon general goodwill or their status as executive government appointed inquiries, to procure information and cooperation from witnesses.²⁹

The Terms of Reference for the 2009 Victorian Bushfires Royal Commission directed the Commission to investigate, inter alia, 'the preparation and planning by governments, emergency services, other entities the community and households' as well as the 'immediate management and response to the fires'.³⁰ The conduct of the Country Fire Authority and the then Department of Sustainability and Environment was central to the inquiry. These agencies, which faced close and intense scrutiny were government agencies subject to ministerial direction and control. They could be directed, and would be expected to, fully cooperate with the inquiry. There are no reported incidents either in this inquiry or other post-disaster inquiries, where coercive powers were required to obtain the cooperation of the fire and emergency services.

²² Ibid 40.

²³ Ibid 35.

²⁴ Ibid 40.

²⁵ Ibid 36.

²⁶ Ibid 38.

²⁷ Ibid 37.

²⁸ Ibid.

²⁹ Ibid 36.

³⁰ Victoria, above n 4, *Final Report Vol III: Establishment and Operation of the Commission*, 68; Appendix A: The Commissions Terms of Reference.

As for a lack of confidence in public institutions, it should be recalled that Australia's fire and emergency services are some of the nation's most trusted institutions. Since 2005 *Australian Reader's Digest* has conducted an annual survey to identify Australia's most trusted professions. Paramedics and firefighters have been rated as the two most trusted professions in every year since 2006. They were joined in 2013 and 2014 by a new profession 'rescue volunteers' to form the top three most trusted professions.³¹ Whilst trust in the first responders may not equate to trust in the senior management of the ambulance or fire service or the government that operates those services, it certainly suggests that there is no lack of public confidence in the integrity of the members who might be expected to come forth to give evidence to a post event inquiry.

There was no suggestion, either in the announcement of the Royal Commission or in the Commission's reports that there was any need to protect witnesses by guaranteeing that their testimony was privileged or to obtain indemnity from prosecution. If there is a lack of trust in the institution, but faith in the individuals, then a royal commission or similar inquiry may be necessary to 'protect witnesses' by freeing them to give honest evidence, even if it is critical of the organisation for which they work or volunteer, without fear of retribution.

The desire to assign responsibility or blame

Finally there is the issue of cross examination. Even though it is not intended, royal commissions, coroner's inquests and other inquiries often fall back on traditional legal methods and forms in order to challenge witnesses and 'reveal' the truth.³² As the coroner inquiring into the 2003 Canberra fires said:

A small number of counsel approached the inquiry very aggressively, leaving me with the impression that they were seeking to turn the inquiry into adversarial litigation rather than seeking the truth about what happened.³³

³¹ <http://www.readersdigest.com.au/>; for the 2014 results see Hazel Flynn, 'Trusted People 2014' *Australian Readers Digest* (Online), July 2014 <<http://www.readersdigest.com.au/trusted-people-2014>> (accessed 3 February 2015).

³² Doogan, above n 5, *Volume 1*, 51.

³³ *Ibid.*

Others have noted the tendency of inquiries generally,³⁴ or particular inquiries to fall into adversarial practices or to risk the temptation to allocate blame³⁵ despite their honest attempt to avoid those outcomes. To quote again from Coroner Doogan:

I take the point that the aim of the inquiry is to seek out the truth of what happened in order to learn from the established facts and endeavour to ensure that, where mistakes have been made or things could have been done in a better way, lessons are absorbed and the prospect of similar mistakes occurring in the future is eliminated or, if this is not possible, reduced. Once the truth is established however, it is often impossible to learn from mistakes made without finding fault on the part of individuals . . . ³⁶

The tendency to adopt adversarial techniques is not surprising given that inquiries are often chaired by former judges and assisted by counsel. In those circumstances the adoption a legal mode of inquiry may derive more from custom and practice than inquiry requirements.³⁷ Prasser argues that

... the adversarial nature of inquisitorial royal commission hearings with public cross-examinations of witnesses reinforces the open and independent nature of their investigations ... [but] such processes necessarily entail legal counsel for both sides, lengthens the inquiry and, as a consequence, increases a royal commission's costs.'³⁸

Pascoe, one of the Victorian Bushfire Royal Commissioners, has said that the court like approach 'has the ability ... to instil high levels of public confidence in the integrity and robustness of the process'³⁹ but that is only true if the public has actual confidence in legal processes and the legal profession. Such confidence is not always obvious so it is not axiomatic that a legal approach will or must instil 'high levels of public confidence'.

³⁴ Ibid, 96; D'Ombra, above n 13, 99; Sulitzeanu-Kenan, above n 8; Prasser, above n 7; Dominic Elliott and Martina McGuinness, 'Public Inquiry: Panacea or Placebo' (2002) 10(1) *Journal of Contingencies and Crisis Management* 14-25; Annika Brändström and Sanneke Kuipers, 'From 'Normal Incidents' to Political Crises: Understanding the Selective Politicization of Policy Failures' (2003) *Government and Opposition* 279-305;

³⁵ Anthony E Schapel, *Inquest Into The Deaths Of Star Ellen Borlase, Jack Morley Borlase, Helen Kald Castle, Judith Maud Griffith, Jody Maria Kay, Graham Joseph Russell, Zoe Russell-Kay, Trent Alan Murnane And Neil George Richardson* (SA Coroners Court, 2008) [70].

³⁶ Ibid 7.

³⁷ Susan Pascoe, 'The 2009 Victorian Bushfires Royal Commission: Lessons for the Conduct of Inquiries in Australia' (2010) 69(4) *Australian Journal of Public Administration* 392-400, 396; Jim McGowan, 'A Missed Opportunity to Promote Community Resilience? – The Queensland Floods Commission of Inquiry' (2012) 71(3) *Australian Journal of Public Administration* 355-363, 360.

³⁸ Pascoe, above n 37.

³⁹ Ibid, 398.

D’Ombraín argues that the ‘adversarial conduct of investigative inquiries is reducing their public policy value’. He refers to a Canadian inquiry that was ‘delayed because of court challenges to its approach to possible findings of misconduct’. That delay, he argued, undermined the usefulness of the inquiry.⁴⁰ That is reminiscent of the coroner’s inquiry into the 2003 Canberra fires that was also delayed by court challenges both to the nature of the proceedings and possible findings.⁴¹ That these challenges were brought by the government and the key leaders of the Emergency Services Bureau suggests that the very parties that would be required implement the recommendations did not have confidence in the coroner or her inquiry and may be expected to have undermined the usefulness of the inquiry.

In 2004 a Council of Australian Governments National Inquiry on Bushfire Mitigation and Management reported that:

Due to the legalistic and potentially adversarial approach that can develop during coronial inquiries into bushfire events, significant periods of time are involved in the establishment, conduct and finalisation of coronial inquiries. Such complexity and delay is problematic for several reasons:

- Operational issues that require rectification may not be identified prior to the next fire season.
- Individuals involved in decision making during a bushfire event are placed under enormous stress for an extended period, often including the following bushfire season, until the coronial process is complete.
- Those that have suffered during the fire event fail to benefit from a timely resolution.
- The public and media are involved in considerable speculation during an extended period of uncertainty.
- The ‘value for money’ from a public perspective is open to question.

... The Inquiry is unconvinced that the public interest is best served by coronial investigations inquiring into operational decisions that are not directly related to the deaths. Coronial investigations into operational issues may reinforce blame and risk avoidance, rather than improving a shared understanding and promoting a learning culture. This is likely to be counterproductive in the longer term. The Inquiry favours post incident investigations and reviews that are most likely to

⁴⁰ D’Ombraín, above n 13, 99-100.

⁴¹ *R v Doogan; ex parte Lucas-Smith & Ors* [2004] ACTSC 91; *R v Doogan* [2005] ACTSC 74; *Lucas-Smith & Ors v Coroner’s Court of the ACT & Ors* [2009] ACTSC 40.

achieve improvements to operational performance and a positive overall result. While individuals need to be held accountable for their decisions and the public needs to be satisfied that all matters of concern have been investigated, bushfire mitigation and management will not progress if blame dominates over learning.⁴²

The Inquiry recommended that:

All reviews and investigations into bushfire events, at any level—internal or independent—need to focus on learning not blame. The inquiry approach needs to focus on this outcome, in the interests of all involved. Coronial inquests into bushfire matters other than deaths may not be the most suitable form of inquiry.⁴³

Notwithstanding these findings and recommendations, the criticism continues. The 2009 Victorian Bushfires Royal Commission was subject to criticism that it became too adversarial and focused on blame. In the final report, the Commission defended its processes:

The Commission notes that the examinations of Mr Rees, Mr Waller, Ms Nixon and Mr Cameron ... varied in length and manner of questioning. These variations can be explained by reasons such as the level and accuracy of detail available in written statements, the willingness of witnesses to make sensible concessions as to areas that could have been improved or actions that were ill-judged, and the time constraints facing the Commission. The Commission rejects, however, any suggestion that counsel assisting's questioning of these witnesses was unfair, unbalanced or otherwise inappropriate...⁴⁴

Even so the treatment of those officers and the conduct of counsel assisting was a matter of concern. Holmes complained of 'the adversarial role of the counsel assisting ... who seemed to have decided the narrative and sought to prosecute that case with the passion of the Spanish Inquisition.'⁴⁵ Rush QC, counsel assisting the Royal Commission, responded to Holmes' criticism. He claimed that 'Mr Holmes' review of the work and the findings of the Royal Commission was superficial, that he overlooked and did not refer to a great volume of evidence in his commentary'⁴⁶ but Rush QC did not deny that there had been vigorous cross examination of witnesses.

⁴² Stuart Ellis, Peter Kanowski and Rob Whelan, *National Inquiry on Bushfire Mitigation and Management* (Council of Australian Governments, 2004), 233-234.

⁴³ Ibid 234.

⁴⁴ Victoria, above n 4, *Final Report Vol II: Fire Preparation, Response and Recovery*, [2.3.5].

⁴⁵ Holmes, above n 6, 387.

⁴⁶ Jack Rush QC, *Keynote Speech NJCA/ANU Expert Evidence Conference*, 12 Feb 2011, <<http://njca.com.au/wp-content/uploads/2013/07/Mr-Jack-Rush-QC-Keynote-Speech-paper.pdf>> (accessed 29 January 2015).

A search for someone to blame is not unusual or unexpected. Wettenhall identifies that an inquiry may adopt one or both of two modes of inquiry. The first 'mode' focuses on 'the need to learn from past mistakes and induce organisation and polices to improve accordingly' the second mode 'may zoom in on questions of responsibility and guilt'.⁴⁷

He says:

The first mode is seen as a way of optimising social abilities to prevent and absorb extreme circumstances and, through professional and technical debriefings and the like, to focus on organisational and system learning. Since it progresses using "more or less routinised organisation and political protocol, it can perform a sanitising function" and help to bring closure to the sense of community crisis. This positive effect can, however be seriously threatened where inquiry activity and associated public debate is more combative and adversarial, more concerned to discover who is responsible and to attribute blame. This second reaction mode features "interaction between actors who are out to protect their self-interests rather than to serve the common good".⁴⁸

With respect to the 2009 Victorian Bushfires Royal Commission he says:

The Teague Royal Commission became a virtual two-headed exercise, with Senior Counsel Jack Rush QC, appearing at times to challenge the commissioners... Aggressive questioning of key officials, especially the then Police Commissioner, by counsellors assisting contrasted with the more conciliatory tone of the final report ... and was also at odds with the commission's publically declared intention at the outset that it was not embarking on a witch-hunt but focusing on lessons that could be learnt for the future.⁴⁹

Even Wettenhall's claim that mode one inquiries focus on 'the need to learn from past mistakes' implies room for personal or institutional blame. The Oxford Dictionary defines 'mistake' as an 'act or judgement that is misguided or wrong'.⁵⁰ By asserting that inquiries are needed to learn from past 'mistakes' implies that the disaster is the product of an 'act or judgement that is misguided or wrong'. In that case it is possible to find the person or persons who made the error. A true mode one inquiry should focus on learning from the event without a preconceived notion that mistakes were made.

⁴⁷ Roger Wettenhall 'Inquiring into disasters: contrasting styles and forms' in Scott Prasser and Helen Tracey *Royal Commissions & Public Inquiries: Practice and Potential* (Connor Court, 2014) 94-111, 96. See also Brändström and Kuipers, above n 34, 279.

⁴⁸ Wettenhall, above n 47.

⁴⁹ Ibid, 105.

⁵⁰ Oxford Dictionaries, <<http://www.oxforddictionaries.com/definition/english/mistake>> (accessed 3 February 2015).

Ewart and McLean say that it is relatively rare to discover that blame is not apportioned for disasters and their consequences.

... this manhunt for 'those responsible' goes beyond organisations and government authorities to encompass individuals, 'therefore purging the organization or community of blame and allowing them to feel closer to being innocent victims'. There are other benefits to finger-pointing by disaster victims: it allows them to 'maintain a level of control' with the level of blame dictated by the severity of the impact of the disaster.⁵¹

Brändström and Kuipers argue that the desire to find someone to blame reflects the modern focus on 'risk management'.

[In] ... contemporary risk societies 'chance', 'accident' or 'tragedy' are no longer accepted as explanations for social ills and physical threats, someone must be blamed for their occurrence... Having a scapegoat at hand for ritual sacrifice in the face of public criticism provides senior office-holders with one more option for surviving scandal and demonstrating resolute 'crisis management'.⁵²

Finding someone to blame may help reassure the public that governments are legitimate and in control and restore 'fantasies of omnipotence and control'⁵³ but it is likely to produce an outcome that is both simplistic and unhelpful. Dominic and Elliot say: 'The apportionment of blame to an individual or to human error ... is a key impediment to organisational learning. There are few disasters in which human error does not play a part. However few disasters have sole or simple causes'⁵⁴

An adversarial or 'mode two' inquiry⁵⁵ has personal consequences. Regehr et al have identified that involvement in what they call 'post-mortem inquiries' '... was associated with significantly higher levels of traumatic stress symptoms and depression' and their 'findings serve as strong support of clinical impressions that have suggested that many

⁵¹ Jacqui Ewart and Hamish McLean, 'Ducking for cover in the 'blame game': news framing of the findings of two reports into the 2010–11 Queensland floods' (2014) 39(1) *Disasters* 166–184, 181 citing T.E Drabeck and E.L. Quarantelli 'Scapegoats, villains and disasters'(1967) 4 *Transaction* 12–17.

⁵² Brändström and Kuipers, above n 34, 292 & 299.

⁵³ Brown, above n 9, 107.

⁵⁴ Dominic Elliott and Martina McGuinness, 'Public Inquiry: Panacea or Placebo' (2002) 10(1) *Journal of Contingencies and Crisis Management* 14–25, 20.

⁵⁵ Wettenhall, above n 47, 96. See also Brändström and Kuipers, above n 34, 279.

emergency responders experience the review process as more taxing than the critical event itself'.⁵⁶ They concluded that:

Although post-mortem inquiries are aimed at protecting the public and improving the quality of service, they may have the opposite result. Stemming from the belief that their efforts are not valued, workers can become increasingly traumatized, demoralized, and possibly even distanced from the public. The final product may be higher costs for emergency, lower quality service, and an increased risk to public safety. Accountability and continuous improvement are important, necessary components of effective service delivery. The findings of this study, however, suggest that we must continue to search for better ways to provide public assurances of quality emergency services that do not unnecessarily contribute strain to an already stressful work environment...

Emergency responders are a valuable resource, and ignoring the needs of those encountering public inquiry processes may not only result in losing the workers involved but may also serve to undermine the confidence of workers throughout the organization. Workers must believe that when things go wrong in a rescue, they will not be persecuted and abandoned.⁵⁷

A 'belief that their efforts are not valued' can extend beyond those directly affected by an inquiry. Responders who see their leaders or colleagues being subject to criticism and vigorous cross examination may feel that it is the efforts of all that are being devalued. This is particularly problematic in Australia where the community depends on volunteers to form the basis of fire and emergency services. If the volunteer members believe that their efforts are not valued and become increasingly traumatized and demoralized then Australia may not be able to field the team of responders required at the next disaster.⁵⁸

The discussion above has argued that there are many factors that may come into play when a government chooses to call an inquiry and the type of inquiry that is used. Despite the official announcement that focuses on the need to learn lessons in order to prevent a similar recurrence, there are other political imperatives that complicate both the process used and the outcome. Of particular concern is the tendency to move from

⁵⁶ Regehr et al, above n 11, 617.

⁵⁷ Ibid 618.

⁵⁸ See also Michael Eburn and Stephen Dovers, 'Australian Wildfire Litigation' (2012) 21(5) *International Journal of Wildland Fire* 488-497; Michael Eburn and Bronwyn Jackman, 'Mainstreaming Fire and Emergency Management into Law' (2011) 28(2) *Environmental and Planning Law Journal* 59-76.

mode one inquiries that seek to learn from past events to mode two with a tendency to look for someone to blame.⁵⁹ Inquiries that subject the witnesses to vigorous cross examination and which focus on ‘the minutiae of every decision’⁶⁰ may be effective at revealing every detail but may increase the cost and time of the inquiry.

The use of cross examination and coercive powers is appropriate where the inquiry is seeking to reveal corruption and maladministration but seems misplaced when seeking to learn from a natural hazard event and inquire into the activities of some of Australia’s most trusted professions. The use of a ‘forensic, inquisitorial and sometimes adversarial approach ... in pursuit of guilt or a scapegoat’⁶¹ will have a dramatic impact upon those involved and can also affect their colleagues. If others identify that they could be subject to similar treatment in the next inquiry they may rethink their decision to turn out during the next emergency.⁶²

Even so, the time, expense and even personal trauma of post event inquiries could be justified if they are delivering findings and recommendations that are increasing national and personal resilience to natural hazards. The next part will consider whether past inquiries have proved effective learning tools and whether the learning justifies the financial and other costs.

⁵⁹ Wettenhall, above n 47, 96. See also Brändström and Kuipers, above n 34, 279.

⁶⁰ Schapel, above n 35, [70].

⁶¹ McGowan, above n 37.

⁶² Eburn and Dovers, above n 58.

II. INQUIRIES AS A POST DISASTER LEARNING TOOL⁶³

This part will analyse the findings of 257 Australian post-event inquiries to answer whether or not there is evidence that they are an effective learning tool.

Methodology

The researchers identified 257 inquiries into the preparation for and response to natural hazard events. The inquiries dataset was compiled from three existing lists⁶⁴ and from discussions with experts in the sector. This list was then used to source digital versions of each inquiry from a range of internet sources including the original inquiry website, online parliament archives, historical collections of inquiries accompanying more recent inquiries and other webpages.

Of the 257 identified inquiries, 174 reports were digitally acquired in a searchable version of the Portable Document Format or PDF. Nine inquiries were acquired in PDF but were not in a searchable form rather they were digital photos of the original inquiry report. 74 inquiries were not found online. Of the 183 inquiries which were acquired many had multiple volumes and parts, for example the 2009 Victorian Bushfires Royal Commission is sorted online in 88 separate PDF documents. In addition inquiries can be made up of inquiry reports, interim reports, depositions, minutes of meetings and submissions. In this study only interim and final reports were analysed. For example in the 1902 Royal Commission into the Mount Kembla Colliery Disaster the commission created 40 documents including depositions and minutes of meetings, only three of these documents are the report. These multiple versions meant that there were 303 PDF documents covering 183 inquiries of which 174 were taken forward for further analysis.

⁶³ The authors acknowledge the invaluable contribution of Dr David Hudson to this section of the report. Dr Hudson assisted with this analysis during completion of his PhD 'Uptake of sensor data in emergency management', at the Fenner School of Environment and Society.

⁶⁴ Casus Calamitas Consulting, 'Contemporary Disaster Inquiries in Australia', 2012 <<http://casuscalamitas.com/2012/12/16/disaster-inquiries-in-australia/>> (accessed 13 February 2015); Casus Calamitas Consulting, 'Historical Disaster Inquires in Australia', 2013 <<http://casuscalamitas.com/2013/02/21/historical-disaster-inquires-in-australia/>> (accessed 13 February 2015); and Eburn and Dovers, above n 58.

To make the process more manageable a decision was made to limit the analysis to inquiries related to bushfires and bushfire management. 87 relevant inquiries were identified and there 51 where the recommendations were readily available. The reports that are the subject of this review include operational reviews (such as the McLeod Inquiry into the Operational Response to the 2013 Canberra fires), parliamentary inquiries (such as the New South Wales parliament's *Joint Select Committee on Bushfires: Report on the Inquiry into the 2001/2002 Bushfires*) coroner's inquiries, Auditors-General reports on fire management and the operation of fire services, and commissioned inquiries (such as the Malone review of the Queensland Rural Fire Service). A list of the reports the subject of this review can be found in Appendix 1.

These 51 inquiries produced 1728 recommendations. Having listed the recommendations, two of the researchers independently coded the recommendations into 31 categories which were then grouped into one of 6 broad themes;

- A – Shared responsibility;
- B – Preparedness;
- C – Response;
- D – Recovery;
- E – Fire agency organisation; and
- F – Research and technology.

Where there was disagreement as to the coding the researchers discussed their differing interpretations and determined the appropriate code by consensus; an overview of these results can be found below in table 1.

Topic	Subtopic	# recs ('39-13)	% total recs ('39-13)	% recs ('90-'99)	% recs ('00-'09)	% recs ('10-13)	Description
Preparedness	Building codes, land use planning and refuges	82	4.7%	6.8%	5.1%	4.1%	Building codes/building design/bunkers/building maintenance/land use planning/refuges/safer places
	Electricity infrastructure	29	1.7%	0.0%	1.1%	1.7%	Electricity infrastructure/electrical authorities
	Fire bans and weather warnings	8	0.5%	0.0%	0.0%	0.3%	Fire bans/fire danger periods/restricting actions in fire danger periods/fire weather warnings
	Hazard reduction burns	71	4.1%	0.0%	4.4%	4.5%	Hazard reduction burns/ public and private and roadside.
	Pre fire season preparation	115	6.7%	0.0%	7.3%	4.2%	Pre fire season preparation (other than hazard reduction burns) including maintaining fire trails preparing/prepositioning equipment, checking and installing gear etc clearing vegetation to ensure a trail is open
Response	Access to fire ground	19	1.1%	0.0%	1.1%	1.6%	Road blocks, access to fire ground by residents and others
	Access to water	13	0.8%	0.0%	0.7%	0.5%	Access to water
	Community warnings and communication.	90	5.2%	2.3%	4.9%	7.2%	Community warnings and communication.
	Cooperation between emergency services	59	3.4%	0.0%	3.3%	4.5%	Cooperation between emergency services
	Emergency powers	9	0.5%	0.0%	0.1%	0.8%	Emergency powers including commandeering assets, declaring state of emergency/requiring people to assist
	Evacuation and shelters	25	1.4%	2.3%	1.2%	1.9%	Evacuation/Stay or go/shelter in place
	Fire ground and interagency communication	43	2.5%	4.5%	3.1%	2.0%	Fire ground and interagency communication
	Incident Management Teams	92	5.3%	4.5%	4.5%	8.1%	Incident Management teams – performance, membership
	Incorporate local knowledge	17	1.0%	0.0%	0.8%	1.6%	Incorporate local knowledge
	Role of police	9	0.5%	2.3%	0.1%	1.1%	Role of police
Recovery	Insurance and legal liability	25	1.4%	0.0%	2.4%	0.2%	Insurance/Compensation/legal liability
	Relief and recovery	32	1.9%	0.0%	2.2%	1.9%	Relief and recovery

Research and technology	Assets and technology	106	6.1%	4.5%	6.2%	6.1%	Assets and technology to be deployed in fire fighting - tankers, aircraft, ppe
	Mapping and data quality	53	3.1%	0.0%	3.4%	3.3%	GIS/Mapping/Data related topic for future sorting
	Research	56	3.2%	0.0%	4.2%	1.3%	Research
Shared responsibility	Community education and preparedness	103	6.0%	4.5%	7.5%	4.4%	Community education/engagement/preparedness
	Inquiry, audit and after action review	76	4.4%	6.8%	5.5%	4.1%	Inquiry, audit and after action review
	Offences	9	0.5%	0.0%	0.1%	0.2%	Law enforcement/offences
	Personal responsibility	14	0.8%	0.0%	0.5%	0.8%	Personal responsibility
	Role of Commonwealth Government	16	0.9%	0.0%	0.9%	0.3%	Role of Commonwealth and Cth agencies (including BoM)
	Role of Local Government	47	2.7%	0.0%	2.2%	2.3%	Role of Local Government
	Whole of government response/State government responsibility	51	3.0%	4.5%	1.8%	3.8%	Whole of government response/State government responsibility
Fire agency organisation	Doctrine, plans, standards and legislative reform	152	8.8%	11.4%	9.2%	9.9%	Doctrine, counter disaster or emergency plans and standards, content of AIIMS, recommendations for legislative reform
	Fire agency organisation, management and authority	157	9.1%	38.6%	5.5%	10.8%	Fire agency organisation/management/funding/role/authority
	OH&S	33	1.9%	0.0%	3.1%	1.1%	OHS
	Training, skills and behaviours	117	6.8%	6.8%	7.5%	5.6%	Training, Skills and behaviours; paid and volunteer
Total number recommendations		1728	639	1728	44	849	

Table 1 – Summary results categorising 1728 recommendations from 51 Australian bushfires and bushfire management inquiries between 1939-2013 including percent of each recommendation type and for the last several decades

Results

Table 1 above shows the number of recommendations from 51 bushfire inquiries in each of the 31 categories identified by the researchers. In addition, the percent of each recommendation type has been calculated which gives a measure of how inquiries have focused on this topic in relation to other topics. This percentage has also been calculated for the last several decades to give an indication of the trend of certain topics. For example, community warnings and communication is becoming more common with 2.3% of recommendations on the topic between 1990 and 1999, 4.9% of recommendations between 2000 and 2009 and 7.2% of recommendations between 2010 and 2013.

Figure 2 and 3, below, continue with this analysis technique showing how topics have waxed and waned as issues of interest to post event inquiries. Building codes, land use planning and refuges were key topics in 1939 returning as a subject of interest in the 1980s and 1990s. These issues 'dropped off' until the Black Saturday inquiry in 2009. Fire bans and weather warnings were important topics in the 1960s, less so in the 1970s then went silent until 2010 where they have been mentioned several times since. Insurance and legal liability was moderately discussed between 1939 and 1960 then was silent until becoming very relevant in the 2000s, since then it has again gone silent. Mapping and data quality were not an issue until the mid-1980s, they became very relevant in the early 2000s after which they declined. Since 2008 they have shown a steady rise as a re-emerging issue.

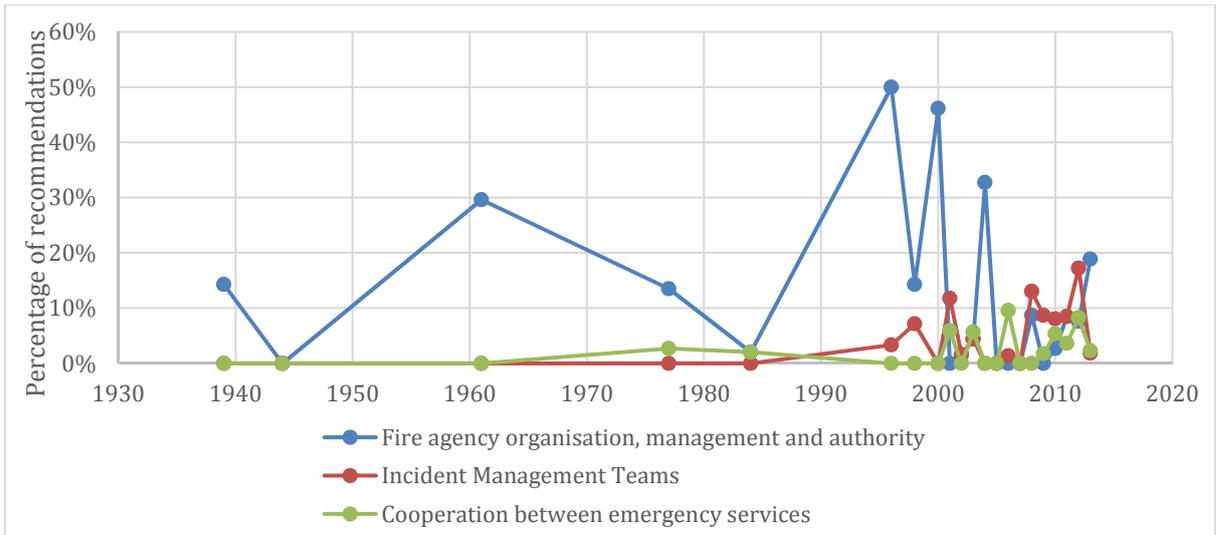


Figure 2 – Percentage of Australian bushfire inquiry recommendations overtime for the following topics: fire agency organisation, Incident Management Teams and cooperation between emergency services

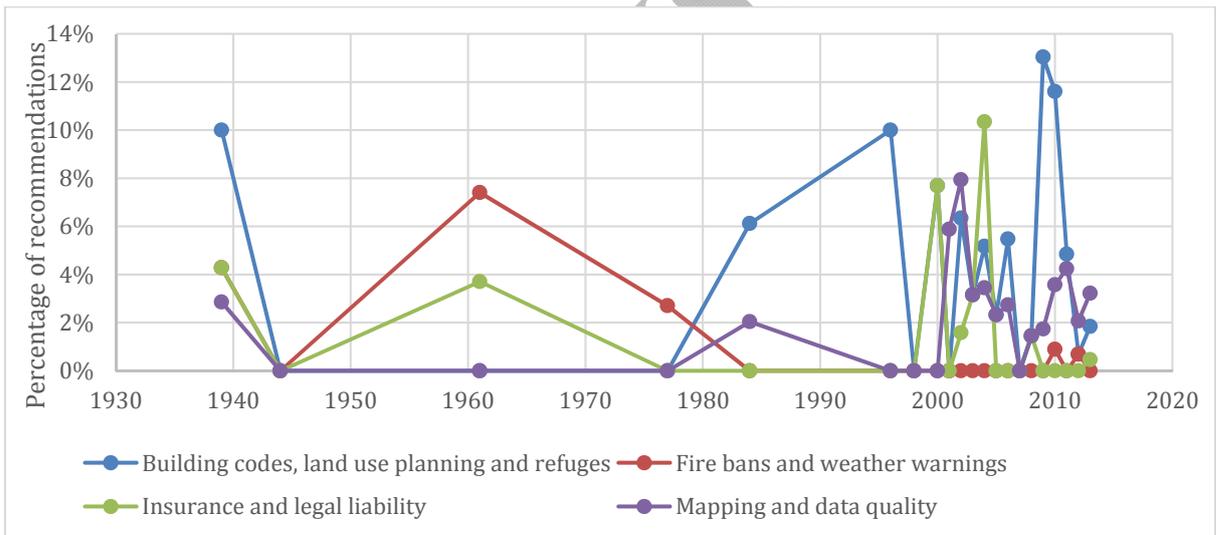


Figure 3 – Percentage of Australian bushfire inquiry recommendations overtime for the following topics: Building codes/land use planning/refuges, fire bans/weather warnings, insurance/legal liability and mapping/data quality

As Figure 4, below, shows different types of inquiries have tended to have different foci. Agency and independent inquiries are more response focused, audits focus

on shared responsibility whilst parliamentary inquiries and Royal Commissions focus on preparedness.

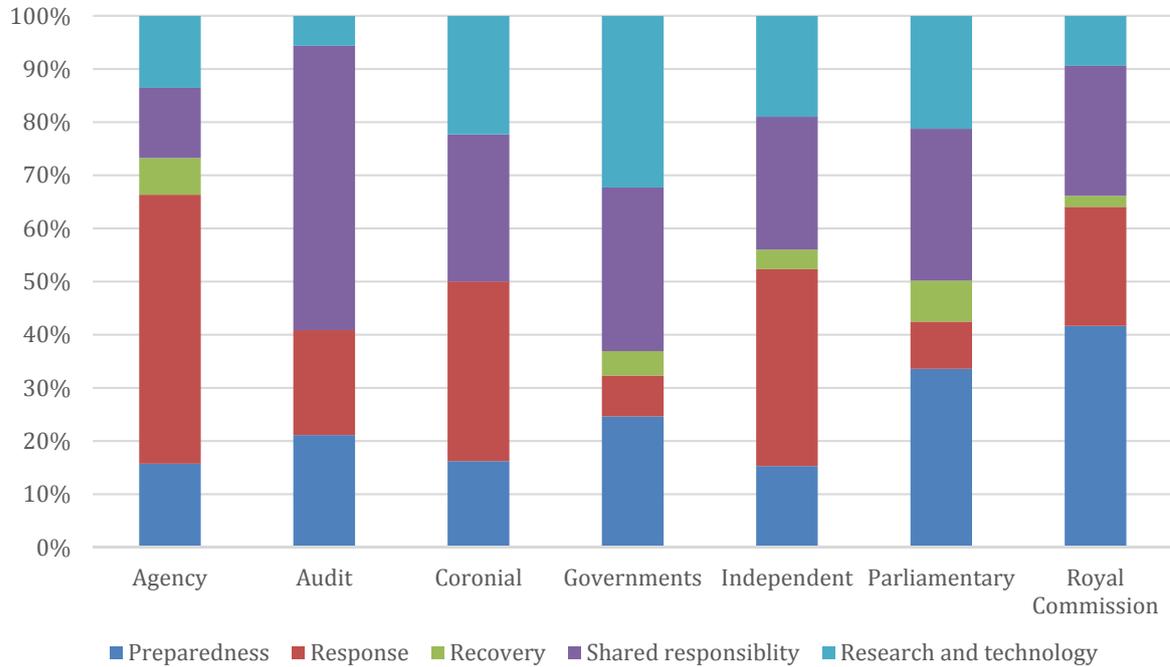


Figure 4 – recommendations across subject categories

Discussion

Notwithstanding the plethora of inquiries devastating fires continue to occur. In his report into the 1989 Hillsborough tragedy, Lord Taylor said:

That it was allowed to happen, despite all the accumulated wisdom of so many previous reports and guidelines must indicate that the lessons of past disasters and the recommendations following them had not been taken sufficiently to heart... there is no point in holding inquiries or publishing guidance unless the recommendations are followed diligently. That must be the first lesson.⁶⁵

Holding an inquiry may give the impression that lessons are being learned and that, by following the recommendations of the last inquiry, the ‘problem’ of fires or disasters will be solved. The fact that catastrophic events continue to recur is evidence either that the community is failing to learn the lessons from the past, or

⁶⁵ Home Office *The Hillsborough Stadium Disaster 15 April 1989; Inquiry by the Rt. Hon. Lord Justice Taylor, Final Report* (HMSO, 1990) [22] and [23].

the inquiries fail to identify the true learning.⁶⁶ Ideally the product of 257 inquiries would be that the Australian community would understand and be prepared for catastrophic fire events and losses on the scale of the 2009 Victorian fires will never occur again. History suggests that this is unlikely; so what has been the value of these inquiries?

Answering that question is not easy and perhaps not possible. It may be that recommendations have been made and implemented and they have indeed mitigated the impact of the next fire event but it does not follow that similar issues have not recurred and further recommendations are required. To put that another way, just because an issue recurs does not mean that the previous recommendation has not been acted upon or that the recommendation was not, at least in part, effective. For example, In 1939 Stretton recommended the establishment of a state fire authority that became Victoria's Country Fire Authority (the CFA). There is no doubt that the presence of the CFA has had significant impact on Victoria's resilience to fires today but the CFA was never expected to stop all fires. The fact that fires occur that are beyond the capacity of the CFA to contain them is not evidence that the recommendation was not acted upon or has not been effective.

It is beyond the scope of this research to explore if and how the various recommendations have been implemented and what impact the changes brought by one inquiry have had on the next event. Even so, our simple survey shows that over time and across jurisdictions there have been 'persistent lessons identified'.⁶⁷ Recurring themes and issues may, or may not, mean that 'the [previous] recommendations [have been] followed diligently'.⁶⁸ Perhaps they have not been followed diligently as, over time lessons are learned and then forgotten, or lessons identified in one jurisdiction are not learned until a similar event occurs in another. It may be that recommendations are being made that just cannot be implemented. Noting that radio communications is a problem during a fire and that work should

⁶⁶ Neil Dufty, 'Evaluating emergency management after an event: gaps and suggestions' (2013) 28(4) *Australian Journal of Emergency Management* 15.

⁶⁷ Kevin Pollock, *Review of Persistent Lessons Identified Relating to Interoperability from Emergencies and Major Incidents since 1986* (Emergency Planning College, 2013).

⁶⁸ Home Office, above n 65.

be done to improve or investigate ways to ensure effective radio coverage does not create the technology, nor the budget to make this happen.

The recommendations may be impracticable or rejected by the industry or government due to conflicting priorities, budget constraints or a belief that they are just not appropriate. There is no guarantee that a royal commission, whether constituted by a single commissioner or a team will actually come up with useful and meaningful recommendations.

It may be that the recommendations are indeed not 'followed diligently'.⁶⁹ Many of the issues identified are 'wicked problems':

A wicked problem is one for which each attempt to create a solution changes the understanding of the problem. Wicked problems cannot be solved in a traditional linear fashion, because the problem definition evolves as new possible solutions are considered and/or implemented.⁷⁰

So even if 'followed diligently'⁷¹ the recommendations may not, and cannot, solve the problem.

Another issue may be competing recommendations. Diligently applying the recommendation from one inquiry may require action contrary to another, and recommendations change over time. For example, following the 1983 Ash Wednesday fires the Review Committee recommended legislative change to 'provide for the appointment of a Minister as Co-ordinator-in-Chief'.⁷² The Review Committee took the view that:

The concept of a *State Disasters Act* which makes one Minister responsible for counter-disaster planning, preparedness, co-ordination of participating agencies and welfare relief measures is sound. In this regard, the Committee believes that the same mechanism should be superimposed on the existing structure of the State Disaster Plan by extending the legislation... The result of this modification would be that ... [i]n the event of a declared disaster... the Minister would assume his responsibilities for the implementation and control of all measures to combat the

⁶⁹ Ibid.

⁷⁰ Attorney General's Department, *Australian Emergency Management Handbook Series, Handbook 8, Lessons Management* (Commonwealth of Australia, 2013) 3.

⁷¹ Home Office, above n 65.

⁷² Victoria, *Report of the Bushfire Review Committee on Bushfire Disaster Preparedness and Response in Victoria, Australia, Following the Ash Wednesday Fires 16 February 1983* (1984) 142.

disaster in his capacity as Co-ordinator-in-Chief.⁷³

The Committee concluded that:

There is strong justification for a policy, formalised by legislation, under which a Minister is designated as Co-ordinator-in-Chief of disaster affairs and is responsible for direction and control across the whole spectrum of preparedness, combat and relief activities.⁷⁴

And they recommended that:

There be a close integration of the responsibilities of the Minister under the State Disasters Act and the State Disaster Plan ... [with] Ministerial responsibility for direction and control of counter—disaster preparedness, combat and relief activities.⁷⁵

The recommendations were ‘followed diligently’⁷⁶ with the passage of the *State Disasters Act 1983* (Vic). Move forward to ‘Black Saturday’ where the 2009 Victorian Bushfires Royal Commission said:

The Commission agrees that the designation ‘Coordinator’ and the description of the role as including coordination of agency activities can lead to confusion about the minister’s role. The Commission is clear that it was not intended for the legislation to imply that the minister had any operational responsibilities.⁷⁷

The Royal Commissioners went on to recommend that:

The State consider amending the *Emergency Management Act 1986* and the Emergency Management Manual Victoria in order to achieve the following:

- remove the title of Coordinator in Chief of Emergency Management from the Minister for Police and Emergency Services
- clarify the function and powers of the Minister
- designate the Chief Commissioner of Police as Coordinator in Chief of Emergency Management, who would have primary responsibility for keeping the Minister informed during an emergency.⁷⁸

Diligently implementing the recommendations from 1983 lead to role confusion and lack of clear command in 2009. Inconsistent recommendations may arise over time and as part of the nature of ‘wicked problems’ where ‘which each attempt to create

⁷³ Ibid 146.

⁷⁴ Ibid 154.

⁷⁵ Ibid.

⁷⁶ Home Office, above n 65.

⁷⁷ Victoria, above n 4, *Final Report Vol II: Fire Preparation, Response and Recovery*, [2.4.1].

⁷⁸ Ibid, Recommendation 11.

a solution changes the understanding of the problem'.⁷⁹ Further experience provides relevant learning so a recommendation is tested but, in light of experience, modified in the next inquiry. Inconsistency can be expected both over time and across jurisdictions.

Finally circumstances change. The recommendations from one inquiry may be applied and 'followed diligently' but the next event won't behave in the same way and will reveal new vulnerabilities. Further landscapes, assets and risk appetite change. A fire that burns native bushland is a different beast to one that burns in the same area 10 years later if during that time a community has been put there, new and varied assets are in place and people that once accepted the risk and know how to manage it now expect assistance from a paid fire service. Preparing to 'follow diligently' the outcomes of the last recommendation is preparing to fight the last war, flood or fire.

⁷⁹ Attorney General's Department, above n 70.

III. CORONERS - A TALE OF TWO INQUESTS

The office of the coroner dates back to at least the 13th century. Since that time, until today, Coroners have had the responsibility of investigating deaths and fires. In many jurisdictions their jurisdiction has also been expanded to include a power to inquire into explosions and disasters. Originally limited to identifying the cause of the death or fire and the identity of the deceased, today coroners can also make recommendations designed to avoid a repeat of the particular tragedy under investigation.⁸⁰ The fire and emergency services should enjoy a close relationship with the coroner as every time they turn out to an emergency call they are likely to be attending an accident or fire that could fall within the coroners' jurisdiction. Coroners' recommendations are best directed at governments and their agencies as they can take the recommendations and convert them to action through policy and if necessary, law reform. As government agencies, the fire and emergency services should, ideally, benefit from the findings of a coroner's inquiry where the issue under investigation is the management of the response. That at least is the theory.

This part will review the outcome of two inquests into deaths where at least one of the issues was how the response was managed by the relevant emergency service. The deaths took place on opposite sides of the earth, one in Scotland and the other in Australia and in very different circumstances. One event led to the death of a woman who had fallen down a disused coal mine and focused on the response by the Strathclyde Fire and Rescue Service;⁸¹ the other event led to the death of a paramedic responding to an injured hiker and the inquest considered the response by the Ambulance Service of New South Wales.⁸² Even given the differences, these inquests are useful comparators given they are investigating the response by the emergency services and made recommendations designed to reduce the chance of a further similar outcome.

⁸⁰ Michael Eburn, *Emergency Law* (Federation Press, 4th ed, 2013), 11-12.

⁸¹ *Fatal Accident Inquiry Under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 Determination by Sheriff Desmond J Leslie, Esquire, Sheriff for North Strathclyde* [2011] FAI 51.

⁸² *Inquest into the death of Michael Wilson*, State Coroner's Court of New South Wales, 16 September 2014.

What will be argued here, however, is that an emergency service that wanted to take the learning identified by the coroner (or in the Scottish case, the Sheriff⁸³) and think about what they should do, or train their staff to do, would find themselves facing completely inconsistent recommendations. Adopting the findings of one would necessarily involve rejecting the findings of the other. If that is the case it begs the question of whether or not coroners do provide effective learning for the emergency services and whether an alternative review process might be more effective.

The death of Alison Hume

Alison Hume died on 26 July 2008 having fallen, and spent many hours, down a disused coal mine. Although the Strathclyde Fire and Rescue Service had arrived on scene at 2.27am Ms Hume was not brought to the surface until 7.42am. She died as a result of a chest injury and hypothermia. These injuries were described 'as "survivable" had prompt action had been taken to rescue her'.⁸⁴

Firefighters who were first on scene had determined that they could manage the rescue with the equipment that they had. They had already lowered one firefighter into the mine in order to secure Ms Hume and provide some basic care. Fire fighters were preparing to lower a paramedic, untrained in relevant rescue and descent techniques, into the mine. At that time Mr Stewart, a more senior fire officer:

... overheard, on an internal broadcast, the decision ... to allow [the paramedic] ... to descend into the hole. His immediate reaction was to attend at the site and assume control for the incident. He was concerned that [the Paramedic] was not trained in the use of SWAH [Safe Working at Heights] equipment nor he was part of Strathclyde Fire and Rescue Service and therefore should not be using Strathclyde Fire and Rescue Service equipment. Mr Stewart determined that [the Paramedic's] descent into the hole had not been properly risk assessed, that the stability of the environment in general had not been risk assessed, and that, in his view such were

⁸³ In Scotland, relevant inquiries are held under the *Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976* (UK). Under that Act the inquiry is conducted by the Sherriff but the jurisdiction is akin to the Coroner under the *Coroners and Justice Act 2009* (UK) and the *Coroners Act 2009* (NSW). In this paper the term 'coroner' will be used to refer to both the NSW Coroner and the Scottish Sheriff.

⁸⁴ All the quotes are taken from the Sheriff's determination at <<<http://www.bailii.org/scot/cases/ScotSC/2011/178.html>>>, accessed 10 December 2015. The online version contains neither page nor paragraph numbers so pinpoint references cannot be provided.

the serious deficiencies in the conduct of the operation to this point and that there was great potential for catastrophic consequences in the event of further land displacement... He instructed that a cordon be set up beyond which no one should venture and that they should await the arrival of Strathclyde Mountain Rescue team who were specifically tasked with the conduct of a rescue which involved rope access.

This decision was supported by other, subsequent incident controllers. There were many issues the subject of discussion and findings by the Sherriff including the legislative remit of the fire service and whether or not this was a rescue they should have been prepared for. This discussion will focus, however, on the decision of the incident controllers to give priority to what they saw as their obligation to comply with Brigade policy and to ensure compliance with their work health and safety obligations. As the sheriff said:

Mr Stewart, in particular, considered that the rescue operation was "a success". In his view he had adhered to the policies and procedures set out by Strathclyde Fire and Rescue Service. He had obtempered⁸⁵ to the letter the instruction contained within the Memoranda from Strathclyde Fire and Rescue Service of the 14 and 27 March 2008. There had been no casualties other than the one to whom the Service was called upon to rescue.

Unfortunately this was not a successful operation: a woman died ...

He went on

For a rescue to be achieved, some imagination, flexibility, and adaptability were necessary. There was clearly a balance to be struck between the interests and safety of the rescuers, and those of the casualty they were there to rescue. It is the policy of Strathclyde Fire and Rescue Service to issue each fireman with a risk assessment aide memoir which sets a flow chart to address the question of risk assessment in any given situation. That flow chart provides "a dynamic risk assessment" and is to be followed by "an analytical risk assessment". However, what presents as a danger to the rescuer, when set against the need to rescue the casualty, can be a matter of fine judgement... there was a preoccupation with adherence to Strathclyde Fire and Rescue Service policy which was entirely detached from the event with which Strathclyde Fire and Rescue Service were confronted. Mr Stewart's risk analysis and assessment of the circumstances was flawed and impeded what should have been a more expeditious rescue of Mrs Hume. The core consideration of a risk assessment is a question of whether or not the risks to be taken are proportionate to the benefits gained. That must be an objective consideration.

Mr Stewart:

⁸⁵ The Oxford English Dictionary defines 'obtemper' as 'To obey, comply with, yield to, or submit to; specifically to obey (a judgment, court order, legal decree, etc.)' <<http://www.oxforddictionaries.com/definition/english/obtemper>> accessed 10 December 2015.

... alluded in his evidence to the understanding that discretion as regards "risk taking" was not only subordinate to but effectively proscribed by "Brigade" policy... [He] unequivocally indicated that he would follow policy and procedure in the first instance...

The Sheriff found that Mrs Hume's death could have been prevented by, amongst other things 'A rigorous and thorough risk assessment by Strathclyde Fire and Rescue Service balancing the conditions of the terrain with the condition of the Deceased and the passage of time to have prevailed over proscriptive Strathclyde Fire and Rescue Service Corporate Policy'. In short the fire service incident controllers should have been more willing to engage in a dynamic risk assessment, to 'balance ... the interests and safety of the rescuers, and those of the casualty' and to take 'acceptable' risks.

The death of Michael Wilson

Michael Wilson was an employee of the Ambulance Service of New South Wales, Australia. He was an experienced and well qualified paramedic and part of the Special Casualty Access Team. One of his roles was to access patients by winching down to them from a helicopter. He died on 24 December 2011 'as a consequence of extensive blunt trauma injuries he sustained during the course of rescuing an injured canyoner'.⁸⁶ The canyoner had fallen some 50-60 metres and sustained a compression fracture of his L3 vertebrae. His injuries were 'neither life threatening, nor time critical'.⁸⁷ On the other hand, the decision to attempt to get the canyoner out by helicopter was time critical due to loss of light at the end of the day. Mr Wilson and the helicopter crew developed a plan to winch the injured man out of the canyon. It was not a plan 'according to the book' and required improvisation and the use of some equipment in ways that were not intended by the Ambulance Service or the manufacturer. In reviewing the circumstances leading to Mr Wilson's death, the Coroner accepted that:

- d. Mr Wilson's recency in ... the procedure which the crew were allegedly 'adapting' for use in the proposed extraction, had expired. CHC's [the helicopter operator] standard operating procedures did not permit Mr

⁸⁶ State Coroner's Court of New South Wales, *Inquest into the death of Michael Wilson*, 16 September 2014
<<http://www.coroners.justice.nsw.gov.au/Documents/michael%20wilson%20finding%20with%20annexure%20a%20attached.pdf>>.

⁸⁷ *Ibid* [54].

Wilson to undertake the operation without an operational/extension permission from CHC's Chief Pilot or his delegate. The absence of such permission was a reason without more for the pilot to terminate the procedure.

- e. The plan went beyond the rescue winching procedures specifically provide for in CHC Standard Operating Procedures and/or contravened those procedures.
- f. The plan involved the use of roping techniques... which were both inappropriate and unapproved for use in a helicopter winching operation...⁸⁸

According to the coroner it was 'it was a plan that should never have been attempted'.⁸⁹ Even so:

No one stopped the plan from being implemented... [The pilot and other paramedics] gave evidence that in their opinion the crew of Rescue 24 were in the best position to assess whether they should proceed with the mission and in any event it formed no part of their task to intervene in the conduct of the mission.

The RCC [Rescue Coordination Centre] did not consider it any part of its role or that of its officers to assess the plan prepared by the crew of Rescue 24; nor was it any part of its task on the evening to provide any form of supervision or oversight of the planning process undertaken by the crew of Rescue 24, the plan developed by the crew of Rescue 24, or the implementation of that plan.⁹⁰

The coroner made several relevant observations including:

- "Early activation of a Duty Operations Manager ... to the correct location would have introduced a level of external command and control."⁹¹
- Subsequent to the accident, and prior to the inquest, the helicopter operator had banned "the use of combined roping techniques" and had implemented "... pause point methodology. There were many times during the operation of this plan when it would have been appropriate to pause and consider calling it "off'..." The coroner added the recommendation that "The CHC Operations Manuel should include a comprehensive procedure governing Hi Line Procedures overland".⁹²
- Also, prior to the inquest, the Ambulance Service had conducted its own review and had made a number of changes to training, practice and procedure and these were reported to and supported by the Coroner.⁹³ One of those recommendations was "that tag lines not be used as substitute for highline equipment. That equipment not be used for purposes other than its designed purpose. If equipment is adapted then it must be submitted for approval, prior to uses... In response to the recommendation a flight staff instruction was issued directing the use of

⁸⁸ Ibid [49].

⁸⁹ Ibid [127].

⁹⁰ Ibid [52].

⁹¹ Ibid [99].

⁹² Ibid [158].

⁹³ Ibid [114] and "Annexure A".

equipment for intended purpose only. It requires that crews do not vary operating procedures unless authorised in the operations manual...'⁹⁴

It is impossible to draw direct parallels between the two events, they were very different both in the circumstances of the rescue and in the issues that the rescuers faced. Even so the dichotomy between the outcomes of these two events is clear. With respect to the death of Mrs Hume, firefighters on the scene perceived that they had the tools and the skills to conduct the rescue even though it would have required them to use their Safe Working at Heights kit in a way that was directly contrary to a direction from the Fire Service. They were stopped by a senior officer who 'obtempered to the letter the instruction' from the Fire Service and ensured that none of the fire fighters were killed or injured. He recognised the need for initiative but not when that ran counter to direct policy. Notwithstanding this he was subject to criticism for failing to exercise 'imagination, flexibility, and adaptability'. His risk assessment did not address the 'question of whether or not the risks to be taken are proportionate to the benefits gained'.

On the other hand, in Australia the crew of Rescue 24 did consider the benefit to the patient of getting him, and them, out of the canyon on Christmas Eve. They demonstrated 'imagination, flexibility, and adaptability' when they modified rescue procedures to suit the situation. They must have believed that the procedure would be effective and would work or else they would not have done it. They were wrong and a paramedic died. The outcome was to recommend actions to ban certain techniques, to put in place rules and procedures that the ambulance service must expect will be honoured even when those on the scene think that they can perform an effective rescue that is 'risk taking' will "not only [be] subordinate to but effectively proscribed by" ambulance policy. Senior officers should be available to step in and 'stop' the execution of a plan that is perceived as too risky or contrary to instructions – that is to prevent another death of a rescuer, the ambulance service should have in place policies and officers to do what the Strathclyde Fire and Rescue Service were criticised for.

⁹⁴ Ibid, "Annexure A" [40] and [41],

The explanation for the different outcomes is obvious. In the Scottish case it was the patient that died and the coroner was looking to ask how that outcome can be avoided next time. In the Australia case it was the rescuer who died. No doubt the outcomes would have been very different if the Scottish fire fighters had descended into the shaft which then collapsed around them or if the Australian rescuers had decided to sit with the patient overnight and he had died from a combination hypothermia and other, otherwise non-life threatening injuries.

In his book, *The Field Guide to Understanding 'Human Error'*, Sidney Dekker recommends against a lesson learning process that makes specific recommendations intended to avoid the next tragedy.⁹⁵ Any recommendation suffers from hindsight bias. As the inquiry begins the inquisitor already knows what happened, in this context who died, and works backward to identify the critical decisions and actions that led to that outcome. That does nothing to explain why the decision makers made the decision that they did. The thesis of Dekker's book is that 'people do not come to work to do a bad job'.⁹⁶ Mr Wilson did not expect to be killed when he and his fellow crew members established a plan to rescue the canyoner. His aim was to exercise his professional skill and judgment to achieve a good result for everyone – to ensure that the response was not 'entirely detached from the event with which [the Ambulance Service of NSW was] confronted'.⁹⁷

In the Scottish inquiry the Sherriff said that 'incident controllers should have been more willing to engage in a dynamic risk assessment, to 'balance ... the interests and safety of the rescuers, and those of the casualty' and to take 'acceptable' risks but the risks were only acceptable once it was known that the fire fighter who was lowered down the mine did not die, and Mrs Hume did. As the Sherriff said 'what presents as a danger to the rescuer, when set against the need to rescue the casualty, can be a matter of fine judgement'. For Mr Stewart, the Strathclyde

⁹⁵ Sidney Dekker, *The Field Guide to Understanding 'Human Error'* (Ashgate, 3rd ed, 2014), 79-81.

⁹⁶ Ibid, 6.

⁹⁷ *Fatal Accident Inquiry Under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 Determination by Sheriff Desmond J Leslie, Esquire, Sheriff for North Strathclyde* [2011] FAI 51.

Incident Controller the judgment was that fire fighters should not descend the mine, for the crew of Rescue 24 it was that the risk to them was not so great that it outweighed the risk to the patient.

Dekker describes this process as starting at the 'sharp end' when a better analysis starts at the 'blunt end' when decisions are being made *before* the outcome is known.⁹⁸ The objective is to understand why the decisions that were made seemed like the way to do a good job at the time. With respect to the death of Mr Wilson the coroner noted numerous failings; there were problems with communication between the Rescue Coordination Centre and police, between police and ambulance, between various parts of the ambulance service and ultimately between the helicopter and Mr Wilson in the canyon. Decisions were made about the allocation of resources and the plan for the rescue. But everyone who made those decisions was trying to do a 'good job'. A good job not only involved rescuing the patient but also ensuring that resources were kept back to ensure there could be a response to the next job, ensuring budgets were met and meeting all the other objectives that employers and peers communicated, either explicitly or implicitly, to their staff and colleagues. The coroner's inquest did not ask questions such as:

- How often had crewmembers departed from the prescribed procedures without injury?
- Did the prescribed procedures actually reflect practice or had practitioners been departing from them to actually make the job work?
- Ambulance and fire services have a culture and are staffed by people who by the very nature of the job at hand want to actively take steps to help. Whilst Mr Wilson had been lowered with overnight gear should the rescue not have been a success⁹⁹ there is no examination of how the culture of the ambulance service would have encouraged him and his colleagues to take risks to get everyone out that night.

There is no doubt that if the rescue had worked it would either have been noted as 'another job well done' or even an 'heroic' and 'resourceful' use of assets, either way encouraging the crew to do something similar next time. For the incident

⁹⁸ Dekker, above n 95, 78.

⁹⁹ State Coroner's Court of New South Wales, *Inquest into the death of Michael Wilson*, 16 September 2014
<<http://www.coroners.justice.nsw.gov.au/Documents/michael%20wilson%20finding%20with%20annexure%20a%20attached.pdf>>, [48].

controller in Scotland a good job was to implement his employer's safety policy. Had that rescue worked, it would have been recorded as a job where everything worked and no doubt he would have been commended.

The NSW coroner and Scottish sheriff were making recommendations based on 'counterfactuals'.

Counterfactuals say what could have happened if certain minute and often utopian conditions had been met. Counterfactual reasoning may thus be a fruitful exercise when recommending interventions against that exact failure in the future. But when it comes to *explaining* behaviour, counterfactuals do not contribute. Counterfactuals are not opportunities missed by the people you are investigating. Counterfactuals are just the products of your hindsight.¹⁰⁰

A coroner's inquest has the goal of 'recommending interventions against that exact failure in the future' but no-one will face exactly the same situation. When making recommendations based on a counterfactual the coroner simply cannot know what would have happened if events had followed the path he or she now recommends.

What is almost inevitable is that following the recommendations from either of these inquests is almost guaranteed to ensure that there is another death. The crew of Rescue 24 in essence did exactly what the Scottish Sheriff wanted rescuers to do, they did not have 'a preoccupation with adherence to ... [NSW Ambulance] Service policy which was entirely detached from the event with which [they] ... were confronted', they exercised 'imagination, flexibility, and adaptability'. They came up with a plan that must, in their minds, have struck an appropriate balance 'between the interests and safety of the rescuers, and those of the casualty they were there to rescue'. They took what was, to them (or else they would not have taken it) an 'acceptable risk'. And Mr Wilson died.

And the Strathclyde Fire and Rescue Service did what the NSW Coroner would have them do. A more senior officer attended the scene and 'introduced a level of external command and control'. The IC followed the service policy and 'banned' the use of Safe Working at Heights equipment for a rescue. In doing so he applied the policy that 'equipment not be used for purposes other than its designed purpose' and he complied with the operations manual that said the appropriate

¹⁰⁰ Ibid 32-33.

response was to call a specialised rescue squad. He did not defer to the crew on the scene but provided supervision and oversight. He took time to 'pause and consider' the proposed rescue, and he called it off. And Mrs Hume died.

DRAFT - FOR DISCUSSION

IV. THE VALUE OF RECOMMENDATIONS¹⁰¹

Recommendations can be lost, ignored or are just not useful. Although coronial inquiries and inquests, and less often Royal Commissions, are called to investigate the circumstances surrounding a calamity, their usefulness in identifying relevant learning, and making recommendations for future action, is questionable.

Some observations may be made about the limitation of current enquiries. First, Royal Commissions and coroners are single minded and respond to a particular event. They make recommendations that are limited to their terms of reference and which deal with a particular event.¹⁰² The Victorian Flood Review noted how changes to Victoria's emergency management arrangements were made in response to the 2009 Victorian Bushfires Royal Commission and were therefore focused on fire. This singular focus runs against the trend in emergency management to consider and coordinate capacities against 'all' hazards.

Second, inquiries make recommendations directed to governments. They might expect that governments can and will adopt laws and policies to give effect to the recommendations and that there will be some commitment to the follow up. However a review of government performance and recommendations for future response may miss other key players in emergency management in particular the conduct of individuals. The 2009 Victorian Bushfires Royal Commission said that effective disaster management involves a sharing responsibility¹⁰³ but it declined to comment on whether or not private citizens had taken effective responsibility for their own wellbeing. Equally the Parliamentary inquiry into the 2013 Wambelong fire¹⁰⁴ made no recommendations regarding individual preparation or the purchase of insurance by property owners and occupiers. The closest that they came to that was a recommendation "That the Office of State Revenue investigate mechanisms to enhance the affordability of insurance for properties and assets in

¹⁰¹ This discussion originally appeared in Michael Eburn and Stephen Dovers, 'Learning lessons from disasters: alternatives to Royal Commissions and other quasi-judicial inquiries', (2015) 74(4) *Australian Journal of Public Administration*, pp. 495–508

¹⁰² Natassia Goode, Caroline Spencer, Frank Archer, Dudley McArdle, Paul Salmon, Rod McClure *Review of Recent Australian Disaster Inquiries* (Monash University, 2011), vi.

¹⁰³ Victoria, above n 4, *Final Report Vol II: Fire Preparation, Response and Recovery*, [9.1].

¹⁰⁴ NSW Legislative Council General Purpose Standing Committee No. 5, *Wambelong Fire: Final Report* (Parliament of NSW, 2015).

fire affected areas'.¹⁰⁵ The issue of using inquiries to develop shared responsibility is discussed in more detail, below.¹⁰⁶

Third, because they are making recommendations to deal with problems raised by a particular event it does not follow that the recommendations should be adopted, as they may conflict with other competing interests. Policy mainstreaming is making 'an issue, whether it is health, access and equity, environment, climate change or emergency management, a whole-of-government issue where all policy sectors must have regard to the overarching policy concern'.¹⁰⁷ A Royal Commission may consider how 'other policy sectors' impact upon emergency management and, in particular upon the event that they are investigating, but they have much less capacity to consider the implications of emergency management, and the Commission's findings and recommendations, on 'other policy sectors'.¹⁰⁸ For example, a Royal Commission could recommend that all homeowners should clear land around their home as a suitable solution to the problem of homes being lost to bushfire due to close proximity of vegetation, but the Commission, subject to its terms of reference, cannot consider how that might impact upon other issues. An inquiry into wildlife protection, on the other hand, might recommend that people are not allowed to clear native vegetation without an impact assessment and local approval, but that would not consider the bushfire threat. Property owners may have other imperatives regarding vegetation, related to thermal comfort (shade), wind protection or simple aesthetic preferences. Governments that are elected by the property owners, but responsible for both ecological preservation and fire management, have to consider how the balance between these competing demands are to be met; Royal Commissions and coroners do not.

Third, inquiries may make recommendations based on submissions by individuals or interest groups and contribute to myths and misunderstandings. Wenger,

¹⁰⁵ Ibid, Recommendation 26.

¹⁰⁶ See p. 60 and following, below.

¹⁰⁷ Eburn and Jackman, above n. 58, 60.

¹⁰⁸ Bushfire CRC, *Mainstreaming Fire And Emergency Management Across Legal And Policy Sectors: Joint Research And Policy Learning*, <<http://www.bushfirecrc.com/projects/1-1/mainstreaming-fire-and-emergency-management-across-legal-and-policy-sectors-joint-resea>>, 31 May 2012.

Hussey and Pittock conducted a review of the inquiries into the 2011 Queensland¹⁰⁹ and Victorian¹¹⁰ floods and the Natural Disaster Insurance Review.¹¹¹ They report:

Issues of liability were found to be a significant barrier to the provision of flood risk information and its incorporation into planning schemes by local government... Councils can be exposed to compensation claims if land is 'down-zoned', subjecting it to flood controls and reducing land value. They can also be liable for losses if they provide flood advice, act or fail to act in respect to flood-prone land. NDIR adds that there is a potential liability for the quality and accuracy of flood information. In one case, a council has decided not provide any information on historic or current flooding unless an application is made under freedom of information legislation.¹¹²

Although this correctly summarises the effect of the reports, the reports themselves are based on submissions by witnesses who report a 'fear' of liability but give no evidence that the fear is well founded. None of the reports cited give any cases where any council has been liable for releasing flood information, though some have been criticised. Research by Eburn and Handmer demonstrates that this 'fear' is unreasonable and unfounded.¹¹³ Even so, the witnesses report a fear that is reproduced in the report of the inquiry as if the fear is well founded and then gets incorporated into subsequent literature reviews and what started as a fear of liability is converted to a statement that liability is a real or 'live' issue.

Another example of errors being adopted by inquiries can be seen in the 2003 Senate inquiry into '*The incidence and severity of bushfires across Australia*'.¹¹⁴

¹⁰⁹ C.E. Holmes, *Queensland Floods Commission of Inquiry: Final Report* (Queensland Government, 2012).

¹¹⁰ Neil Comrie, *Review of the 2010–11 Flood Warnings and Response – Final Report* (Government of Victoria, 2012).

¹¹¹ John Trowbridge, Jim Minto and John Berrill, *Natural Disaster Insurance Review: Inquiry into flood insurance and related matters* (Commonwealth of Australia, 2011).

¹¹² Caroline Wenger, Karen Hussey and Jamie Pittock, *Living with Floods: Key lessons from Australia and Abroad* (National Climate Change Adaptation Research Facility, 2013), 27-28. Though it is noted that none of these were Royal Commissions.

¹¹³ Michael Eburn and John Handmer, 'Legal Issues and Information on Natural Hazards' (2012) 17 *Local Government Law Journal* 19-26.

¹¹⁴ The Senate Select Committee on Agricultural and Related Industries, *The Incidence and Severity of Bushfires across Australia* (Commonwealth of Australia, 2010).

That report had a discussion on 'liability' where it purportedly dealt with legal liability from hazard reduction burns.¹¹⁵ Notwithstanding that heading, the report did not deal with legal issues or liability. Rather it dealt with political issues where a burn that escaped control areas 'caused a lot of adverse publicity'¹¹⁶ and that 'there is often an outcry if a prescribed burn escapes'.¹¹⁷ One submission did deal with legal liability, the witness, a well-known fire scientist, claimed:

People that own bush blocks are dead scared of doing their own little bit of burning off, which used to be done through winter on an almost daily basis 30 years ago. Now it is, 'If the burn gets over my fence and burns my neighbour's grass, he's going to sue me.'¹¹⁸

Apart from being outside this witness's field of expertise, the suggestion that landowners now sue, where once they did not is simply not supported by any evidence either before the inquiry or that could be located in subsequent research.¹¹⁹ This is followed by a claim for legal protection for volunteers even though 'We have not come up against a situation yet where ... volunteers have been in trouble with the law'.¹²⁰ In fact the Committee does not discuss 'liability' at all but the inference is that there is an issue that needs to be at least considered and which helps feeds the public myths of fire management and maintains volunteer concerns.

Even though there is significant legal protection for fire fighters and in particular, volunteers, and even though litigation against the fire services is rare, and none existent against individual fire fighters, they remain concerned¹²¹ and there are repeated calls to amend legislation to ensure that responders are not exposed to personal liability for actions undertaken in good faith.¹²² It is important to

¹¹⁵ Ibid, pp 63 -65.

¹¹⁶ Ibid, p 64.

¹¹⁷ Ibid.

¹¹⁸ Ibid.

¹¹⁹ Eburn and Dovers, above n 58.

¹²⁰ Ibid, p 65.

¹²¹ David Ipp et al, *Review of the Law of Negligence, Final Report* (Commonwealth of Australia, Canberra, 2002), 107, 170. A 2007 Bushfire CRC report of new volunteers in the CFA reported that 17% were very concerned, 41% somewhat concerned and 42% were not at all concerned about being sued; Jim McLennan and Adrian Birch *CFA Report Number 1:2007: Survey of New Volunteers at Twelve Months: April-September 2005 Entry Cohorts-Revised* (2007, Bushfire CRC).

¹²² R Murray, R. and K White *State of fire: A history of Volunteer firefighting and the CFA in Victoria* (Hargreen, 1995); Auditor General, Victoria, *Fire prevention and preparedness'*

correctly identify the problem: if legal liability is the problem the solution may be to change the law; but if fear of liability is the issue another solution is required. If inquiries act on unsupported allegations, they may and do make recommendations to solve the wrong problem.¹²³

Finally, inquiries do not and cannot consider the budget implications of their recommendations although this is something governments must do. A Royal Commission into road deaths may recommend increasing road safety by reducing speed limits, having separate roads for cars, trucks and motorcycles, investing more in law enforcement, and in trains to get trucks off the road. It is likely that those measures would reduce the road toll but equally likely that this would be at an unacceptable expense. A Royal Commission looking at issues of fire safety could recommend increased hazard abatement zones, investing in more firefighting resources and identification of places that are too high a risk and which should be subject to compulsory buy back to move people to 'safer' areas. But these options may be more than government can, or is willing to pay for, and more than some members of the public may find acceptable.

The 2009 Victorian Bushfires Royal Commission did recommend buy-back of fire prone land¹²⁴ and that single-earth wire return (SEWR) and 22-kilovolt distribution feeders be replaced with aerial bundled or underground cabling.¹²⁵ These were originally rejected by the Brumby government in part on the basis of cost¹²⁶ and research by the Powerline Bushfire Safety Taskforce found that the Victorian community was unwilling to pay the cost of meeting that recommendation.¹²⁷ In 2005 the South Australian coroner recommended 'that the

(Government of Victoria, 2003); McLeod, above n 2; House of Representatives Select Committee on the Recent Australian Bushfires, *A Nation Charred: Inquiry into the Recent Australian Bushfires*, (Parliament of Australia, 2003); Council of Australian Governments *National Inquiry into Bushfire Mitigation and Management* (Commonwealth of Australia, 2004); Senate Select Committee on Agriculture and Related Industries *The incidence of bushfires across Australia* (Commonwealth of Australia, 2010).

¹²³ Eburn and Dovers, above n 58.

¹²⁴ Victoria, above n 4, Recommendation 46.

¹²⁵ Ibid, Recommendation 27.

¹²⁶ 'Brumby announces bushfire response', *Sydney Morning Herald*, 27 August 2010: Karen Kissane, 'Brumby plays fast and loose' *The Age*, 1 September 2010.

¹²⁷ Powerline Bushfire Safety Taskforce, *Consultation paper*, (Energy Safe Victoria, 2011), 11; Powerline Bushfire Safety Taskforce, *Final Report*, (Energy Safe Victoria, 2011), 4.

Minister for Emergency Services give further consideration to acquiring a firefighting helicopter to be permanently or primarily stationed in South Australia'¹²⁸ without having to regard the cost or feasibility of investing in such an expensive, dedicated resource.

Lessons identified or lessons learned?

It is not clear that post event inquiries, and in particular a Royal Commission, produces useful learning. The process may identify lessons, but learning only occurs when they are adopted and change is made. It is hard to identify the extent to which recommendations from past inquiries have been implemented or the extent to which they affected later outcomes. The 2009 Victorian Bushfires Royal Commission was the first to recommend the creation of an 'implementation monitor' to assess the State's success in implementing the Commission's recommendations.¹²⁹

Research has revealed a very low adoption of coroner's recommendations. One study looked at coronial proceedings in 2004 (or 2002, 2003 and 2004 for the smaller jurisdictions of Tasmania and the Australian Capital Territory, and 2003 and 2004 in the Northern Territory) and found that coroners had made 484 recommendations. Of those recommendations:

- 24 (5%) had been put in place before the formal recommendation was made;
- 147 (30%) were implemented;
- 43 (9%) were partially implemented;
- 61 (13%) were not implemented; and for
- 209 (43%), evidence could not be found as to what had been done with those recommendations.¹³⁰

A survey in Queensland, covering 2002 and 2003, found that 105 recommendations were made by Coroners and directed to public agencies; 46 (43.8%) of the recommendations were implemented, 42 (40%) were not implemented and 17 (16.2%) were partially implemented.¹³¹ Legislation in Victoria and the Northern Territory now require an agency that receives a

¹²⁸ Chapel, above n 35, Recommendation 30.

¹²⁹ Victoria, above n 4, Recommendation 66.

¹³⁰ Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12 *Australian Indigenous Law Review*, 4.

¹³¹ Queensland Ombudsman, *The Coronial Recommendations Project* (2006).

coroner's recommendation to report back on whether or not the recommendation been implemented.¹³² In other jurisdictions the response to coronial recommendations remains 'piecemeal'.¹³³

DRAFT - FOR DISCUSSION

¹³² *Coroners Act 2008* (Vic) s 72; *Coroners Act 1993* (NT) ss 46A, 46B.

¹³³ Brazil, Raymond, 'The Coroner's Recommendation: Fulfilling its Potential? A Perspective from the Aboriginal Legal Service (NSW/ACT)' (2011) 15(1) *Australian Indigenous Law Review* 94, 95.

V. THE NEED TO BE HEARD AND TO TELL THE STORY

Humans are storytelling animals; ‘studies show that if you give people random, unpatterned information, they have a very limited ability not to weave it into a story’.¹³⁴ Whether a fire or other disaster was caused by neglect, wilful default or just a series of random, unpatterned events that by sheer coincidence lined up in such a way to reveal an underlying vulnerability and thereby convert a hazard into a disaster, people will try to link it up to create a story. In societies where ‘chance’, ‘accident’ or ‘tragedy’ are no longer accepted as explanations for social ills and physical threats¹³⁵ that story will often become a story of ‘fault’. With knowledge of the actual outcome, it is easier to weave the events into a story, based on counterfactuals, where ‘if only’ someone had done something differently the ultimate outcome would have been avoided.

Even if we do not create the story, telling a story is more effective way to communicate than simply relating uncontested facts. People need to tell their story; and everyone’s story will be different. Of the one event each person will have experienced it differently and have their own story that is true and can add to any broader understanding of the event. Story telling is essential.

The 2009 Victorian Bushfires Royal Commission knew of the need to tell stories. Before formal hearings ‘The Commissioners made it their first priority to listen in their local communities to people affected by the fires. These powerful sessions provided a human backdrop to the Commission’s deliberations and helped the Commissioners identify themes and priorities for their work’.¹³⁶ The Commission reported that:

The decision to go out into the fire-affected communities as soon as practicable after 16 February 2009 and seek community input was novel.

The community consultations were not hearings, and the information obtained from them was not formal evidence. The information was, however, of great value and helped the Commission determine areas for further research and investigation before starting its formal hearings. The consultations also gave the affected communities the opportunity to shape the direction of the Commission’s work.

¹³⁴ Jonathan Gottshcall, *The Storytelling Animal: How Stories Makes us Human* (Mariner, 2012), 105.

¹³⁵ Brändström and Kuipers, above n 34, 292 & 299.

¹³⁶ Victoria, above n 4, *Interim Report (No 1)*, [17].

Additionally, the Commissioners were able to see at first hand the impact of the fires on the landscape and on communities in the immediate post-fire period.¹³⁷

The Commission also heard stories from lay witnesses, that is ‘people who were directly affected by the bushfires and who told their personal stories orally to the Commission (but who did not represent a particular organisation)’.¹³⁸ The statements of the lay witnesses were published as an electronic volume of the Commission’s final report. The Royal Commission also told the story of every person who died in the fires detailing, as best they could, ‘information about the last known actions’ of those that died.¹³⁹ The stories told by the lay witnesses, and of the deceased, tell part of the story of the Black Saturday fires but only part of the story.

Other people were also involved, including fire fighters and emergency managers from the Chief Officers to front line volunteers. Their stories were heard, too, but in Commission hearings subject to examination and cross examination and where the stories of the firefighters were translated through the official response of the agency to which they belonged. There is no volume where ‘non-lay’ witnesses got to explain how the day developed for them; what information they had and what choices they had to make and why the decisions they made, made sense at the time, even if outcomes were not ideal or intended.

As has been noted, above, studies have indicated that post event inquiries are harmful for responders.¹⁴⁰ In her book, *Ashes of the Firefighters*, Vivien Thomson sought to report on the experiences of firefighters who had been involved in responding to catastrophic fires. The fires were the subject of numerous post-event inquiries including the acrimonious coronial inquiry into the 2003 Canberra fires.¹⁴¹ Although the book was meant to be a reflection of the impact of firefighting, it quickly becomes apparent that one of the most traumatic events that

¹³⁷ Ibid, *Final Report Vol III: Establishment and Operation of the Commission*, [1.1.1].

¹³⁸ Ibid, *Final Report Vol IV: The Statements of Lay Witnesses*
<<http://vol4.royalcommission.vic.gov.au/intro.html>>.

¹³⁹ Ibid, *Final Report Vol I: The Fires and the Fire-Related Deaths*.

¹⁴⁰ Regehr et al, above n 11, 618; Eburn and Dovers, above n 58.

¹⁴¹ Doogan, above n 5; *R v Doogan; ex parte Lucas-Smith & Ors* [2004] ACTSC 91; *R v Doogan* [2005] ACTSC 74; *Lucas-Smith & Ors v Coroner's Court of the ACT & Ors* [2009] ACTSC 40.

many of the contributors faced was the post-event inquiry.¹⁴² In her introduction, Thomson says:

It was a steep learning curve, what we had to learn and what we had to experience after a major fire like the ACT and Port Lincoln fires. We had to become legal experts, we had to fight to be heard, all of a sudden there were so many experts around ready to comment, we had to fight to have representation, we had to learn how to navigate through the inquiries and investigations to ensure we would have our say...¹⁴³

DRAFT - FOR DISCUSSION

¹⁴² Vivien Thomson, *Ashes of the Firefighters* (2013), 62, 74, 78-84, 92-93, 112-120, 124-136.

¹⁴³ *Ibid* x-xi.

VI. THE CURRENT POSITION

The analysis above paints a gloomy picture. After a significant hazard event there are pressures to call an independent inquiry. Hopefully the driving force is a desire to identify what happened and identify lessons that may better inform future practice, but the reality is that there are multiple 'other' considerations that influence the decision to establish an inquiry. Royal Commissions and coronial inquiries have a tendency to fall back on tried and true legal behaviour with lawyers seeking to protect their client's interests; witnesses are required to answer questions rather than tell their story; fact finding and recommendations are limited by the particularities of the event, the terms of reference or the governing legislation. Each inquiry makes recommendations to avoid the last event, but the next event will not be the same as the last event – 'a tendency ... to spend the peace time studying how to fight the last war'.¹⁴⁴

Recommendations are necessarily counterfactuals, they are predictions that some other approach or some reform will work better but the future possibility is being judged against a past, known outcome. What implementation of the recommendations will actually achieve is unknown until the next event and sometimes diligent application of one inquiry's recommendations will produce a result that is subject to a contrary-recommendation after the next event.

Identifying areas of improvement and making recommendations may not help. Recommendations may not be implemented, may be impracticable or may conflict with other social and policy concerns. The agency required to implement them may reject the inquiry's balance or not accept the quality of the evidence that the inquiry relies upon. This is particularly true in parliamentary inquiries where submissions may be received and accepted without critical reflection, and where political interests may encourage the investigating body to prefer submissions that support other political beliefs or objectives.

People who have been through these events need to tell their story. Telling their story may not only be less traumatic than being cross examined, it allows different

¹⁴⁴ J. L. Schley, 'Some Notes on the World War' (1929) 21 *The Military Engineer* 55.

perspectives to be shared, and relevant issues to be aired. Allowing some people to express their dissatisfaction with the response to an emergency or the warning that they are given is one perspective. Responders also need to be able to tell their story about what they were doing, what they were experiencing and what they were trying to do. To give one example, in the 2009 Victorian Bushfires Royal Commission lay witnesses were invited to tell their story. One of those witnesses¹⁴⁵ said:

Looking back, I feel that the communication from authorities was very haphazard on that day. We saw no one all day and all night until after we had fought the fire by ourselves, whereas I know that other people in the area had visits from police cars, the CFA and other agencies. It seems to me that the approach to going out to warn or help people was very random. We were essentially left by ourselves and just had to survive as best we could. I feel quite amazed and very lucky that we managed to save our lives that night. We are indeed most fortunate to be alive.

It may have appeared to this witness that 'the approach to going out to warn or help people was very random'. If responders were also invited to tell their story the inquiry may get an insight into the issues that they were facing, how they were making decisions and how they were reacting to the emergency. If the response was in fact 'random' the reasons for that may be better understood both by the inquiry and more importantly, the affected community. If it was not random that could also be explained.

Limiting the story of the response to the official agency account, told through documents, and log books and the evidence of senior officers, does not reflect that 'story'. Where a wildfire has devastated a community, causing loss of life and property, members of the emergency service from local volunteers to senior managers are also affected.

Second victims are practitioners who have been involved in an incident that (potentially) hurt or killed someone else ... and for which they feel personally responsible... The lived experience of a second victim represents rich data for how safety is made and broken. Those accounts can be integrated in how an individual and an organization [and a community] handle their risk and safety.¹⁴⁶

¹⁴⁵ Patricia Easterbrook <<http://vol4.royalcommission.vic.gov.au/indexaa67.html?pid=138>>, [81].

¹⁴⁶ Stanley W.A. Dekker and Hugh Breakey "Just Culture: Improving safety by achieving substantive, procedural and restorative justice' (2016) 85 *Safety Science* 187-193, 192.

There are alternative ways to investigate events, even tragic and fatal events, that try to understand the whole story and recognise that generally speaking people are trying to do the right thing. These will be explored in the next part to consider whether they may be useful models for future investigation of the response to natural disasters.

DRAFT - FOR DISCUSSION

VII. ALTERNATIVE MODELS

This part will consider three alternative models of post event inquiries adopted in other high risk areas as well as a response that is becoming increasingly important in the area of criminal law. The three models to be considered are:

1. 'No blame' investigation adopted in civil aviation;
2. The 'open disclosure' model adopted in medicine; and
3. Inquiries based on principles of restorative justice.

Civil Aviation 'no blame' investigations

The world's civil aviation community has a stated commitment to investigate air safety accidents without looking for blame or fault. Annex 13 to the 1944 *Chicago Convention on International Civil Aviation* provides that the 'sole purpose' of any investigation into an aircraft accident or incident is to prevent future accidents or incidents. 'It is not the purpose of [the investigation] ... to apportion blame or liability'.¹⁴⁷

Australia gives effect to Annex 13 through the *Transport Safety Investigation Act 2003* (Cth).¹⁴⁸ Pursuant to that Act, the Australian Transport Safety Bureau (the ATSB) '... conducts 'no blame' aviation safety investigations...' it 'does not investigate for the purpose of taking administrative, regulatory or criminal action'.¹⁴⁹ A report into an investigation conducted by the ATSB must 'not include the name of an individual unless the individual has consented to that inclusion'.¹⁵⁰ Neither a draft nor a final report may be admitted into evidence in any civil or criminal proceedings.¹⁵¹

Smart argues that

Aviation accident investigation practice and procedures are generally recognised as

¹⁴⁷ *Convention on International Civil Aviation*, opened for signature 7 December 1944, 15 UNTS 296 (entered into force 4 April 1947) Annex 13, clause 3.1 (http://www.emsa.europa.eu/retro/Docs/marine_casualties/annex_13.pdf) accessed 29 February 2016.

¹⁴⁸ See, in particular, *Transport Safety Investigation Act 2003* (Cth) s 12B and *Transport Safety Investigation Regulations 2003* (Cth) r 5.3(1)(a).

¹⁴⁹ Australian Transport Safety Bureau, 'Aviation Safety' (commonwealth of Australia, 2014) <<https://www.atsb.gov.au/aviation/aviation-safety/>> (accessed 25 February 2016).

¹⁵⁰ *Transport Safety Investigation Act 2003* (Cth) s 25(4).

¹⁵¹ *Ibid* s 27.

providing a good model for investigation practice in the other modes of transport...; The fundamental reason why the aviation model has been used in the other modes is because it has been able to establish public and industry trust in its ability to conduct thorough and objective investigation into the circumstances of aircraft accidents. This trust extends to a confidence that the process will swiftly address the public safety issues arising from any accident while at the same time meeting the needs of survivors and bereaved families by keeping them updated on the progress of the investigation.¹⁵²

The question considered here is whether that model can also be extended to more wide ranging events such as a disaster or bushfire. It is suggested that the same fundamentals need to be met for any post event inquiry, that is the process needs to 'swiftly address the public safety issues ... while at the same time meeting the needs of survivors and bereaved families' but that may be more difficult when the disaster is spread over time and location and involves multiple single events such as deaths or house losses in different areas.

Smart identifies a number of factors that engender the trust in aviation investigation. They are

- The aviation industry's safety culture;
- The independence of the investigating body;
- The quality of the investigation body;
- Treatment of those affected by accidents.¹⁵³

These factors are considered, below, in the context of the fire and emergency services to consider whether there are lessons that could be drawn for post disaster inquiries from the Civil Aviation 'no blame' model.

The ... industry's safety culture: the aviation industry is a high-risk industry. It depends on members of the public having confidence in the industry in order to buy tickets to fly. But flying is inherently dangerous so the safety culture of the aviation industry is essential. The development of a safety culture is assisted by a 'simple international and national regulatory structure and the fact that major safety developments are, in general, driven on the international stage rather than by individual States or companies'.¹⁵⁴

¹⁵² K. Smart, 'Credible investigation of air accidents' (2004) 11 *Journal of Hazardous Materials* 111-114, 111.

¹⁵³ Ibid.

¹⁵⁴ Ibid, 112.

Fire and emergency services may have a safety culture when it comes to protecting their own members (something which cannot be explored here) but they are already involved when things are going wrong. The fire and emergency services can do much to help people and communities prepare for inevitable hazard events and the fire protection and building industries have done much to decrease resilience. Even so the fire and emergency services, and the inquiries into them, arise after they have had to respond to the emergency. In civil aviation it is the civil aviation industry that is responsible for all aspects of certifying aircraft, pilots, airports, air traffic controllers and the response to any emergency. Fire brigades on the other hand, do not control all aspects of fire management, they are not in control of building design or regulation, fuel management, land use planning, etc nor do they control the ignition source. Whereas the community can rightly see that an aircraft accident is necessarily a failure of the civil aviation industry, the presence of a fire or a flood and death or injury is not necessarily a failure of the fire or emergency services.¹⁵⁵

What follows is that even if the emergency services have a high commitment to safety that cannot be equated to the aviation industries standing as a 'high-reliability' organisation.

The independence of the investigating body: 'Perhaps the most important prerequisite for public and industry trust is independence. In the immediate aftermath of any major transport accident one of the first questions put to Government Ministers is "will there be an independent investigation?"'¹⁵⁶ A similar question is asked following a fire or other devastating emergency. As noted the only true standing body with power to investigate a death or fire is the coroner. States may establish other ad hoc inquiries such as a Royal Commission or there may be a more limited departmental or agency review of operations.

The European Commission has issued a directive on 'Establishing the Fundamental Principles Governing the Investigation of Civil Aviation Accidents and Incidents'

¹⁵⁵ Michael Eburn and Stephen Dovers, 'How chief officers view the measures of success in fire policy and management', (2014) 29(3) *Australian Journal of Emergency Management* 16-21.

¹⁵⁶ Smart, above n 152, 112.

(Council Directive 94/56/EC)' which says, inter alia "Each Member State shall ensure that technical investigations are conducted or supervised by a permanent civil aviation body or entity..."¹⁵⁷ In Australia that entity is the ATSB¹⁵⁸ that is separate from Air Services Australia¹⁵⁹ and the Civil Aviation Safety Authority (CASA).¹⁶⁰ No similar standing body exists for the fire and emergency services. There is no 'National Disaster Inquiry Centre' that is separate from the fire and emergency services, local and state governments and building developers, to conduct investigations into the effect of disasters and how hazards could have been mitigated before they struck.

The quality of the investigation body: "In my view, one of the most important factors in establishing trust in the investigation process is that of the professional qualities of the individual investigators...If they are unable to establish their credibility, expertise and knowledge of the subject area, then crews and others involved will not feel inclined to open up to the investigator and the evidence we are able to gather is less than optimum. If they are unable to deal sensitively with the survivors and families, these groups may well feel alienated from the investigation process".¹⁶¹

Inquiries into fires and disasters have been led by independent judicial officers¹⁶² as well as experienced experts in the field.¹⁶³ Former police chief officers, with their history of investigative capacity have also been commissioned to undertake relevant investigations.¹⁶⁴ There is a growing industry and professionalization in

¹⁵⁷ Ibid 113.

¹⁵⁸ Established by the *Transport Safety Investigation Act 2003* (Cth).

¹⁵⁹ Established by the *Air Services Act 1995* (Cth).

¹⁶⁰ Established by the *Civil Aviation Act 1988* (Cth).

¹⁶¹ Smart, above n 152, 113.

¹⁶² See Victoria, above n 4; Doogan, above n 5.

¹⁶³ Bruce Esplin, Malcolm Gill and Neal Enright *Report of the Inquiry into the 2002–2003 Victorian Bushfires* (Government of Victoria, 2003); Stuart Ellis, Peter Kanowski and Rob Whelan, *National Inquiry on Bushfire Mitigation and Management* (Commonwealth of Australia, 2004).

¹⁶⁴ See for example, Keelty, above n 3; M.J Keelty, *Appreciating the Risk: Report of the Special Inquiry into the November 2011 Margaret River Bushfire* (Government of Western Australia, 2012); M.J Keelty, *Sustaining the unsustainable Police and Community Safety Review – final report* (Queensland, 2013); also M.J Keelty, *Inquiry into the 2013 WA Senate Election December 2013* (Australian Electoral Commission, 2013).

the field of fire investigation¹⁶⁵ and fire brigades have extensive powers to conduct investigations to determine the cause of a fire, but these investigations are limited compared to post-disaster inquiries. Determining whether a fire was started due to deliberate ignition, an electrical failure or some other cause is not the same as questioning a community's preparation and the response to fires burning across large areas and affecting hundreds or thousands of people.

Whilst there may be a small number of people who are developing expertise in running complex inquiries¹⁶⁶ the fact remains that there is no cadre of appropriate inquiry leaders. Most people who are called upon to investigate a major event from preparation through to response and recovery will do so only once in their career. Judicial officers, in particular, may have particular expertise in managing a court room and drawing inferences from evidence, but they are likely to know little about the actual subject matter under investigation. On the other hand, the use of emergency managers to investigate how an emergency was managed may be perceived as introducing bias to the inquiry. If the investigator associates him or herself with the emergency management community they may not be able to, or may not be seen to, 'deal sensitively with the survivors and families'.¹⁶⁷

Both Victoria and Queensland have taken some steps to create a standing body that can review the performance of the emergency services and the preparation for and response to an emergency. In Victoria, the Inspector-General of Emergency Management is to 'provide assurance to the Government and the community in respect of emergency management arrangements in Victoria'.¹⁶⁸ To do that the Inspector General is given extensive powers to 'monitor and review' the emergency management performance in that State.¹⁶⁹ In Queensland, the Inspector-General of Emergency Management has similar functions and authority.¹⁷⁰ The Victorian Inspector General has conducted an inquiry into the

¹⁶⁵ Craig Poulter, *Should Fire Investigators be classified as experts in court?* (Masters in Fire Investigation Thesis, Charles Sturt University, 2015).

¹⁶⁶ M.J Keelty seems to be the most prolific.

¹⁶⁷ Smart, above n 152, 113.

¹⁶⁸ *Emergency Management Act 2013* (Vic) s 62.

¹⁶⁹ *Ibid* ss 68-73.

¹⁷⁰ *Disaster Management Act 2003* (Qld) ss 16B-16Q.

2015 Wye River – Jamieson Track fire.¹⁷¹ This appears to be the first report on the response to an emergency that was led by the Inspector General, rather than a review or report on the implementation of recommendations from other inquiries.¹⁷² Notwithstanding the Inspector-General's undoubted 'credibility, expertise and knowledge of the subject area' the report and the process has been criticised.¹⁷³

Treatment of those affected by accidents: "... the treatment of the bereaved families and the survivors ... has probably the greatest impact on the reputation of the accident investigation body. In particular, it has a very direct impact on whether or not an atmosphere of trust can be established between these groups and the investigators. If it is perceived that the organisation is not capable of conducting an independent and objective investigation and meeting the needs of the families, then there will be conflict between the investigation body and the affected families which will destroy confidence and trust in the process".¹⁷⁴

The 2009 Victorian Bushfires Royal Commission was mindful of the need to honour survivors holding public meetings in fire affected communities before the formal hearing of evidence. Trust is essential for both the 'primary' victims but also for the 'second' victims.¹⁷⁵ Appropriate treatment of all those involved, including responders, is necessary to ensure that everyone has trust in the inquiry and its

¹⁷¹ Inspector-General for Emergency Management, *Review of the initial response to the 2015 Wye River – Jamieson Track fire* (Government of Victoria, 2016).

¹⁷² See for example Inspector-General for Emergency Management, *Lancefield-Cobaw Fire - IGEN Interim Progress Report* (Government of Victoria, 2016).

¹⁷³ Emma Younger, 'Victorian authorities defend back-burn days before homes destroyed at Wye River, Separation Creek' ABC News (Online) 14 January 2016 <<http://www.abc.net.au/news/2016-01-14/victorian-authorities-defend-back-burn-days-before-homes-destroy/7088170>> accessed 2 March 2016); Richard Willingham, 'Wye River blaze: firefighters' union calls for inquiry' *The Age* (Online) 14 January 2016 <<http://www.theage.com.au/victoria/wye-river-blaze-firefighters-union-calls-for-coronial-inquest-20160113-gm5haw.html>> (accessed 2 March 2016); Farrah Tomazin, 'Victorian bushfires: Backburning not to blame for Wye River fire, investigation finds' *The Age* (Online) 14 January 2016 <<http://www.theage.com.au/victoria/victorian-bushfires-backburning-not-to-blame-for-wye-river-fire-investigation-finds-20160123-gmcldu.html>> (accessed 2 March 2016).

¹⁷⁴ Smart, above n 152, 114,

¹⁷⁵ See p 31, above.

processes. This is necessary to avoid conflict between the investigation bodies and those whose actions are being investigated.¹⁷⁶

What might post-disaster inquiries look like when modelled on aviation safety investigation?

If aviation safety were to provide a model for future investigation one could imagine there would be a standing body such as the *Natural Hazards Investigation Authority* (the NHIA). Following the impact of a fire, flood or other hazard event – particularly one that causes a fatality – experienced NHIA investigators would attend the scene, take photographs, statements and collect other evidence. They would be entitled to ask relevant questions of anyone and make findings and recommendations independent of government. They would have to, over time and by the quality of their investigations, convince those involved that they have appropriate expertise, independence and respect to ensure that the community had trust and confidence in their findings and reports. The inquiry could make no findings of fault or negligence and the reports would not be admissible in evidence.

When described in those terms, it appears that there is little to be gained over current procedures. Today when there is a fire, flood or other hazard, particularly when there is a fatality, there is an independent investigation led by experts in investigation – the police. The police may be supported by expert fire cause analysis provided by the fire brigades or independent consultants.

Since 2009 the Bushfire Cooperative Research Centre has added to post event investigations by undertaking detailed studies of areas impacted by fire to help understand property losses, community understanding and the steps people took to prepare for and respond to the impact of the fire.¹⁷⁷ It is hoped that this will

¹⁷⁶ See *R v Doogan; ex parte Lucas-Smith & Ors* [2004] ACTSC 91; *R v Doogan* [2005] ACTSC 74; *Lucas-Smith & Ors v Coroner's Court of the ACT & Ors* [2009] ACTSC 40.

¹⁷⁷ *Victorian 2009 Bushfire Research Response: Final Report* (Bushfire CRC, 2009); Jim McLennan, Patrick Dunlop, Leanne Kelly and Glenn Elliott, *Lake Clifton Fire 10 January 2011: Field Interview Task Force Report-Community Bushfire Safety* (Bushfire CRC, 2011); Jessica Boylan Colleen Cheek and Timothy Skinner, *Preliminary Report on the January 2013 Fires in the South-Eastern Tasmania Research Project* (Bushfire CRC, 2013); Jon Marsden-Smedley *Tasmanian Wildfires January-February 2013: Forcett-Dunalley, Repulse, Bicheno, Giblin River, Montumana, Molesworth And Gretna: Report Prepared For The Tasmania Fire Service* (Bushfire CRC, 2014); Lyndsey Wright (ed), Jim McLennan, Adrian Birch, Bronwyn Horsey and Trent Penman *Community Understanding And Awareness Of Bushfire Safety:*

continue with the new Bushfire and Natural Hazards Cooperative Research Centre.¹⁷⁸ Continuing this rapid research deployment would allow the Centre to develop and accrue expertise and capacity both across time and across different events.

As noted above¹⁷⁹ there is a standing body to investigate deaths, fires and sometimes disasters,¹⁸⁰ and that is the coroner. A coroner, just like the ATSB cannot determine criminal responsibility¹⁸¹ or civil liability.¹⁸² As with an ATSB report, a coroner's report is not admissible in subsequent legal proceedings to prove how a death or fire occurred.¹⁸³ Coroners are familiar with dealing with the bereaved, are not bound by the rules of evidence and have established means to sympathetically deal with those that come before them.¹⁸⁴ Whilst an ATSB type investigation may be less adversarial than a coroner's hearing but the loss of ability to openly test the evidence and question witnesses may mean that there is less confidence in that process than a coronial inquest.

The medical profession and 'open disclosure'

The medical profession is a high risk profession where decisions are made that literally affect life and death. Poor outcomes, whether they are linked to below standard practice or not, are traumatic and can lead to blame and litigation with associated trauma for practitioners. It is also an industry where individual decisions are affected by systemic issues. Doctors, nurses and other health professionals all work in a system that determines the resources available at any

January 2013 Bushfires Research For New South Wales Rural Fire Service (Bushfire CRC, 2014).

¹⁷⁸ It should be noted that the Bushfire and Natural Hazards Cooperative Research Centre has funded the research project that has culminated in this report.

¹⁷⁹ See p 10, above and following.

¹⁸⁰ *Coroners Act 1997* (ACT) s 19; *Coroners Act* (NT) s 28.

¹⁸¹ *Coroners Act 2009* (NSW) ss 81(3) and 82(3); *Coroners Act* (NT) s 34(3); *Coroners Act 2003* (Qld) s 45(5)(a); *Coroners Act 2003* (SA) s 25(3); *Coroners Act 1995* (Tas) ss 28(4) and 45(4); *Coroners Act 2008* (Vic) s 69; *Coroners Act 1996* (WA) s 25(5)..

¹⁸² *Coroners Act 2003* (Qld) s 45(5)(b); *Coroners Act 2003* (SA) s 25(3); *Coroners Act 1996* (WA) s 25(5).

¹⁸³ *Evidence Act 2005* (Cth) s 91; *Evidence Act 2011* (ACT) s 91; *Evidence Act 2005* (NSW) s 91; *Evidence Act 2001* (Tas) s 91; *Evidence Act 2008* (Vic) s 91. The section is said to also reflect the common law: *Gonzales v Claridades* [2003] NSWSC 508.

¹⁸⁴ See for example, NSW Coroners Court 'Support Services' (31 March 2015) <http://www.coroners.justice.nsw.gov.au/Pages/support_services/support_services.aspx> accessed 3 March 2016.

given time and are subject to variations in demand. A doctor's failure to order a test that leads to a missed diagnosis may well be due to limited resources, the number of other people needing the doctor's attention, the number of other people and the priority given to those who need the same test, the hours the practitioners have been asked to work, how many other staff are on duty etc. Even so the law may attribute the failure as the individual practitioner's rather than the systems negligence.

There are also occasions when even a conscientious, competent practitioner can fail to perform at the standard that could and should have been expected of a reasonable practitioner in the circumstances. That conduct amounts to negligence and can lead to an adverse outcome and subsequent legal consequences for the practitioner and his or her professional indemnity insurer.

In order to improve patient outcomes and help retain trust in the profession, the medical profession has moved to a policy of 'open disclosure' that is 'designed to enable health service organisations and clinicians to communicate openly with patients when health care does not go to plan'.¹⁸⁵

Open disclosure is the open discussion of adverse events that result in harm to a patient while receiving health care with the patient, their family and carers. The elements of open disclosure are:

- an apology or expression of regret, which should include the words 'I am sorry' or 'we are sorry'
- a factual explanation of what happened
- an opportunity for the patient, their family and carers to relate their experience
- a discussion of the potential consequences of the adverse event
- an explanation of the steps being taken to manage the adverse event and prevent recurrence.¹⁸⁶

¹⁸⁵ Australian Commission on Safety and Quality in Health Care, *Australian Open Disclosure Framework* (Sydney, 2013), 8 <<http://www.safetyandquality.gov.au/wp-content/uploads/2013/03/Australian-Open-Disclosure-Framework-Feb-2014.pdf>> accessed 9 March 2016.

¹⁸⁶ Ibid 11.

Open disclosure 'is not a legal process' and 'does not imply that an individual or service has blameworthy facts to disclose'.¹⁸⁷ Open disclosure is supported by eight guiding principles. They are:

1. Open and timely communication;
2. Acknowledgement;
3. Apology or expression of regret: an apology or expression of must not contain an admission of liability or apportion blame;
4. Supporting, and meeting the needs and expectations of patients, their family and carers;
5. Supporting, and meeting the needs and expectations of those providing health care: all staff must be encouraged and able to recognise and report adverse events;
6. Integrated clinical risk management and systems improvement: the information obtained about incidents from the open disclosure process should be incorporated into quality improvement activity;
7. Good governance; and
8. Confidentiality.

For the fire and emergency services this process may not be of immediate relevance. It could be useful where there is an adverse outcome at a single incident eg where a rescue is delayed or worse due to equipment failure or where a person is injured by the emergency services in the course of their response. In that case there is a one-to-one relationship between the service provider and the injured person and there is an opportunity to quickly recognise both the adverse outcome and the contribution of the services to that event.

The protocol is less likely to be relevant where, for example, a bushfire burns out a community with large number affected. The 'adverse outcome' is clear but the cause of it and whether or not there is anything to be disclosed is not so clear. The Open Disclosure protocol recognises these limitations:

Disclosing multiple adverse events or large-scale harm (or potential harm) to multiple individuals or the general public is out of scope of the Framework.¹⁸⁸

A critical issue in the open disclosure process, particularly from a staff perspective, is the avoidance of blame. For health professionals, attribution of blame can have long term consequences and must be a matter for the disciplinary bodies. For the

¹⁸⁷ Ibid 9.

¹⁸⁸ Ibid 25.

point of learning from an event and supporting those harmed by the event, attributing blame is not helpful.

Health service organisations should ensure that policies, protocols and practices regarding open disclosure focus on restoration, service recovery and improving quality and patient safety, not on attributing blame. If appropriate, issues relating to individuals should be left to disciplinary processes.¹⁸⁹

Open disclosure is not a legal process and does not replace or affect any person's legal rights. Open, honest disclosure coupled with meeting out of pocket expenses may remove people's need or desire to litigate¹⁹⁰ but it may not. The open disclosure may even be a trigger for litigation by identifying both that an adverse outcome occurred and that it was due to factors that are sufficient to meet the legal definition of negligence. Open disclosure is however about maintaining the patient's wellbeing and continuing the therapeutic relationship between health institutions, patients and their families. It follows that although legal issues are relevant and should be considered when developing open disclosure policies 'It is not intended that legal considerations should inhibit implementation and practice of open disclosure'.¹⁹¹

The principle of open disclosure should apply anywhere including in the emergency services. The emergency services should be willing to discuss with affected communities what happened, what they did and if anything did not work as intended or anticipated what that might mean. Where loss and damage can be attributed to actions by the emergency services, even where the service was trying to save life and property but was unable to do so without any suggestion of fault, it is likely that a sincere apology or expression of regret would be well received. That is not to say the medical open disclosure protocol could or should apply as the situation is different, but there can be no doubt that an open discussion of what happened should be the ideal. The Review of the Open Disclosure policy (that led to the current 2014 protocol) found that

Health professionals support disclosure but barriers remain to its practice including:

¹⁸⁹ Ibid 33.

¹⁹⁰ Ibid 30.

¹⁹¹ Ibid 40.

- perceived medico-legal consequences of disclosure
- concerns about preparedness for involvement in open disclosure
- difficulty with communicating openly in the context of risk management¹⁹²

Similar views may affect fire and emergency service personnel.¹⁹³ Personnel may fear that there will be legal implications for themselves or their agency if they admit that actions did not go as planned or that mistakes were made. They may also feel that they will be personally exposed if they make a disclosure or raise doubts or concerns about the actions of others.

A fear of legal liability should not stop open disclosure. Government agencies are expected to act as model litigants.¹⁹⁴ One of the obligations of the model litigant is to pay 'legitimate claims without litigation, including making partial settlements of claims or interim payments, where it is clear that liability is at least as much as the amount to be paid'.¹⁹⁵ Acting as a model litigant does not deny a government the right to resist claims for compensation where legal liability is not established or the government has a defence available under law. A government should not however try to hide evidence and should not require 'the other party to prove a matter which the [Government] ... or the agency knows to be true'.¹⁹⁶ This policy, although not referred to, was reflected in findings by the NSW Legislative Council's

¹⁹² Australian Commission on Safety and Quality in Health Care, *Open Disclosure Standard: Review Report* (Commonwealth of Australia, 2012), ix.

¹⁹³ Eburn and Jackman, above n 58, House of Representatives Select Committee on the Recent Australian Bushfires, *A Nation Charred: Inquiry into the Recent Australian Bushfires*, (Parliament of Australia, 2003).;

¹⁹⁴ *Legal Services Directions 2005* (Cth) Appendix B; The Rule of Law Institute of Australia, *Model Litigant Rules*, (u.d.) <<http://www.ruleoflaw.org.au/priorities/model-litigant-rules/>>; see also Department of Justice and Attorney-General, *Model Litigant Principles*, (Queensland Government, 19 December 2014) <<http://www.justice.qld.gov.au/justice-services/legal-services-coordination-unit/legal-service-directions-and-guidelines/model-litigant-principles>> and Department of Justice, *Model Litigant Policy for Civil Litigation* (NSW Government, u.d.) <https://www.google.com.au/url?sa=t&rct=j&q=&esrc=s&source=web&cd=3&cad=rja&uact=8&ved=0ahUKEwjmrft-kjLAhWkj6YKHfmXAqMQFggnMAI&url=http%3A%2F%2Fwww.justice.nsw.gov.au%2Flegal-services-coordination%2FDocuments%2Fcabinetapp-mlp.pdf&usq=AFQjCNElqw6Xw2RPd9-eIXonxlfySwDWwg&sig2=z9emr_rE0BKNoU3Lgnuk6g>.

¹⁹⁵ *Legal Services Directions 2005* (Cth) Appendix B, cl 2(b).

¹⁹⁶ *Ibid* cl 2(e)(i).

enquiry into the Wambelong (or Coonabarabran) fire of 2013. In the inquiry's final report, the committee said:

The committee appreciates that the government's public liability scheme arrangements rest upon the establishment of the government's legal liability for the losses incurred and that this will occur via a legal process. The committee accepts this but we underscore the massive strain that the length of the process and its adversarial nature are placing upon those who intend to make a claim. It is already two years since the fire occurred and people are still faced with the uncertainty of whether they will be duly compensated for their losses. They continue to suffer emotionally, financially, and in terms of community relationships. The committee considers that the government has a moral obligation to do all that it can to expedite the process of establishing any legal liability for the losses incurred by property owners as a result of the Wambelong fire. Should it be found liable, it must also expedite the process of paying compensation claims. Of course, it also has a moral obligation to ensure that all payouts are fair.

The Committee recommended:

That the NSW Government take all reasonable steps to expedite the process of establishing any legal liability for the losses incurred by property owners as a result of the Wambelong fire, and in the event that it is found liable, expedite the process of paying compensation claims.¹⁹⁷

If an open disclosure policies reveals facts that establish that a government or its agency has been negligent, that is not something that either governments, their agencies, staff or volunteers should resist. If however, open disclosure explains how decisions were made and why outcomes occurred it may equally reveal that there is no legal liability or satisfy community concerns.

Fear of personal liability, although misplaced,¹⁹⁸ is a different matter. An emergency service volunteer who fears he or she may be financially ruined or face criminal charges could not be expected to provide open disclosure. Similar concerns lead to the recommendation in the Open Disclosure Standard that those involved in open disclosure must support and meet the needs and expectations of those involved.

Health service organisations should create an environment in which all staff are:

- encouraged and able to recognise and report adverse events
- prepared through training and education to participate in open disclosure

¹⁹⁷ NSW Legislative Council, above n. 104, p 159.

¹⁹⁸ Eburn and Jackman, above n 58.

- supported through the open disclosure process.¹⁹⁹

Fire and emergency services would also need to provide support for staff and volunteers involved in any response with adverse outcomes.

A key difference between the no-blame aircraft accident inquiry and open disclosure is the protection given to the documents. As discussed above, air accident reports must not name people nor are they admissible in evidence.²⁰⁰ The open disclosure model is not supported by legislation and so disclosures are not protected. Even so explaining what happened, and even making apologies for unexpected outcomes, do not constitute legal admissions of liability.²⁰¹ Insurers, in particular the manager of government self-insurance funds, should work with agencies to ensure that after an event, agencies are willing to open and frankly discuss their response to an emergency, how and why decisions were made and to reflect on any action that did not lead to outcomes as hoped or expected.

What might post-disaster inquiries look like when modelled on 'open disclosure'?

The open disclosure process is not so much an investigation as a starting point. For the medical profession it reflects their professional duty to advance the welfare of their patients even if that might conflict with their own self-interest. Further if it is the health system that has caused an adverse outcome, it is also the health system that must assist the person to recover from or live with the consequences of that outcome.

The fire and emergency services are different. Most people come into contact with the emergency services only when an event occurs. Where the emergency is a fire or flood, individuals may never have any contact with the emergency services even though the decisions made by the emergency services may well determine what impact the fire or flood has on distant individuals. If a fire burns out a home, it is not the fire service that will be responsible for making good the damage. Most people do not have either the pre-existing or continuing relationship with the fire

¹⁹⁹ Australian Commission on Safety and Quality in Health Care, above n 185, 13.

²⁰⁰ *Transport Safety Investigation Act 2003* (Cth) ss 25(4) and 27.

²⁰¹ See for example *Civil Liability Act 2002* (NSW) s 69.

and emergency services that they may have with their medical practitioners and the health system more generally.

Even so a clear commitment to give full and frank disclosure to affected individuals and communities, without waiting for a formal inquiry, examination in chief and cross-examination, might go some way to reduce calls for expensive, and we argue, often ineffective inquiries. Further, if open disclosure reveals evidence that either establishes or refutes claims of negligence that may reduce the pressure for, and cost of, litigation.

A commitment to open disclosure would require consideration of legal and insurance issues. More importantly it would require consideration of how to build community confidence in the process. When a health care team seek to disclose an adverse event to a person they have the pre-existing relationship, the opportunity to meet with a person whether in hospital, the health facility, the person's home or some other venue. They can take time to develop trust and assure the person that the service is there to be honest and frank about 'what happened'. Time can be taken to engage the person involved, ensure appropriate communication in a culturally sensitive manner and provide ongoing support.²⁰² That may not be possible where, for example, a fire has burnt out a community or a flood has devastated large areas.

In the event of a widespread natural hazard event, the people involved will come from a myriad of backgrounds, have suffered different consequences and have their own agenda for attending any meeting where the services are intending to discuss their response to, and the outcomes from the particular event. Emergency managers, unlike doctors, are not trained or experienced in having one-on-one dialogue with those affected by their decisions nor do they have that sort of direct relationship. A doctor that is proposing surgery knows who will be affected and has a relationship with that person. A fire manager making decisions on how to manage the fire cannot identify before the event who will be affected by their decisions and the people affected will be strangers. Further, managing a

²⁰² Australian Commission on Safety and Quality in Health Care, above n 185, 28-29.

community meeting is nothing like a one-on-one consultation. As noted ‘Disclosing multiple adverse events or large-scale harm (or potential harm) to multiple individuals or the general public’ is not considered part of the health system’s open disclosure process.²⁰³

Even so, any government agency should be open about its actions and outcomes and be willing to discuss with affected individuals how decisions were made. If necessary that could include recognising the harm that decisions may have caused. That recognition and even an appropriate expression of regret or apology will not constitute an admission of legal liability, but where legal liability can be established governments and their agencies should seek to meet that liability without requiring litigation or extending it beyond the point where it is apparent that liability will be established. To that end ‘open disclosure’ sounds like a further step in any government’s obligation to act as the model litigant. The open disclosure framework adopted by the health system would be applicable where there has been a clear adverse event such as an escaped hazard reduction burn that has destroyed a home, or where a responder has been killed or injured in the course of his or her duties. After a complex, large scale event with a large number of affected people, communities and organisations, the sort of practices anticipated in the Open Disclosure Standard do not seem applicable.

Although agencies should remain committed to an honest and frank discussion of their actions and decisions, the situation is more complex and would need management in another and more formal way. In a sense that is what the Royal Commission or coroner’s inquiry is meant to achieve. It allows each agency and individuals to reveal what they know or saw in an open way. A Royal Commission and a coroner cannot determine legal issues (such as liability or guilt). Evidence given at those proceedings, particularly where a person objects to giving the evidence, cannot be used against the person in subsequent proceedings²⁰⁴ and the findings of the inquiry are not binding or admissible in subsequent litigation.²⁰⁵

²⁰³ Ibid.

²⁰⁴ See for example *Coroners Act 2009* (NSW) s 61; *Inquiries Act 2014* (Vic) ss 40, 80 and 112.

²⁰⁵ *Matthews v SPI Electricity (No. 3)* [2011] VSC 399.

What follows is that the best place for open disclosure following a major complex fire or hazard event is in fact in the sort of inquiry that is already so familiar. For that to work agencies and the relevant inquiry must work to build trust with each other and the community and there must be strong resistance to falling back into traditional adversarial roles. Experience shows that despite regular reminders that inquiries are not adversarial but fact finding, the temptation to resort to adversarial practices appears impossible to resist.

Inquiries based on principles of restorative justice

Restorative justice is an increasing feature of the criminal justice system in Australia and around the world. The aim of restorative justice is to deal with the harms caused by crime by allowing victims to face offenders and explain the impact of their behaviour and to give offenders the chance to account for their behaviour and to reach agreement on how they may make good (to the extent that is possible) the damage caused by their behaviour.²⁰⁶

Restorative justice is a process whereby all the parties with a stake in a particular offence come together to resolve collectively how to deal with the aftermath of the offence and its implications for the future.²⁰⁷

One form of restorative justice practice is are Victim Offender Reconciliation Programmes or VORPS.

In VORPS, restorative justice takes the form of a face-to-face encounter between the victim and the offender, facilitated by a trained mediator, who is preferably a community volunteer. The mediator's role is not to impose his or her interpretation or solution upon the 'parties to the conflict', but to encourage them to tell their stories, express their feelings, ask questions of each other, talk about the impact and implications of the crime, and eventually come to an agreement about what the offender will do to make restitution.²⁰⁸

²⁰⁶ Gerry Johnstone, *Restorative Justice: Ideas, Values, Debates* (Willan Publishing, 2003), 1-2.

²⁰⁷ T.F. Marshall 'The evolution of restorative justice in Britain' (1996) 4 *European Journal on Criminal Policy and Research* 21-43, cited in Paul McClod 'Toward a Holistic Vision of Restorative Juvenile Justice: A reply to the Maximalist Model' (2000) 3(4) *Contemporary Justice Review* 357-414, 358. McClod argues that Marshall's definition has been incorporated in the International Network for Research on Restorative Justice for Juveniles, *Declaration of Leuven* (May 13, 1997; and reproduced in (1997) 5(4) *European Journal on Criminal Policy and Research* 118-122) and a Working Party of the UN Alliance of NGOs.

²⁰⁸ Johnstone, above n. 206, 3.

Whilst responding to fires and floods is not an issue of criminal law (even if the fire is caused by arson) there are similar issues. The event causes massive harms in loss of property, life and a sense of security. People are traumatised by the losses and the impact on their lives. They may feel that the state agencies failed them in the preparation and planning and the response. Responders are also members of the affected communities so volunteer emergency service personnel who are responding on behalf of their community may feel let down if their actions aren't valued or honoured by the community or if they feel that their agency didn't properly support them or allow them to take actions that they thought were required. Equally staff from agencies such as land management agencies and local government authorities also live in the affected communities and can be both victims as well as receiving blame and criticism for their actions. Just as crimes cause harm that needs to be repaired, so do significant natural hazard events.

Could restorative justice practices help communities rebuild trust and understand how and why outcomes occurred? Could there be "... a process whereby all the parties with a stake in a particular [natural hazard event such as a catastrophic fire or flood] come together to resolve collectively how to deal with the aftermath of the [event] and its implications for the future"?²⁰⁹ Perhaps:

... a face-to-face encounter between those affected by the incident, facilitated by a trained mediator, who is preferably a community volunteer. The mediator's role [unlike a Royal Commissioner or coroner] is not to impose his or her interpretation or solution upon the 'parties to the conflict', but to encourage them to tell their stories, express their feelings, ask questions of each other, talk about the impact and implications of the event, and eventually come to an agreement about what the community needs to do to facilitate recovery and manage future hazard events?²¹⁰

One driving factor in the push for restorative justice in the context of the criminal law is to allow those that are affected by crime to have a voice and an influence in the process. Under current criminal law a prosecution is brought by the state. The victim (where there is one) is reduced to the role of a witness, there to assist the prosecution to prove that the offender failed to comply with a valid law. The victim's views on what charges the accused should face, what penalties should be imposed and how any trial should proceed may be considered but are subordinate

²⁰⁹ Marshall, above n. 207.

²¹⁰ Johnstone, above n. 206, 3.

to the position of the prosecutor.²¹¹ The prosecutor does not 'represent' the victim and the victim has no active voice during the trial. In the same way those that have suffered a loss during a catastrophic event such as a bushfire or flood may be asked to give evidence or tell their story before a formal inquiry. They may even be consulted about the direction the inquiry may take, but their views are subordinate to the inquiry chair or counsel assisting. It is those parties, governed by the inquiry's terms of reference or authorising legislation, that determine what witnesses will be called and what matters will or will not be the subject of investigation. Witnesses, whether before a criminal court, a Royal Commission or a coronial inquest are left with the role of answering the questions asked by counsel rather than taking an active part in reviewing and understanding the events that have affected them.

Zehr says, of crime and criminal justice:

Victims experience crime as deeply traumatic, as a violation of the self. They experience it as an assault on their sense of themselves as autonomous individuals in a predictable world. Crime raises fundamental questions of order, of faith...

Victims have many needs. They need chances to speak their feelings. They need to receive restitution. They need to experience justice: victims need some kind of moral statement of their blamelessness, of who is at fault, that this thing should not have happened to them. They need answers to the questions that plague them. They need a restoration of power because the offender has taken power away from them.

... Victims have serious important needs, yet few, if any, of them will be met in the criminal justice process.

In fact, the injury may very well be compounded. Victims find that they are mere footnotes in the process we call justice. If they are involved in their case at all, it will likely be as witnesses; if the state does not need them as witnesses, they will not be part of their own case. The offender had taken power from them and now, instead of returning power to them, the criminal law system also denies them power.²¹²

If we consider that the 'offender' is a catastrophic bushfire or flood rather than a person, the description is still apt. Victims who have experienced a catastrophic bushfire or flood and who have lost their home, the lives of friends and loved ones or the catastrophic impact on their community have also suffered an assault on

²¹¹ Ibid 12.

²¹² Howard Zehr, 'Retributive Justice, restorative justice' in Gerry Johnstone (ed) *A Restorative Justice Reader: Texts, sources, context* (Willan Publishing, 2003) 69-82, 69.

themselves and their perception of a predictable world and want to seek to hold someone to account. If the 'offender' is the hazard, the offender cannot be held to account – it cannot be cross examined or punished or asked to take some measures to make good the damage that it has caused; but responders, those that are entrusted to protect communities from the hazard, can be.

As noted above it is a function of the Royal Commission to help restore faith in community and government control that has been lost by the catastrophic event. But the traditional model of the coroner's inquest or Royal Commission adopts the trappings of a legal trial. Those that suffered during an event, whether responder or householder, are reduced to the role of a witness. They do not have a right to appear in person and those from government agencies will be denied that right as their 'story' is told by senior officers representing 'the organisation'.

Braithwaite and Strang say that restorative justice

... does not subordinate emotion to dispassionate justice, as in the blindfolded icon of justice balancing the scales. Nor does restorative justice subordinate emotion to rational bureaucratic routines. Space is created in civil society for the free expression of emotions, however irrational they may seem ... where there is moral ambiguity over right and wrong in a conflict, [the authors] ... prefer allowing the ambiguity to stand rather than coerced allocation of responsibility. Speaking to participants in advance of a conference inviting them to own as much responsibility as they feel able to volunteer can be enough to trigger a virtuous circle of owning responsibility instead of a vicious circle of denial and blaming the other.²¹³

Consider again the model of the Royal Commission or the coroner's inquest.

Witnesses are not invited to speak or express their emotions. Witness are allowed to answer questions put to them by counsel. It is counsel that makes submissions to the Commissioners or coroner as to what inferences and findings are open on the evidence that has been led. Where there is ambiguity it is up to the tribunal to determine where responsibility lies and more importantly, who is responsible for ensuring that the same circumstances do not arise in the future. There remains a circle of blame where those that have lost may blame governments, agencies or responders for their alleged failings and are in turn blamed for their lack of

²¹³ John Braithwaite and Heather Strang, 'Introduction: Restorative Justice and Civil Society' in Heather Strang and John Braithwaite (eds) *Restorative Justice and Civil Society* (Cambridge University Press, 2001) 1-13, 10-11.

preparation, failure to remain informed over conditions or failure to take the advice of the emergency services. Finding a method of post event inquiry that could facilitate ‘a virtuous circle of owning responsibility’ would help ensure that responsibility is truly shared.²¹⁴

Wachtel and McCold say:

Used widely, restorative practices can significantly contribute to the grander project of enhancing the civility of society. By involving all of those affected by a specific offence, conference and circles enhance democratic processes by moving responsibility for decision –making away from judges and lawyers and giving it to those citizens with a direct interest at stake. But the potential of restorative practices goes beyond resolving specific incidents of wrong-doing to providing a general social mechanism for the reinforcement of standards of appropriate behaviour. Restorative practices demonstrate mutual accountability – the collective [shared] responsibility of citizens to care about and take care of one another...

If we are serious about conceiving of taking responsibility as a democratic virtue, then it will not be enough to cultivate restorative practices in formal criminal justice institutions. Restorative justice concepts ‘... are directly relevant to the harms suffered in the course of everyday life and routine conflict, and where the event is not classified as a crime’.²¹⁵

That bushfires and natural hazards create conflicts even when there is no crime is clear. Consider the reactions to the 2014 Wambelong fires as reported in the parliamentary inquiry calling for retribution against the National Parks and Wildlife Service. And the 2003 Coronial inquiry into the Canberra bushfires made specific adverse comments regarding the performance of the leaders of the then Emergency Services Bureau. Even so, subsequent claims of negligence against both the Australian Capital Territory and New South Wales were later withdrawn or lost at trial.

Following the 2009 Victorian Bushfires Royal Commission states engaged in more extensive hazard reduction burns. In Victoria, a burn escaped and did significant damage. Dwyer says:

Unfortunately, the last bushfire Royal Commission — after the 2009 Black Saturday fires — resulted in finger pointing, blame, vilification and scapegoating. We have already seen these characteristics at the start of this year’s fire season, which only

²¹⁴ The principle of ‘shared responsibility’ is discussed at p. 60 and following, below.

²¹⁵ Ted Wachtel and Paul McCold ‘Restorative Justice in Everyday Life’ in Heather Strang and John Braithwaite (eds) *Restorative Justice and Civil Society* (Cambridge University Press, 2001) 114-129, 114-115.

keeps us looking backwards when we need to look forward...

As the recent Lancefield fire in Victoria reminded us, managing bushfire risk is a risky business. While the media reported the community's inflammatory anger, saying that "Heads should roll for this", we need to remember that Royal Commissions have repeatedly found that planned burning has an important role in reducing bushfire risk...

If we had a more sophisticated way of learning and the resources to go with this, we could have a system that is more dynamic and realistic. To do that, we need to make a cognitive shift and move from the expectation that emergency services are completely responsible for preparing for fires. Instead, we need to move to a position where the community is an active participant in making decisions about their safety and property.

This includes community involvement in planning to prevent fires. It also means people living in high-risk areas need to work with emergency services on a year-round basis, rather than viewing bushfires as a summer phenomenon.²¹⁶

It should also mean community involvement in reviewing a fire or other hazard and owning with government, their responsibility for decisions that contributed to the impact of the event. McLaughlin et al say that restorative justice in the context of the criminal law is to restore the role of community.

A corollary of the critique of the overwhelming power held by state bureaucracies and agencies is restorative justice's view of the role of 'community' in formal legal processes. Marginalization or exclusion of community from the processes of determining outcomes ... explains the failure of statutory legal practices ... Restoring the historical place of community is central to the founding propositions of most restorative justice proponents.²¹⁷

The Royal Commission and the coroner's inquiry are the province of experts. Whilst community members may be asked to give evidence their evidence is tailored. They are 'briefed' by counsel before being called, their testimony is usually limited to answering questions about issues that the tribunal, or counsel assisting, have determined will be the focus of the inquiry. The questions asked are matters for counsel who then make submissions to the tribunal on the inferences that should be drawn, the understanding that should be accepted and the recommendations that should be made. The recommendations themselves are

²¹⁶ Graham Dwyer, 'Learning to learn from bushfires' *Pursuit* (Uni of Melbourne), 23 November 2015 <https://pursuit.unimelb.edu.au/articles/learning-to-learn-from-bushfires>.

²¹⁷ Eugene McLaughlin, Ross Fergusson, Gordon Hughes and Louise Westmarland 'Introduction: Justice in the Round – Contextualising Restorative Justice' in Eugene McLaughlin, Ross Fergusson, Gordon Hughes and Louise Westmarland (eds) *Restorative Justice: Critical Issues* (SAGE, 2003), 1-17, 7.

handed down from the bench to be implemented by the others. Compare that to restorative justice practices, in this case described by Canadian Crown Attorney Rupert Ross in remote northern Canada. Local judges:

... prefer putting those tables in a circle shape, hoping that this will reduce the adversarial nature of the process. ... My own impression is that such an arrangement does make people feel more comfortable and also contributes to a fuller community participation. Perhaps people feel better joining as equals a group discussion aimed at finding solution than they do making formal and solitary suggestion to an all-powerful judge.²¹⁸

Contrast that mental picture to images from the 2009 Victorian bushfires Royal Commission:



219

²¹⁸ Rupert Ross, 'Return to the Teachings' in Gerry Johnstone (ed) *A Restorative Justice Reader: Texts, sources, context* (Willan Publishing, 2003) 125-143, 126.

²¹⁹ 'Proceedings commence in the Victorian Bushfires Royal Commission' *ABC News* (Online) <<http://www.abc.net.au/news/2009-04-20/proceedings-commence-in-the-victorian-bushfires/1657154>>, 20 April 2009 (accessed 29 June 2016).



220



221

220 <<https://residentjudge.files.wordpress.com/2010/04/bushfirescommission.jpg>> (accessed 29 June 2016).

221 Institute of Public Administration Australia, Victorian Division, *YIPAA mid year events* <http://www.vic.ipaa.org.au/news/october-2010/yipaa-mid-year-events>, 5 August 2010, (accessed 29 June 2016).



This is not a meeting of equals but a system where people are invited to make 'formal and solitary suggestion to an all-powerful' panel of Commissioners.

To be fair, the 2009 Victorian Bushfires Royal commission did lead the way with community consultation. The Commissioners did hold:

Community consultations for fire-affected communities ... Consultations gave individuals from fire-affected communities an opportunity to discuss their views about key issues in relation to the inquiry being conducted by the Victorian Bushfires Royal Commission. The consultation sessions were open to those Victorians who lived or worked in the communities directly affected by the bushfires.²²³

The role of the consultations in contributing to the final recommendations of the Commission is not clear.

The community consultations were not hearings, and the information obtained from them was not formal evidence. The information was, however, of great value and helped the Commission determine areas for further research and investigation before starting its formal hearings. The consultations also gave the affected communities the opportunity to shape the direction of the Commission's work... In all, consultation sessions were held in 14 communities and about 1,250 people attended... Once each session concluded, summary notes were made available on

222

<https://wikis.utas.edu.au/download/attachments/12852122/Commissioners%20at%20bench_400x195.jpg?version=1&modificationDate=1280199066573&api=v2>, (accessed 29 June 2016).

223

Victoria, above n 4, *Community Consultations* <<http://pandora.nla.gov.au/pan/96781/20100923-0223/www.royalcommission.vic.gov.au/Community-Consultations.html>>, 31 July 2010 (accessed 8 April 2016).

the Commission's website.²²⁴

The notes from each consultation meeting identified the community's report on the impact of the fires, what worked well and 'what did not work well and what should be done differently'.²²⁵ Those reports may have shaped the issues that the Commissioners, and counsel assisting, identified for more formal investigation but did not form the basis of the final report or the Commission's recommendations.

Further, not all inquiries take this approach. Recent inquiries have taken a more collaborative model. The Keelty inquiry into fires in the Perth Hills region of Western Australia held:

... almost fifty hearing involving about 100 witnesses. Community Meeting and interviews provided the Special Inquiry with personal interactions to ensure that access was given to as many people as possible to inform the Special Inquiry.²²⁶

Further, although the Inquiry had the power to compel witnesses to appear and produce documents, '[I]imited use was made of those powers' as 'for the most part, everyone involved was keen to cooperate and assist the Special Inquiry'.²²⁷

Another inquiry that avoided the trappings of a legal process was the inquiry into the January 2016 Waroona Fire (also in Western Australia) conducted by the former Chief Officer of Victoria's Country Fire Authority, Euan Ferguson. In the Prologue Ferguson said:

The Special Inquiry has had the benefit of time and the luxury of hindsight... Hindsight is a wonderful thing. But we must act with disciplined caution when exercising this hindsight. It must always be remembered that those who were key players in this fire emergency were not afforded such luxury. Many individuals, be they citizens or members of agencies or in community teams, worked in extreme and challenging conditions... Fast decisions had to be made with information that was incomplete and sometimes conflicting. There were many unknowns. People made decisions. Assumptions changed. Best laid plans failed. Teams used their initiative and adjusted. Even the most straightforward of tasks became complex. Emergency and essential services worked to create order out of chaos. Everyone worked against time and the progression of the fire.

It would be easy to look at any shortcomings and be tempted to fall into the trap of finding fault and allocating blame. This must be resisted... Blame is a poor tool for

²²⁴ Victoria, above n 4, *Final Report Vol III: Establishment and Operation of the Commission*, [1.1.1].

²²⁵ Victoria, above n 223.

²²⁶ Keelty, above n 3, 1.

²²⁷ *Ibid* 2.

strengthening resilience. Whilst blame is a natural reaction, it is a waste of energy. Wherever possible it has been the intent of this Special Inquiry to regard any shortcomings firstly as shortcomings in the systems of work for bushfire management. Everyone works within a system. If we want to improve the way that people operate within that system, then we must look to improving the system, rather than to first look to allocating blame on individuals. Good decisions come from wisdom, knowledge and experience. It is through a process of identifying then implementing lessons that systems can be improved and we can better equip people to make good decisions so that such large and destructive fires are dealt with properly, or better still, avoided. This is how we, and future generations, gain wisdom.

All of the people the Special Inquiry met with: citizens, landowners, farmers, business owners, personnel from agencies, essential services and from emergency services, were genuine in their commitment to do the best they could during this crisis. The Special Inquiry noted a strong urge from all the witnesses and submissions to understand the failings in the current systems of work, to learn from this tragic experience, and to change the future.²²⁸

Again contrast that result with the outcome from the Royal Commission into the 2011 Queensland Floods. This inquiry was ‘conducted within a legal framework: witnesses gave evidence and were cross examined, exhibits were tendered and transcripts prepared’²²⁹. One outcome of the inquiry was to single out three dam engineers for possible prosecution over their evidence before the inquiry.²³⁰ The three were cleared by the Queensland Crime and Misconduct Commission. In his detailed report John Jerrard QC reviewed the evidence the engineers including their cross examination. He concluded that the ‘conduct of the engineers is consistent with their having honestly attempted to follow the [Dam’s operations] Manual’s instructions, without grasping at that time that there was an essential inconsistency in those.’²³¹ It was the inconsistency in the manual – the system in which they worked – rather than a deliberate attempt to mislead that lead to discrepancies in their evidence. One wonders what might have happened had the engineers, in the presence of the Commissioners, been allowed to talk together, to compare notes and to try to identify for the benefit of the Commission what had

²²⁸ Euan Ferguson, *“Reframing Rural Fire Management”*: Report of the Special Inquiry into the January 2016 Waroona Fire Volume 1 (Government of Western Australia, 2016), 11-12.

²²⁹ Queensland, Queensland Floods Commission of Inquiry, *Final Report* (2012) 35.

²³⁰ *Ibid*, 509.

²³¹ *Advice of John Jerrard QC concerning examination of material provided to the Crime and Misconduct Commission pursuant to Recommendation 16.1 of the Queensland Floods Commission of Inquiry’s final report*, [108] <<<http://www.ccc.qld.gov.au/corruption/past-investigations/2012-examination-of-wivenhoe-dam-engineers-conduct/advice-from-john-jerrard-qc-word-version.doc>>> (2012) (accessed 7 July 2016).

happened? Rather they were taking to details of the manual and compliance and matters of procedure. To be sure the Inquiry identified that ‘the Manual itself was ambiguous, unclear and difficult to use, and was not based on the best, most current research and information’²³² and that may have been valuable learning, but it came at considerable personal cost. With this outcome it would not be surprising if future witnesses were less keen, or even unwilling, to cooperate and assist an Inquiry.²³³

Sharing responsibility

The 2009 Victorian Bushfires Royal Commission took the view that effective disaster management involved a shared responsibility.

Pervading the Commission’s report is the idea that responsibility for community safety during bushfires is shared by the State, municipal councils, individuals, household members and the broader community. A fundamental aspect of the Commission’s recommendations is the notion that each of these groups must accept increased responsibility for bushfire safety in the future and that many of these responsibilities must be shared...

Shared responsibility does not mean equal responsibility: in the Commission’s view there are some areas in which the State should assume greater responsibility than the community. For example, in most instances state fire authorities will be more capable than individuals when it comes to identifying the risks associated with bushfire; the State should therefore assume greater responsibility for working to minimise those risks.²³⁴

The notion of shared responsibility has also been adopted in the National Strategy for Disaster Resilience.²³⁵ However merely stating that there is a shared responsibility does not define who is responsible for what. Sharing responsibility

... requires collective action, when multiple actors are working towards the same goal and acceptance of obligations to act, based on the expectations, rules, and norms in society. Shared responsibility carries with it certain legal and policy ramifications: **for responsibility to be shared, it must be specified, accepted and complied with.**²³⁶

²³² Ibid, [112].

²³³ Keelty, above n 3, 1.

²³⁴ Victoria, above n 4, *Final Report Vol II: Fire Preparation, Response and Recovery*, [9.1].

²³⁵ Council of Australian Governments, *National Strategy for Disaster Resilience* (Commonwealth of Australia, 2011) <<https://www.ag.gov.au/EmergencyManagement/Documents/NationalStrategyforDisasterResilience.PDF>>.

²³⁶ Anna Lukasiewicz, Stephen Dovers and Michael Eburn, ‘Sharing responsibility for disaster resilience: What are the obligations of the community?’ (Forthcoming; emphasis added).

The Royal Commission may make recommendations on the balance of shared responsibility and governments may adopt policies to encourage individuals, communities, business and the non-government sector to accept responsibility but neither the inquiry or legislative process allows for communities or individuals to expressly 'accept' or own the responsibility that others think does, or should, belong to them. Adopting restorative justice practices, after a major event, would be to adopt:

... a cooperation soliciting approach that encourages a process of acceptance of responsibility, facing the consequences by making amends to individuals and relationships, and encouraging re-acceptance into the community'.²³⁷

Such an approach would also be consistent with developing policy that has been adopted in preparing for and preventing disasters. The Tasmania Fire Service adopts Community Protection Planning – 'An innovative emergency management, community protection & resilience building initiative'.²³⁸ As part of the Community Protection Planning process the fire service establishes, for each community, a Bushfire Protection Plan, a Bushfire Response Plan and a Bushfire Mitigation Plan.

The purpose of the response plan is to better equip emergency managers and responders, so that the community and its assets are better protected, particularly when bushfires are burning out of control. These plans bring together corporate and local knowledge, thereby making firefighting resources safer and much more effective.²³⁹

The plan will 'identify operational priorities including the location of likely vulnerable people or groups, valuable community assets that will assist in post-fire recovery, safe access and egress routes, primary hazards and water supplies'.²⁴⁰ The identification of 'valuable community assets' is essential as the protection of assets that the community have identified as valuable is a key priority (after

²³⁷ McClod, above n 207, 380.

²³⁸ <http://www.fire.tas.gov.au/Show?pageId=colCommunityProtection> (5 May 2016), accessed 24 May 2016.

²³⁹ <http://www.fire.tas.gov.au/Show?pageId=colCommunityProtection>

²⁴⁰ State Fire Commission, *State Bushfire Safety Policy* (v 1, 27 June 2014), 11 http://www.fire.tas.gov.au/userfiles/stuartp/file/Miscellaneous/SFC_04_14_StateBushfireSafetyPolicy.pdf accessed 24 May 2016.

issuing warnings and protecting vulnerable people) for the Tasmania Fire Service when responding to out of control bushfire.²⁴¹

Emergency Management Victoria is developing 'a Community Based Emergency Management (CBEM) approach' that 'places people at the centre of decision making processes...'²⁴²

Community based emergency management is a collaborative planning and engagement approach, designed to support communities and organisations in developing a safer, more resilient and sustainable future.

This is an ongoing process, where the collective local knowledge, expertise and resources can support people to work together and build on combined strengths. Working together to adopt and use these processes through the development of mutual goals and solutions can strengthen relationships to be drawn upon during good times and critical times of need. Maintaining these processes and relationships before, during and after emergencies also aims to build the capacity and capability to manage long term chronic stresses and cope with acute shocks, including future emergency situations...

The community based emergency management approach is based upon:...

- Collaborative decision making through the development and use of locally tailored and appropriately facilitated processes to plan for the future...²⁴³

The move to the development of resilient communities with shared responsibility for planning and preparing for inevitable hazard events should be extended to shared responsibility for reviewing those events and considering what lessons can be drawn for future action. Where there has been cooperative planning there will be 'the development of mutual goals and solutions' but it is inevitable that expectations and goals will not be met when a catastrophic event causes significant loss of life, property and community values. As Emergency Management Victoria says 'Maintaining these processes and relationships before, during ***and after*** emergencies...' is important.²⁴⁴ As argued above, a catastrophic event where people may believe that others have not met their responsibilities – for example

²⁴¹ http://www.fire.tas.gov.au/userfiles/stuartp/file/CommunityProtectionPlans/OPERATIONALPRIORITIES_4018.pdf

²⁴² <https://www.emv.vic.gov.au/our-work/current-projects/community-based-emergency-management/> accessed 24 May 2016

²⁴³ Emergency Management Victoria, *Community Based Emergency Management: Working together - before, during and after - Overview* (Government of Victoria, 2016) <http://fire-com-live-wp.s3.amazonaws.com/wp-content/uploads/20160303044558/Community-Based-Emergency-Management-Overview.pdf> accessed 24 May 2016.

²⁴⁴ Ibid, emphasis added.

that the local national park did not undertake sufficient hazard mitigation, or the fire response was inadequate or that individuals did not adequately listen to warnings or take pro-active steps to prepare their property – will fracture and harm those pre-existing relationships. An inquiry where ‘all the parties with a stake in [the particular event] ... come together to resolve collectively how to deal with the aftermath of the [event] and its implications for the future²⁴⁵ will identify shortcomings and perceived shortcomings (which may not be the same thing) and allow the community to collectively identify what outcomes were unexpected, unplanned or unacceptable and what the implications for future are.

The use of restorative justice beyond criminal law is not unique and is growing

The use of restorative justice principles is expanding beyond traditional criminal law. Restorative principles lie behind attempts at peacebuilding²⁴⁶ and post-conflict inquiries in South Africa, Rwanda, Northern Ireland²⁴⁷ and East Timor.²⁴⁸ Restorative justice practices have also been suggested as an appropriate response for industrial disasters.²⁴⁹ Nova Scotia, Canada, is currently holding its first restorative public inquiry - *The Nova Scotia Home for Colored Children Restorative Inquiry*. According to the inquiry website:

A traditional public inquiry is focused on uncovering facts and laying blame. We need to understand not only what happened, but why it happened and why it matters for all Nova Scotians. **We need a process shaped by restorative principles that does no further harm, includes all voices and seeks to build healthy and just relationships so we can learn and act together.**

The Restorative Inquiry will look at the past with a focus on future solutions: not only preventing any more harm, but making meaningful changes that will help us treat each other more justly and equitably in the future.²⁵⁰

Two of the goals of the inquiry are to ‘Support collective ownership, shared

²⁴⁵ Marshall, above n 207.

²⁴⁶ Jennifer J. Llewellyn and Daniel Philpott ‘Restorative Justice and Reconciliation: Twin Frameworks for Peacebuilding’ in Jennifer J. Llewellyn and Daniel Philpott (eds) *Restorative Justice, Reconciliation and Peacebuilding* (Oxford University Press, 2014), 14-36.

²⁴⁷ Kathleen Daly, ‘Restorative Justice: The Real Story’ in Declan Roche (ed) *Restorative Justice* (Ashgate, 2004), 85-109, 87.

²⁴⁸ John Braithwaite, Hilary Charlesworth and Adérito Soares, *Networked Governance of Freedom and Tyranny: Peace in Timor-Leste* (ANU E Press, 2012), 202-230.

²⁴⁹ Davalene Cooper, ‘Thinking About Justice “Outside Of The Box”: Could Restorative Justice Practices Create Justice For Victims Of International Disasters?’ (2008) 42(4) *New England Law Review* 693-700.

²⁵⁰ <https://restorativeinquiry.ca/>, accessed 7 June 2016 (emphasis added).

responsibility and collaborative decision-making’ and to learn ‘what happened, what matters about what happened for the future, who was affected and how, and the contexts, causes and effects of what happened...’²⁵¹ The Inquiry process

... involves three elements of work related to its overall objectives:

Relationship building

Learning and understanding

Planning and action.²⁵²

These goals and work elements would be fitting in an inquiry into a complex event such as the 2003 Canberra fires or the Black Saturday fires of February 2009.

The Canadian Inquiry is headed by a ‘Council of Parties’. The 12-member council includes a coordinator, a judge and counsel as well as nominees from the affected community and the government. All members of the Council are appointed ‘as “commissioners” pursuant to the *Public Inquiries Act*.²⁵³ The Council of Parties is to function collectively as a collaborative commission to lead the Inquiry’.²⁵⁴

Members of the Council of Parties ‘have the duties, powers and functions accorded commissioners ... including the power to summon witnesses or evidence’.²⁵⁵

Exercising the power to compel witnesses to attend or produce evidence must be used only as a last resort.

The Council of Parties will utilize all existing relationships and connections to seek voluntary participation. It will issue summons only in situations where it is not otherwise possible to gain information or participation from individuals and/or organizations. Recognizing there may be situations and circumstances in which individuals and/or organizations will not be permitted or do not feel authorized to participate without external authority compelling them to do so, summons could provide such external permission.²⁵⁶

Even where a summons is issued, witnesses will not be expected to face a hostile inquiry.

RI [Restorative Inquiry] staff will contact those who receive a summons to explain the nature of the process and the reason for the summons. A support person will be assigned to facilitate an individual’s participation where a summons has

²⁵¹ The Nova Scotia Home for Colored Children Restorative Inquiry *Mandate & Terms of Reference* (Nova Scotia, 2015), 6.

²⁵² Ibid 9.

²⁵³ RSC 1985, c I-11.

²⁵⁴ Above n. 251, 16.

²⁵⁵ Ibid 17.

²⁵⁶ Ibid 18-19.

been issued. The support person will provide information, orientation and accompaniment through the process according to the wishes of the individual.

In cases where a summons has been issued, the RI will maintain a non-adversarial approach consistent with the principles of the RI to the extent possible.²⁵⁷

A number of people will support the inquiry and those giving evidence. These include:

- Facilitators – to plan and guide gatherings
- Briefers/Navigators – prepare people to understand the process, provide contact and information
- Knowledge Gatherers – record and report back major learnings and recommendations from circle gatherings...²⁵⁸

The Inquiry's terms of reference provide for implementation and follow up. The 'Reflection and Action Task Group' is made up 5 Deputy Ministers and a direct representative of the Premier as well as community representatives and members of the Council of Parties. The Group's role is to:

- Work in collaboration with Council of Parties to facilitate and ensure active and full involvement and engagement of public and government institutions with the RI.
- Consider findings and recommendations throughout the RI process and make plans for appropriate action and implementation in conjunction with the planning and action stages of the RI.
- Submit a report to be tabled in the Nova Scotia Legislature annually for three years from the start of the RI on government participation and action to report progress on advancing objectives/goals and impact of the RI.²⁵⁹

What might post-disaster inquiries look like when modelled on 'restorative justice'?

Following an emergency event those affected – people who have lost loved ones, property, economic activity, natural assets which carry an emotional attachment as well as responders and those thought responsible for the event (if anyone) – would after sufficient time, come together with a trained mediator/facilitator to hear each person's perspective on the event. 'The mediator's role is not to impose his or her interpretation or solution upon the parties..., but to encourage them to tell their stories, express their feelings, ask questions of each other, talk about the impact and implications ... and eventually come to an agreement ...'²⁶⁰ about what

²⁵⁷ Ibid 19.

²⁵⁸ Ibid 23.

²⁵⁹ Ibid 25.

²⁶⁰ Ibid.

happened, why and how it happened, how the community might respond differently in future and allocate and accept responsibility for future planning and preparation.

There would still be place for the Royal Commissioner or other formally appointed enquiry. Rather than 'hear' evidence and submissions, before 'handing down' findings and recommendations, the inquiry would collate reports from affected communities and collate them to report to government and agencies what those communities identified as causes of the tragedy and future solutions. We have previously argued that:

Royal commissions and special inquiries are 'omnibus' in nature; they are required to address multiple and diverse issues. These broad ranging inquiries can stretch the capacities of the inquiry commissioners and staff and make the reports long and cumbersome. Reviewing the nature, form, structure, and approach of independent reviews to revise procedures and address the complexity of the inquiry would allow faster, more effective peer, and collaborative learning.

Rather than appoint a commissioner or even a team of commissioners to review all aspects of an event, consideration should be given to establishing an independent inquiry panel, similar to the current royal commission model, supported by specialist panels to investigate issues that are raised by the particular event; for example issues of communications, inter-agency coordination, local government capacity, warning systems, land management, infrastructure management, policy and management failure, and the adequacy of the response, all of which are distinctly different issues requiring quite different forms of skills and investigative processes.

The overarching inquiry panel could undertake a rapid issues assessment calling on the community, experts, and agencies.

The restorative justice based community panels would feed into the overarching enquiry reporting on how communities perceived the event, the response and the implications for the future. Not all events are however, about relationships and competing priorities. Some are technical such as how the fire started; how buildings withstood the fire, wind or flood water; how or why communications failed and the like. For those matters, the

... broad survey, listening, and issue-identification process would be followed by referral of specific issues to a relevant specialist panel to undertake a detailed investigation. Witnesses with evidence relevant to a particular issue could give evidence before the specialist panel that would be managed by trusted professionals with expertise in the area, rather than by lawyers with their adversarial approach. A compilation and synthesis process would complete the whole exercise.

Although it is ideal to conduct an inquiry, focussed on learning lessons to reduce the risk of future tragedies, in a no-blame environment, it may appear that there is in fact culpability, that the event was caused by, or managed with, neglect or deliberate misfeasance. Should the preliminary rapid assessment identify such issues, or a reluctance to cooperate, then a relevant specialist panel with coercive powers could be empanelled. That panel could investigate that which witnesses do not wish to reveal, but could also afford the protection required by natural justice. Relevant witnesses before this panel would be aware that particular allegations are under investigation and those that are being investigated would be on notice, before the hearings began, of the findings of the preliminary inquiry, could respond to allegations of misconduct or misfeasance, and could be represented by counsel.²⁶¹

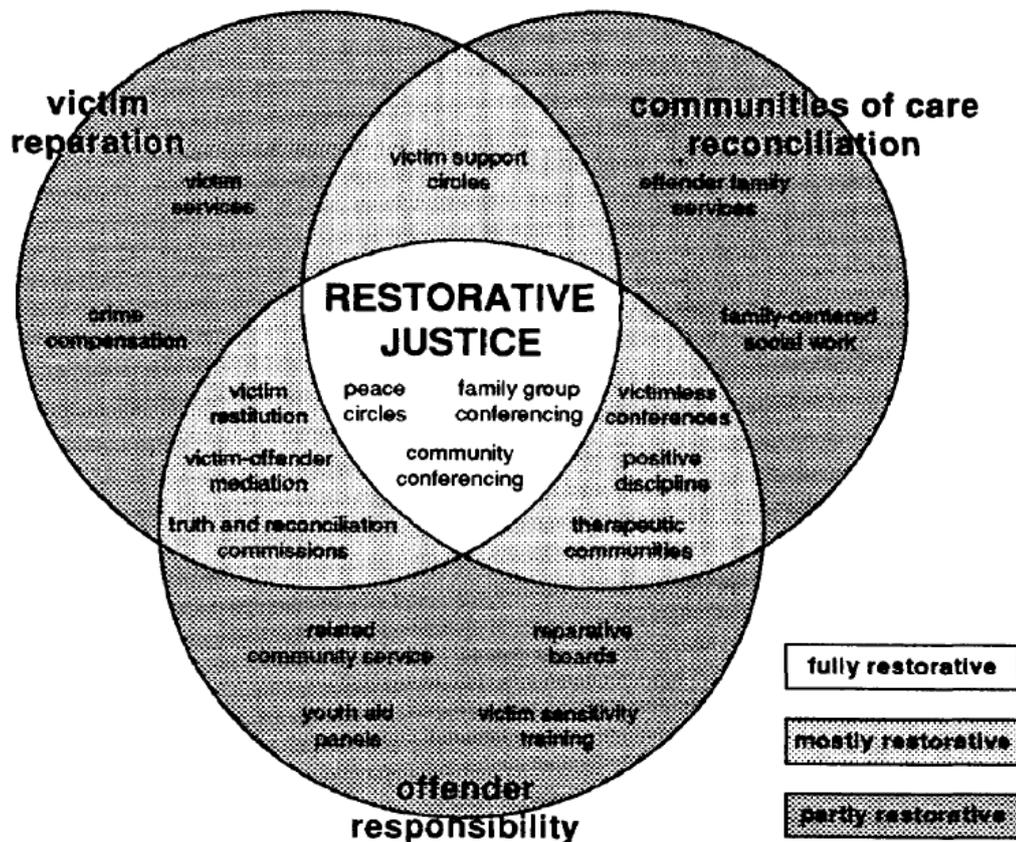
DRAFT - FOR DISCUSSION

²⁶¹ Eburn and Dovers, above n 101, 504.

VIII. COMPENSATION

Funding recovery is a significant part of disaster management. In Australia governments, and in particular, the Federal Government does provide funding to help states and territories to meet the costs of disaster recovery as well as providing immediate financial support to those affected by a disaster.²⁶²

McCold argues that the payment of reparations or compensation is 'partly restorative', as shown below:²⁶³



Given the restorative role of reparations it is appropriate to at least consider issues of compensation here even if these are not directly related to identifying lessons

²⁶² Attorney General's Department, *Natural Disaster Relief and Recovery Arrangements Determination 2012 v2.0* (Commonwealth of Australia, 2015); *Social Security Act 1991* (Cth) ss 1061KA-1061KE (Disaster Recovery Allowance) and ss 1061K- 1061PAAE (Australian Government Disaster Recovery Payment).

²⁶³ Paul McCold, 'Toward a Holistic Vision of Restorative Juvenile Justice: A Reply to the Maximalist Model' (2000) 3(4) *Contemporary Justice Review* 357-414, 401.

for future action. Failure to address issues of compensation will fail to redress losses caused by natural hazard events and, more importantly in the context of this report, will leave aggrieved persons to seek compensation before the courts with the return to adversarial proceedings and huge costs.

Following the 9/11 terrorist attacks on the United States the US government introduced a no fault compensation scheme that was open to everybody who was killed or injured. By agreeing to take part in the no-fault scheme people waived their right to sue. An attorney was appointed to manage the scheme and to assess the value of each person's claim based on the normal legal principles for the quantification of damages.²⁶⁴ Without going into the details of the scheme or how damages were calculated, it is apparent that the scheme was focused on the needs of those who had suffered loss and removed the need to spend time and millions of dollars to prove legal culpability or blame.

Compare the US response to the outcomes following recent Australian (albeit non-terrorist) disasters. Following the 2003 Canberra fires, it took nearly 10 years to resolve the complex litigation, in that case with claims against the ACT settling and the court finding that there was no legal liability on the part of New South Wales.²⁶⁵ In Victoria, following the 2009 'Black Saturday' fires there was class action litigation. The Kilmore/East Kinglake and Marysville class actions settled for \$494 million and \$300 million respectively.²⁶⁶ The litigation did not, however, determine how much each claimant would get. The terms of settlement provided for a complex scheme where individual claimants must now submit evidence of their losses, to be assessed by court appointed lawyers, who will determine the value of their claim. They will not get paid that amount but rather an amount that represents the 'proportion which his or her claim bears to the total value of all claims' and, in any event, the amount awarded will be limited to 80% of the

²⁶⁴ Kenneth R. Feinberg, *What is life worth? The unprecedented effort to compensate the victims of 9/11* (Public Affairs, New York, 2005).

²⁶⁵ *Electro Optic Systems Pty Ltd v The State of New South Wales; West & West v The State of New South Wales* [2012] ACTSC 184; *Electro Optic Systems Pty Ltd v State of New South Wales; West & Anor v State of New South Wales* [2014] ACTCA 45.

²⁶⁶ *Matthews v AusNet Electricity Services Pty Ltd & Ors* [2014] VSC 663; *Rowe v AusNet Electricity Services Pty Ltd & Ors* [2015] VSC 232.

assessed value of the claim.²⁶⁷ Further, all the costs of administering the scheme must be met before the compensation is paid.²⁶⁸

Apart from payment of damages, the defendants had to pay an amount toward the plaintiff's legal costs. The award for costs was \$60 million and \$20 million respectively. That does not include the legal costs incurred by the defendant companies and the State of Victoria. Apart from these legal costs, the State of Victoria spent a further \$40 million on the 2009 Victorian Bushfires Royal Commission. That figure does not include the costs of all the various parties that appeared before the Royal Commission so there is no doubt the total costs were much higher. It follows that these reported costs of \$120 million represent a very small percentage of the actual costs involved in both the Royal Commission and the litigation.

Given that it is insurance companies paying out the damages following Australia's bushfires have, through the collection of premiums wise investment and reinsurance, the means to meet their obligations then it must be time to consider some sort of no fault catastrophic compensation scheme and divert the money that is currently being spent on legal costs to improving community resilience.

One solution may be to use the settlement scheme adopted in Victoria as a model for future disasters. All insurers who are at risk eg those that offer household insurance, insurance for critical infrastructure and government insurers or self-insurers could contribute to a fund that can be used to pay out compensation following a significant disaster that meets a prescribed threshold in terms of losses or is a declared disaster for the purposes of the scheme. The scheme could be operated as an 'opt in' scheme, where people who opt in waive any right to sue but do get a guaranteed payment or a compulsory scheme so that in the event of a declared disaster this becomes the only available compensation and common law rights to sue in negligence are removed.

²⁶⁷ *Matthews v SPI Electricity Pty Ltd (SCI 2009 04788) "Kilmore Bushfire Class Action" Settlement Distribution Scheme, Overview, [C](iv)(c) and (d).*
<<<http://www.supremecourt.vic.gov.au/home/law+and+practice/class+actions/kilmore+east+kinglake+bushfire+class+action+settlement/settlement+distribution+scheme>>>

²⁶⁸ *Ibid, Overview, [C](vii).*

In a scheme such as this insurers may pay out in circumstances where liability could not be established but the cost and time savings would be significant and could justify that exposure. In the event of a declared terrorism incident, the Commonwealth Government, through the Australian Reinsurance Pool Corporation will compensate an insurance company for amounts paid to an insured for damages caused by the terrorism incident.²⁶⁹ A similar scheme could, if necessary, operate to provide cover for declared disaster events. Such a scheme would recognise that, by definition, a disaster occurs when the resources of the state that are normally sufficient to respond to a hazard are overwhelmed and the losses reflect not just the hazard but the choices that have been made on how resources have been allocated to disaster mitigation and response. It might also help communities to rebuild by creating a sense of shared responsibility for the losses. In 2011, following the Queensland floods, the Commonwealth government imposed a levy on most taxpayers in order to fund reconstruction in the affected areas. When introducing the *Tax Laws Amendment (Temporary Flood Reconstruction Levy) Bill 2011* (Cth) the Prime Minister Julia Gillard said:

As Australians, we stick together. United in mateship. United in our shared desire to help those in need. This bill formalises that desire to help. Beyond the legal and budgetary language, it simply says this:

You won't be alone. We will get through this together. We won't let go.²⁷⁰

Providing compensation for those affected by disasters, without having to spend 5-10 years in complex litigation at costs that run into the hundreds of millions of dollars would carry the same message.

It is beyond the scope of this report to consider the constitutional, legal and financial issues that would be involved in establishing such a scheme. Further such a scheme would be outside the field of identifying 'lessons learned' and post event inquiries. The issue is raised here because failure to address issues of funding recovery will also fail to address necessary issues for restorative justice.

²⁶⁹ *Terrorism Insurance Act 2003* (Cth) ss 6-8, 35 and 37.

²⁷⁰ Commonwealth, *Parliamentary Debates*, House of Representatives, 10 February 2011, 381 (Julia Gillard).

Accordingly the need to consider these issues is raised, but they will require further research.

DRAFT - FOR DISCUSSION

IX. A STANDING BODY TO CONDUCT FUTURE INQUIRIES?

The principle aim of this report has been to consider alternative models for post-event inquiries and, ultimately, to argue that inquiries should consider the use of restorative justice practices when reviewing the preparation for and response to natural hazard events.

Various suggestions have been considered but the report has not addressed 'who' should conduct the inquiries. As noted, inquiries such as a Special or Royal Commission, issued after the event are 'ad hoc' inquiry bodies. Coroners represent a standing authority to investigate fires and deaths but their jurisdiction is necessarily limited by the terms of the relevant legislation and by the demands on their time to investigate all manner of deaths. A focus on the cause' of a fire or death can limit the ability of the inquiry to take a holistic, all of government review of process and policy choices that may have contributed to a disaster.

Today the Bushfire and Natural Hazards CRC and before that, the Bushfires CRC, is leading the way with conducting immediate post hazard research on property losses and human behaviour before and during a hazard event.²⁷¹ The Australian Fire and Emergency Services Authorities Council (AFAC) is a key player in distributing reports and for sharing the lessons learned amongst relevant agencies.

The Inspector General for/of Emergency Management?

Both Victoria and Queensland have established an office of Inspector General for, or of, Emergency Management that have begun to take the lead in post event inquiries.²⁷² In Victoria, the Inspector General for Emergency Management is to monitor and review the emergency management agencies with a view to providing 'assurance to the Government and the community in respect of emergency management arrangements in Victoria'.²⁷³ As part of that process the Inspector

²⁷¹ See for example Lyndsey Wright (ed), Jim McLennan, Adrian Birch, Bronwyn Horsey and Trent Penman, *Community Understanding and Awareness of Bushfire Safety: October 2013 Bushfires* (Bushfire CRC, 2014).

²⁷² *Emergency Management Act 2013* (Vic) Part 7 and *Disaster Management Act 2003*(Qld) Part 1A.

²⁷³ *Emergency Management Act 2013* (Vic) ss 62 and 64.

General was asked to 'review aspects of planning for, and response to, the December 2015 Wye River – Jamieson Track fire'.²⁷⁴ The review led to the production of an interim and then final report but the findings of the IGEM were not without controversy²⁷⁵ and calls for a more independent inquiry, in particular from the United Firefighters Union ('UFU'):

In an eight-page submission to the coroner ... the union said it would be "inappropriate" for the inspector general to investigate because it was "not perceived as being independent" and did not have the power to compel witnesses, which it said made some firefighters feel they could not openly criticise the decision to burn around the fire.²⁷⁶

In another report:

The Inspector-General for Emergency Management is examining the fire, but Mr Marshall said that would not go far enough.

"It is clearly not appropriate for a government body to inquire into a fire for which government agencies may have some liability," he said.²⁷⁷

And '... the firefighters' union branded that [Inspector General for Emergency Management's interim] report ... a whitewash'.²⁷⁸

It may be that these calls from the UFU reflects industrial issues in the fire industry. It may be, too, that the Inspector General is, or is not yet, sufficiently independent of agencies to have the confidence of all stakeholders. That confidence could develop over time and with effective reviews and confidence by all stakeholders that the findings from reviews are acted upon and adopted.

A Fire and Emergency Safety Bureau?

In the discussion on Civil Aviation inquiries it was identified that the aviation industry engenders public trust because of:

²⁷⁴ Inspector General for Emergency Management, 'Evaluation and Review: Review of the 2015 Wye River – Jamison Track Fire' (16 March 2016) <<http://www.igem.vic.gov.au/home/our+work/reviews/> accessed 25 May 2016.

²⁷⁵ Melissa Meehan, '[Vic coroner to investigate Wye River fire](#)', *The Australian* (Online), 29 January 2016.

²⁷⁶ Calla Wahlquist, '[Firefighter union calls for coronial inquest into Wye River backburning](#)', *The Guardian* (Online), 19 January 2016

²⁷⁷ Richard Willingham, '[Wye River blaze: firefighters' union calls for inquiry](#)', *The Age* (Online), 14 January 2016.

²⁷⁸ Aisha Dow and Richard Willingham, '[State Coroner to investigate Wye River bushfire](#)', *The Age* (Online), January 29, 2016

- The aviation industry's safety culture;
- The independence of the investigating body;
- The quality of the investigation body;
- Treatment of those affected by accidents.²⁷⁹

It has been argued that the way current enquiries treat those affected by hazard events, in particular responders, does not engender trust.²⁸⁰ The suggestion that post event inquiries should adopt restorative justice practices is intended to build confidence by ensuring that all of those affected by both the disaster and the inquiry are treated with respect.

The question of the independence of the investigating body and the quality of the investigation body also need to be considered. The Australian Transport Safety Bureau is a standing body that has that well established reputation. A standing 'Fire and Emergency Safety Bureau' may be able, over time, to establish that same standing. This section will discuss the recommendation of establishing a Fire and Emergency Safety Authority to:

- 1) Conduct post event inquiries or
- 2) Where the scale and public interest in an event requires it, to act as a secretariat to an appointed ad hoc inquiry and
- 3) To act as a repository of 'lessons learned' reports and to make sure that information is shared across all jurisdiction and all agencies.

A standing institution to conduct inquiries

Appointing an ad hoc enquiry, such as a Royal Commission or a Special Inquiry, does require the members of the enquiry to quickly come to grips with the administrative requirements for establishing their inquiry as well as spending time learning the basics of the field that is the subject of their inquiry. When writing about her experiences as one of the 2009 Victorian Bushfires Royal Commissioners, Susan Pascoe said:

One of the challenges in establishing a short term organisation such as a royal commission is that the sporadic occurrence of such inquiries means that institutional memory is lost from one inquiry to the next, or difficult to locate within the bureaucracy.

²⁷⁹ Smart, above n 152.

²⁸⁰ Eburn and Dovers, above n 58; Eburn and Jackman, above n 58; Vivien Thomson, above n 142.

... Future royal commissions would benefit from a full record in a handbook of the services quickly and appropriately provided. For example we were provided with reading matter from the Department of Premier and Cabinet (DPC) on royal commissions; with expert architectural services on the design of the hearing rooms from the Department of Justice (DOJ); and with specific advice on the hiring of premises and on the design of the budget from the Department of Treasury and Finance (DTF). The rapid provision of these short term services was of great value in getting the VBRC speedily mobilised. Difficulties with swift formation have adversely affected the effective operations of many previous royal commissions and public inquiries at both state and Commonwealth levels. It highlights the need for initial central coordination for ad hoc inquiries.²⁸¹

A recommendation from the Australian Law Reform Commission's (ALRC) inquiry into Royal Commissions was that:

The Australian Government should develop and publish an Inquiries Handbook containing information for those responsible for establishing inquiries, inquiry members, inquiry participants and members of the general public on a range of matters relating to Royal Commissions and Official Inquiries...²⁸²

The ALRC also considered whether or not there should be a standing inquiry body to avoid the need for ad hoc enquiries. The Commission:

... noted that the advantages of a permanent inquiries body include the: potential saving of costs in setting up an inquiry; retention of institutional knowledge; and capacity to conduct preliminary research to determine whether a full inquiry is necessary. On the other hand ... there may not be a consistent or ongoing need for a standing body. Royal Commissions are established relatively infrequently, and maintaining a permanent inquiries body may be an inefficient use of resources. Further, it may be better to attract and appoint staff, and determine the administrative structure and powers of each inquiry, on an 'as needs' basis.²⁸³

The ALRC was considering Commonwealth inquiries that may be called on an infrequent basis to consider a myriad of issues. The infrequent use of these inquiries and their broad scope means it is neither practical nor efficient to maintain a standing body, but that may not be true when consideration is being given to specialised bodies that are likely to be frequently called upon. The Commission identified that there are standing agencies such as the Australian Commission for Law Enforcement Integrity, the Australian Transport Safety Bureau, the Inspector-General of Intelligence and Security and the Commonwealth

²⁸¹ Pascoe, above n 37, 394-395.

²⁸² Australian Law Reform Commission, *Making Inquiries: A New Statutory Framework*, Report 111 (2009) Recommendation 6-1, p 121.

²⁸³ Ibid [5.30].

Ombudsman and that these should continue to conduct investigations into areas of their specialised knowledge and responsibility.²⁸⁴

Rail accidents may not seem related to fires, floods and other natural hazards but even so there may be an analogy. Train travel is a frequent part of Australian life and accidents although rare, are probably inevitable. Contributing to rail safety are the actions of agencies limited by budget and the need to provide on time rail services. Following a fatal train accident at Glenbrook, in the Blue Mountains outside of Sydney, the Special Commission of Inquiry headed by Acting Justice Peter McInerney QC recommended the establishment of ‘a separate and independent Rail Safety Inspectorate and a separate and independent Rail Accident Investigation Board’.²⁸⁵ The Rail Accident Investigation Board would report directly to Parliament, not to the relevant department or Minister,²⁸⁶ and would be funded by government,²⁸⁷ not by the commercial interests involved in the rail industry. The Board would also be separate from the regulator and the Safety Inspectorate in the same way that today, Australian Transport Safety Bureau is separate from the Civil Aviation Safety Authority. In an inquiry into a subsequent train accident McInerney noted that his recommendations had not been adopted.²⁸⁸ Even so, we shall return to McInerney’s recommendations, below.

Given that fires and other natural hazards are an inevitable part of living in Australia²⁸⁹ and losses will occur, it is inevitable that the Australian community will want to continue to review hazard events and identify lessons for future action. The concerns of the ALRC, that a standing body would have ‘significant periods during which no ... major public inquiry is taking place’ is unlikely to be true for a Fire and Emergency Safety Bureau. A bureau that is legally separate from the industry and regulators, like the ATSB and McInerney’s recommended

²⁸⁴ Ibid [5.51].

²⁸⁵ New South Wales, Special Commission of Inquiry into the Glenbrook Rail Accident, *Second Interim Report* (2000) 47.

²⁸⁶ Ibid, 52

²⁸⁷ New South Wales, Special Commission of Inquiry into the Glenbrook Rail Accident, *Final Report* (2001) 178.

²⁸⁸ Ibid, 204. Today investigation into rail accidents is conducted by the Australian Transport Safety Bureau <https://www.atsb.gov.au/rail/> (23 July 2015), accessed 7 July 2016.

²⁸⁹ Crossweller, above n 1.

'Rail Accident Investigation Board' could conduct investigations that, where necessary, could look at the actions, policy and contributions of the community, government, business and agencies.

There would still be a role for an agency such as the Inspector General for Emergency Management. McInerney recommended both a Rail Safety Inspectorate and a Rail Accident Investigation Board. The Rail Safety Inspectorate would 'follow up on any recommendations that have been made to ensure that the operator, or operators, have put systems in place for controlling any risk that may be identified'.²⁹⁰ It would '... monitor and ensure compliance ... with recommendations made by the Rail Accident Investigation Board... [and] monitor whether any accredited organisation or organisations are properly discharging their safety responsibilities ...'²⁹¹

Undertaking that sort of review and follow up is consistent with the current legislation governing the Inspectors General. In Victoria the Inspector General is, inter alia, to 'develop and maintain a monitoring and assurance framework for emergency management'.²⁹² In Queensland the Inspector General is to, inter alia, 'review, assess and report on performance by entities responsible for disaster management...' and 'monitor compliance by departments with their disaster management responsibilities'. It would be very appropriate for the Inspectors General to follow up on an inquiry by the Fire and Emergency Safety Bureau but that does not mean they should conduct the post event inquiries. First their mandate is limited to agencies of the state and those with responsibilities under emergency management legislation and plans, which could mean that their power to investigate other contributors, including their own role, would be missed. As McInerney QC said when recommending a rail safety inspectorate separate from the investigation board:

The Rail Safety Inspectorate should be an operational organisation which accredits and monitors safety on an ongoing basis. The [Investigation] Board should be responsible for accident investigation and be a specialist investigatory body. Its investigations would provide a check or balance which would demonstrate whether

²⁹⁰ New South Wales, above n 285, 52.

²⁹¹ New South Wales, above n 287, 173-174.

²⁹² *Emergency Management Act 2013* (Vic) s 64(1)(a).

the Rail Safety Inspectorate is performing its functions properly ...²⁹³

A separate Fire and Emergency Safety Bureau could play the same role vis-à-vis the Inspectors-General for/of Emergency Management.

Further, with respect to the proposed Rail Accident Investigation Board McInerney recommended that the '... Board should not be involved in investigating every accident or incident ...'. In the context of railways it was recognised that rail operators and the regulator would investigate accidents and 'near misses'. In the same way there is no doubt that fire and emergency services, including the Inspectors-General for/of Emergency management will continue to review their performance after each event. Accordingly the Fire and Emergency Safety Bureau should have the power to supervise an agency investigation and to give directions or to undertake its own investigation as it sees fit.²⁹⁴

A standing secretariat

Even if an office such as a Fire and Emergency Safety Bureau or the Inspectors-General can establish itself as an effective investigator for single events, for state wide, catastrophic events there may still be room, and a need, for an 'independent inquiry panel'. As noted, above,²⁹⁵

One of the challenges in establishing a short term organisation such as a royal commission is that the sporadic occurrence of such inquiries means that institutional memory is lost from one inquiry to the next, or difficult to locate within the bureaucracy.²⁹⁶

One way to avoid that is to have a standing secretariat. In that case when an inquiry was called, an appropriate chair with sufficient skill and independence could be appointed but he or she would be supported by the secretariat. The ALRC saw merit 'in formalising arrangements for the establishment and administrative support of Royal Commissions and other ad hoc public inquiries.'²⁹⁷

The Commission recognised that a permanent administrative body can help deal with:

²⁹³ New South Wales, above n 285, 52.
²⁹⁴ New South Wales, above n 287, 177.
²⁹⁵ See p 75, above.
²⁹⁶ Pascoe, above n 37, 394-395.
²⁹⁷ Ibid [5.50].

- the need to retain institutional knowledge in relation to the administration of inquiries to ensure that inquiries can be established rapidly and conducted efficiently and effectively;
- the need for inquiries to access to appropriately skilled personnel to provide administrative and technical assistance; and
- the need for inquiries to have flexibility and control over their own administration to ensure their independent operation.²⁹⁸

Even so the Commission did not support the creation of standing secretariat noting that ‘there are often significant periods during which no Royal Commission or other major public inquiry is taking place. In the ALRC’s view, having regard to recent trends, there is unlikely to be a consistent and continuing need for a permanent administrative body to support inquiries’.²⁹⁹ Again, it should be recalled that the ALRC was considering Commonwealth inquiries that may be called on an infrequent basis to consider a myriad of issues. The frequency of natural hazard events means that this is not likely to be the case with a standing body that can serve the other purposes suggested here.

The specific focus of an agency such as the proposed Fire and Emergency Safety Bureau would mean that staff could develop relevant ‘institutional knowledge’ that could be applied to the next inquiry. This is unlike a body that might be called upon to support Royal Commissions where the subject of one Commission may bear no relationship to the last. It follows that if the reasons behind the Commission’s reluctance to recommend a standing inquiry body do not apply in the field of post event natural hazards, a standing institution – a Fire and Emergency Safety Bureau – could prove a useful facility to support inquiries, even if it was not charged with actually conducting the inquiry.

On this model there various levels of inquiries. For limited impact, ‘near miss’ events and events that only impact upon agencies, an agency internal review, supervised by the Bureau may be sufficient. For larger events the centre would conduct its own inquiries and for significant events the matter could be stepped up to a Special Commission or Royal Commission supported by the Fire and Emergency Safety Bureau.

²⁹⁸ Ibid [8.32].

²⁹⁹ Ibid [8.31].

Again, what is being suggested is not unprecedented. The Australian Law Reform Commission recommended that

... the Royal Commissions Act should be amended to provide for the establishment of two tiers of public inquiry... Royal Commissions should be the highest form of inquiry established to look into matters of substantial public importance... It is recommended that the second tier of inquiry be called 'Official Inquiries'. Such inquiries should be established by a minister to look into matters of public importance.

Whilst the Commonwealth has not acted on those recommendations, the State of Victoria has. The *Inquiries Act 2014* (Vic) provides for the establishment of a Royal Commission,³⁰⁰ a Board of Inquiry³⁰¹ or a Formal Review.³⁰² The significant difference between a Royal Commission and a Board of Inquiry is that before a Royal Commission, a witness cannot rely on legal professional privilege, the privilege against self-incrimination or any statutory duty to avoid answering questions or producing required documents.³⁰³

A centre to share lessons learned

A Fire and Emergency Safety Bureau could also serve as a clearing house for post event inquiries. In that regard a centre may serve as a repository for the official reports and also as a centre charged with making the identified learning available to agencies. Such a centre could assist agencies to incorporate learning and also collate data on if and how recommendations are implemented and identify further learning from that process. McInerney, when recommending the establishment of a Rail Accident Investigation Board said that:

It should be part of the ongoing functions of the Rail Accident Investigation Board to collect, analyse and report on data in relation to rail safety matters not only from New South Wales but also from interstate and overseas. The Board should have the power to distribute the information thereby obtained to the Department of Transport, the Rail Safety Inspectorate and any accredited organisation.

In addition to its accident and incident investigation function, the Rail Accident Investigation Board should:

- (i) Maintain a no fault incident and near miss reporting system for the entire

³⁰⁰ *Inquiries Act 2014* (Vic) Part 2.

³⁰¹ *Ibid*, Part 3.

³⁰² *Ibid*, Part 4.

³⁰³ *Ibid*, ss 32-34.

rail industry.

- (ii) Monitor rail accident investigations throughout the world, maintaining a library of such investigation reports.
- (iii) Maintain the incident database currently compiled by the Transport Safety Bureau, and report annually on the safety performance of accredited organisations to Parliament.³⁰⁴

A Fire and Emergency Safety Bureau could take a similar role. There are examples of lessons learned centres that could provide useful comparators. The Australian Civil-Military Centre:

... is responsible for the management of whole-of-government lessons learned from civil-military-police coordination in conflicts and natural disasters overseas. The Lessons Program focuses on the inter-agency level of decision making and coordination...

Our objective is to deliver a coordinated and collaborative approach to civil-military-police lessons management across Australian government agencies, supported by a methodology for design, monitoring, evaluation, dissemination and implementation.³⁰⁵

In the United States the Center for Army Lessons Learned 'identifies, collects, analyzes, disseminates, and archives lessons and best practices... in order to share knowledge and facilitate the Army's and Unified Action Partners' adaptation to win wars'.³⁰⁶

Also in the United States, the Wildland Fire Lessons Learned Centre was established as 'a safety-oriented Center for Lessons Learned' to 'collect and disseminate sanitized incident accounts to increase organizational safety learning'.³⁰⁷ The objective was to assist the five federal fire agencies to 'obtain a clear quantitative picture of the pattern of safety incidents, their causes, trends, and the lessons learned; and to identify potential problems at the earliest.'³⁰⁸

³⁰⁴ New South Wales, above n **Error! Bookmark not defined.**

³⁰⁵ <https://www.acmc.gov.au/lessons-learned/>, accessed 21 June 2016.

³⁰⁶ <http://usacac.army.mil/organizations/mccoe/call>, accessed 21 June 2016.

³⁰⁷ TriData, 'Wildland Firefighter Safety Awareness Study' (1996) Phase III, p. 19-20.

³⁰⁸ Ibid, 29.

Moving forward

It is unlikely that any jurisdiction, or the Commonwealth, will simply set up a Fire and Emergency Safety Bureau to work as suggested here. Developing this would require time to determine if the benefits actually exist. It may be that an organisation such as AFAC, the Australian Institute for Disaster Resilience or the Bushfire and Natural Hazards CRC could take the lead to develop a 'prototype' to test the effectiveness of such an agency.

AFAC members for example, could establish a separate body corporate to act as the first Fire and Emergency Safety Bureau. Independent of AFAC with its own board it could begin as a clearing house to report on lessons identified by agencies and researchers. Providing a central portal for information to be released to the emergency management community and the community generally, could be a first step to facilitate learning and to build a reputation for independence, honesty and an industry commitment to sharing information – good and bad – and so establish a reputation for the 'industry's safety culture'.³⁰⁹

In due course it could engage with restorative justice practitioners to assist agencies to conduct post event reviews and lower level inquiries, the equivalent of the Victorian 'Formal Review' or 'Board of Inquiry'. If agencies, the community and the government saw value in the product governments may then be prepared to legislate to ensure the Board's independence and to provide that the Board could compel witnesses (where necessary), that witnesses would be protected from any form of retaliation and that evidence given before any inquiry could not be used in subsequent legal proceedings.

Passing the necessary legislation to establish a Board and to make relevant amendments to evidence law would be within the jurisdictional competence of each state and territory. One advantage of the Australian federation is that the States and Territories can serve as experimental laboratories, so one state could create such an institution and then other states could follow if satisfied that the Centre is making a useful contribution.

³⁰⁹ Smart, above n. 152.

If a Board were to operate nationally such legislation would need to be either Commonwealth legislation or passed in a cooperative way by the State and Territory jurisdictions. The Commonwealth may have difficulty having laws that would make it mandatory for agencies and others to implement recommendations of any such investigation body, as the Commonwealth does not have specific powers in the area of emergency or disaster management.³¹⁰ Even so the Commonwealth would have the power to establish a body that could ‘ask questions’³¹¹ about an event, how it occurred, what contributed to it and its ultimate impact and how might others learn from it.³¹²

³¹⁰ *Australian Constitution*, s 51.

³¹¹ Nicholas Aroney, ‘The Constitutional First Principles of Royal Commissions’ in Scott Prasser and Helen Tracey *Royal Commissions & Public Inquiries: Practice and Potential* (Connor Court, 2014) 23-35, 25.

³¹² *Australian Constitution*, s 61. *Victoria v Commonwealth* (1975) 134 CLR 338, 397 (Mason J), 412-3 (Jacobs J), 424 (Murphy J).

X. CONCLUSION AND RECOMMENDATIONS

This review of post event inquiries has argued that there is no simple solution on how best to learn from natural hazards. The systems we have, and those we might have, bring their own merits and demerits. In making the recommendations here the key objective is to suggest a system that will ensure:

- The emergency management industry's safety culture;
- The independence of the investigating body;
- The quality of the investigation body; and
- The appropriate treatment of *all* those affected by disasters.³¹³

It is the principle recommendation of this report that agencies and governments give consideration to adopting restorative justice practices into post event inquiries to allow the process to serve as 'process whereby all the parties ... come together to resolve collectively how to deal with the aftermath of the [event] and its implications for the future' and to restore community relationships.

As a corollary to the focus on restorative justice, consideration needs to be given to compensation to those affected by natural hazard events. Although not fully explored here, it is suggested that consideration should be given to establishing a no fault catastrophic compensation scheme based perhaps on the scheme adopted in the United States following the 9/11 terrorist attacks and the compensation arrangements agreed to as part of the settlement of the Black Saturday bushfire class actions.

Finally it was suggested that there should be a *Fire and Emergency Safety Bureau* to:

- Conduct lower level inquiries;
- Act as a standing secretariat to higher level, ad hoc inquiries and to
- Act as a clearing house to share lessons learned.

To advance this experiment we suggest that one jurisdiction or an agency such as AFAC, the Australian Institute for Disaster Resilience or the Bushfire and Natural

³¹³ Ibid.

Hazards CRC should take a lead role to establish the *Fire and Emergency Safety Bureau*. The *Bureau* would:

1. Work with agencies to establish a position as a clearing house for sharing lessons learned by agencies in a manner akin to the US Wildland Fire Lessons Learned Centre.
2. Work with governments and agencies and, if possible, ad hoc inquiries, to introduce restorative justice practices into post event inquiries.
3. In due course the Centre could take the lead in conducting post event inquiries, taking a role akin to the Australian Air Transport Safety Bureau and would work to establish a reputation:
 - a. for a commitment to developing the industry's safety culture;
 - b. as an independent investigating body;
 - c. For ensuring high quality investigations; and
 - d. For ensuring fair treatment of those affected by incident.
4. Inquiries conducted by the *Fire and Emergency Safety Bureau* would be based on the principles of restorative justice and be facilitated by restorative justice practitioners.
5. In due course, and once the *Bureau's* reputation in conducting incident investigations is established, the Centre and the industry would work with Parliament to expand its remit to larger events which would, in due course, require legislative amendment to provide legal protection to witnesses so that statements made during an inquiry could not be used in evidence in other proceedings.

DRAFT - FOR DISCUSSION

Appendix 1: Inquiries included in this review (by year).

1. Stretton, L. (1939). *Report of the Royal Commission to Inquire into the Causes of and Measures Taken to Prevent the Bush Fires of January, 1939, and to Protect Life and Property, and the Measures Taken to Prevent Bush Fires in Victoria and Protect Life and Property in the Event of Future Bush Fires* (Victoria).
2. Stretton, L. (1944). *Report of the Royal Commission to Inquire into the Place of Origin and the Causes of the Fires which Commenced at Yallourn on the 14th of February, 1944 : the Adequacy of the Measures which had been taken to Prevent Damage and the Measures to be taken to Protect the Undertaking and Township at Yallourn* (Victoria).
3. Rodger, G.J. (1961). *Royal Commission appointed to enquire into and report upon the bush fires of December, 1960 and January, February and March, 1961 in Western Australia. The measures necessary or desirable to prevent and control such fires and to protect life and property.* (Western Australia).
4. Barber, E. (1977). *Report of the Board of Inquiry into the Occurrence of Bush and Grass Fires in Victoria.* (Victoria).
5. Miller, S.I et al. (1984). *Report of the Bushfire Review Committee on bushfire preparedness in Victoria, Australia, following the Ash Wednesday fires 16 February 1983.* (Victoria).
6. Milton, P. (Chair), (1984). *House of Representatives Standing Committee on Environment and Conservation, Report: Bushfires and the Australian Environment* (Commonwealth).
7. Hiatt, J.W. (Coroner), (1996) *Inquiry into the cause and origin of the bushfires occurring in New South Wales between 31st December, 1993 and 14th January, 1994 and Inquests into the manner and cause of death of Norman John Anthes, Robert Eglinton Page, William John Roach and Pauline Mary O'Neil.* (New South Wales).
8. NSW Audit Office (1998) *Performance Audit Report: Rural Fire Service - The Coordination of Bushfire Fighting Activities.* (New South Wales).
9. Jones, R. (Chair), (2000). *NSW Legislative Council, General Purpose Standing Committee No 5: Report on Inquiry into the NSW Rural Fire Service.* (New South Wales).
10. Stevenson, J. (Coroner), (2001). *Inquest into the Deaths of Mark Douglas Cupit, Claire Wynne Dean, George Allan Fitzsimmons and Eric Furlan and Inquiry into fire at Mt Kuring-Gai National Park.* (New South Wales).
11. Johnstone, G. (Coroner), (2002). *Report of the Investigation and Inquests into a Wildfire and the Deaths of Five Firefighters at Linton on 2 December 1998.* (Victoria).
12. Price, J. (Chair) (2002). *Joint Select Committee on Bushfires: Report on the Inquiry into the 2001/2002 Bushfires.* (New South Wales).
13. Cameron, J.W. (Auditor General), (2003). *Fire prevention and preparedness.* (Victoria).
14. Esplin, B. (Chair), (2003). *Report of the Inquiry into the 2002-2003 Victorian Bushfires.* (Victoria).
15. McLeod, R. (2003). *Inquiry into the Operational Response to the January 2003 Bushfires in the ACT.* (Australian Capital Territory).
16. Nairn, G. (Chair), (2003). *A Nation Charred: Report on the inquiry into bushfires.* (House of Representatives Select Committee into the recent Australian bushfires, Commonwealth).

17. Pearson, D.D.R. (Auditor-General), (2004). *Performance Examination: Responding to Major Bushfires*. (Western Australia).
18. Brown, M. (Chair) (2004). *Legislative Assembly Public Accounts Committee: Review of Fire Services Funding*. (New South Wales).
19. Ellis, S. et al. (2004). *National Inquiry on Bushfire Mitigation and Management*. (Council of Australian Governments).
20. Hope, A.N. (Coroner), (2005). *Inquest into the death of Judith Lesley Ward and Lorraine Melia ('Albany fires')*. (Western Australia).
21. Emergency Services Commissioner (2005). *Examination of Prescribed Burning Practices*. (Victoria).
22. Breuer, L (Presiding Member), (2005). *Parliament of South Australia, Environment, Resources and Development Committee: Eyre Peninsula Bushfire and Native Vegetation*. (South Australia).
23. Doogan, M. (Coroner), (2006). *Inquests and Inquiry into Four Deaths and Four Fires between 8 and 18 January 2003*. (Australian Capital Territory).
24. 2007, Monterola, V. (Chair), (2007). *Ministerial Review of Bushfire Management in South Australia*. (South Australia).
25. Poole, G. (Auditor-General), (2008). *Management of Rural Fire Services in Queensland*. (Queensland).
26. 2008, Coroner Schapel, A.E. (Coroner) (2008). *Inquest into the Deaths of Star Ellen Borlase, Jack Morley Borlase, Helen Kald Castle, Judith Maud Griffith, Jody Maria Kay, Graham Joseph Russell, Zoe Russell-Kay, Trent Alan Murnane And Neil George Richardson ('Wangary fires')*. (South Australia).
27. Pandazopoulos, J. (Chair), (2008). *Parliament of Victoria, Environment and Natural Resources Committee: Inquiry into the Impact of Public Land Management Practices on Bushfires in Victoria*. (Victoria).
28. Fire and Emergency Service Authority of Western Australia (2009). *Post Incident Analysis: Bridgetown Complex Fire 23 (Peninsula), Fire 24 (Hester), Fire 26 (Ferndale), Thursday January 15th 2009 to Tuesday January 20th 2009*. (Western Australia).
29. Hope, A.N. (Coroner), (2009). *Inquest into the deaths of Trevor George Murley, Lewis Kenneth Bedford and Robert Wayne Taylor ('Boorabin fires')*. (Western Australia).
30. Department of Premier and Cabinet (2009). *Review of Western Australia's bushfire preparedness*. (Western Australia).
31. Teague, B et al. (2009). *2009 Victorian Bushfires Royal Commission: Interim Report 1*. (Victoria)
32. Teague, B et al. (2009). *2009 Victorian Bushfires Royal Commission: Interim Report 2*. (Victoria)
33. 2010, Ferguson, E. (2010). *A Review of the Ability of the Department of Environment and Conservation Western Australia to Manage Major Fires*. (Western Australia).
34. Noetic Solutions Pty Limited (2010). *Major Incident Review of Toodyay Fire December 2009* (Western Australia).
35. 2010, Heffernan, B. (Chair) (2010). *Senate Select Committee on Agricultural and Related Industries: The incidence and severity of bushfires across Australia*. (Commonwealth).
36. Teague, B et al. (2010). *2009 Victorian Bushfires Royal Commission: Final Report*. (Victoria)
37. Noetic Solutions Pty Limited (2011). *Post Incident Analysis for Blackwood Fire 11 – Milyeannup-Sollya, 23 November to 5 December 2011*. (Western Australia).

38. 2011, Blake H.M (Auditor-General), (2011). *Special Report No. 99: Bushfire Management*. (Tasmania).
39. Ellis, S. (2011). *Major Incident Review: Lake Clifton, Red Hill and Roleystone Fires June 2011*. (Western Australia).
40. Emergency Services Commissioner (2011). *Review of the Tostaree Fire*. (Victoria).
41. 2011, Fire Services Commissioner (2011). *Review of Community Bushfire Warnings*. (Victoria).
42. Keelty M.J. (2011). *Shared Responsibility: The Report of the Perth Hills Bushfire February 2011 Review*. (Western Australia).
43. Key, S. (Presiding Member), (2011). *Natural Resources Committee Bushfire Inquiry Final Report*. (South Australia).
44. Wendt, W. (Chair), (2011). *Public Accounts and Public Works Committee: Management of Rural Fire Services in Queensland*. (Queensland).
45. O’Gorman, A.P. (Chair), (2011). *Community Development and Justice Standing Committee: Western Australia’s Readiness for the 2011-12 Bushfire Season* (Western Australia).
46. Eldridge, L. (2012). *Review of the Operations of Bushfires NT*. (Northern Territory).
47. Noetic Solutions Pty Limited, (2012). *Post Incident Analysis for Blackwood Fire 8 – Ellensbrook- Gnarabup, 23/24 November 2011*. (Western Australia).
48. Keelty, M.J. (2012). *Appreciating the Risk: Report of the Special Inquiry into the November 2011 Margaret River Bushfire*. (Western Australia).
49. Cooper, M. (Auditor General) (2013). *Performance Audit Report: Bushfire Preparedness*. (Australian Capital Territory).
50. Hyde, M. (2013). *2013 Tasmanian Bushfires Inquiry*. (Tasmania).
51. Malone, T. (2013). *The Malone Review into Rural Fire Services in Queensland 2013*. (Queensland).

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