Submission No 37

INQUIRY INTO CORONIAL JURISDICTION IN NEW SOUTH WALES

Organisation: Independent Bushfire Group

Date Received: 21 July 2021

INDEPENDENTBUSHFIREGROUP

Submission to the Select Committee Inquiry into Coronial Jurisdiction in NSW

by the Independent Bushfire Group

The Independent Bushfire Group (IBG) welcomes the opportunity to provide suggestions to the Select Committee.

The Independent Bushfire Group is a voluntary collaboration of 12 bushfire practitioners with a collective experience base of 450 years. We formed the IBG following the 2019/2020 bushfires and then prepared detailed submissions to both major fire inquiries: the *Royal Commission Into National Natural Disaster Arrangements* and the *NSW Independent Bushfire Inquiry*. Several of our members have, in the past, appeared in the Coroner's Court in our capacity as Incident Controllers and Deputy Incident Controllers of major bushfire emergencies.

Our submission draws upon our experiences in this regard and makes some suggestions for changes in approach by the Coroner, relating to major bushfire events. Major fire events will continue to occur in NSW and, with a warming climate, the frequency and severity of these is highly likely to increase. This being the case, the Coroner can anticipate an increase in workload.

IBG suggestions, in relation to points (i) – (iv) of the terms of reference as they relate to bushfires, are:

1. There is a need to **reform the process** used to identify and act on **learnings from bushfire events**. Coronial inquiries into bushfires often do not conclude until several years after the event, but damaging fires can happen every year. The findings from the most recent bushfire coronial, into the "Sir Ivan Doherty Drive Leadville Fire" of February 2017, was released on 30 October 2019, two years and eight months after the event. Yet this report held important lessons for the disastrous 2019-2020 Black Summer bushfires that were well underway by then. The first deaths had already occurred. It would not have been feasible to fully incorporate the Sir Ivan coronial findings into the bushfire operations of Black Summer. The same situation occurred with the coronial inquiry into the Wambelong fire, which occurred in January 2013 with the coronial findings handed down two years and nine months later in October 2015.

   This is not to discount the enormous **value of coronial inquiries**, but to point to the shortcomings of the overall system of review; bushfire agencies' management of lessons learned, and inquiry processes into bushfires. When fires cause loss of life and property damage, agencies typically defer to expected or planned coronials and so do not to undertake their own comprehensive investigations. They also avoid any public information or comment. When that happens, no findings or learnings are delivered to the public or the firefighting community until the coronial inquiry is completed. With all due respect, agencies doing their own investigation is not best practice, and nor are the police best placed to inquire into complex and technical operational matters. Independent bushfire expertise is required.

   The **highest purpose** of a bushfire review system should be to **identify and act on lessons learned** in as timely a fashion as possible, and to explain events to the public. To achieve this, it is suggested that agencies should be encouraged, *by the Coroner*, to commission their own

analyses, preferably independent, which then become advice to the Coroner in any inquiry. A summary of findings should also be **released publicly** (recognising the need for specific confidentialities). Agency-commissioned analysis should be focused on issues and systems and should be comprehensive, independent and blame free.

Several of the following points relate to specific aspects of this issue.

2. **After Action Reviews** should occur soon after each significant fire incident. This does not always happen in an open, inclusive and independent way, or at all levels of an operation. The process needs to be well facilitated so that there can be an honest analysis of what worked well, why it worked and the lessons to be adopted for future similar scenarios. More importantly, what did not work as planned should be identified, along with how this learning can lead to a situation where the same or similar strategies are not repeated in future incidents. The lessons learnt from such processes should inform the incident controller's report and feed up to higher level reviews. In most cases this report and documents from any other review will be tendered to the Coroner prior to the commencement of an inquiry.

3. Coronial inquiries may deliver lessons identified, but this is not the same as **lessons learned and acted upon**. There needs to be a formal mechanism, **Action Statement**, for agencies to report on their progress in implementing the findings/recommendations set out by the Coroner. This should be undertaken regularly (half yearly), be independently audited, publicly available and perhaps tabled in parliament.

4. The Coroner could focus more on the **lessons learned** aspects with a view to encouraging improvement in emergency management. This needs to be blame free and less adversarial. Ideally the court should facilitate an **open and frank discussion** rather than relying on the formal ways that traditionally have occurred where a barrister will manage the flow of information from the witness. This is really important because firefighting is not a precise action but based on judgement, the science of fire behaviour, the weather window and the availability of suitable resources. It is rare that everything will go according to plan.

5. The **timing of Coronial Inquiries** is often a problem. At times it may be more than two years before the Inquiry into a bushfire commences and it could be another year or more before the process concludes and the Coroner hands down findings and recommendations. If resourcing is inadequate then this deserves to be reviewed in the interests of timeliness. Given bushfires are an annual occurrence, the significant operational gains from the coronial recommendations could be lost or outdated by the time they are handed down. Bushfire lessons need to be identified and acted upon in a timely manner, especially in NSW where the same issues from one fire season can arise less than six months later and the stakes for life, property and the environment are so high.

6. Given the format of Coronial Inquiries and the lengthy delays that occur, we suggest a **standard template** is needed that is agreed between the Coroner and all fire agencies. This would mean that the Coroner would receive reports that meet the court's needs, contain sufficient detail and importantly have a significant emphasis on the lessons that were learned from the incident.

7. Establishing the position of an independent **Inspector General of Emergency Management** as seen in Queensland and Victoria would be of enormous value. This would enable an independent review without fire agencies self-evaluating after incidents. This level of independent analysis can ensure that all relevant pieces of information are available for consideration by the court. This would complement the work of the police who at times possess very limited understanding and appreciation of the complexities of fire management and in particular post fire review.

8. Except in a case of arson, coronial inquiries into bushfires rarely relate to other indictable offences. Therefore, it is unfortunate that government agencies and the police often adopt in-principle opposition to the **public release of any information** or documents that can be construed as relevant to a coronial investigation, even if it is not particularly significant to the inquiry and irrespective of any public interest consideration. Non-release seems to be a default position. IBG has experience of this situation and believes that the justification of a coronial investigation is often used to prevent or delay the release of potentially awkward information, rather than for legitimate legal reasons. We recognise that legal reasons sometimes do apply, but there needs to be independent oversight of what information can be released and that which should not be released.

   We proffer that the public interest is best served by maximum transparency, and empowering **public discourse** on issues which are important to communities. In the case of bushfire, traumatised communities and firefighters are often kept 'in the dark' until coronial findings are delivered. We believe this is unacceptable.

   We submit that the coroner and investigating police should adopt and actively apply the **GIPA Act principle** that "*There is a presumption in favour of the disclosure of government information unless there is an overriding public interest against disclosure*." This connects with several of our points above about how After Action Reviews should be utilised. The Australian Institute for Disaster Resilience (AIDR), a Commonwealth Government body, has produced the *Lessons Management Handbook* (2019) and rightly addresses concerns about potential legal processes such as coronials, inquiries and litigation. The AIDR counsels that legal issues should **not stand in the way of lessons management**. "*Those involved in the lessons process should, generally, not be concerned how the material may be used in legal proceedings… during the debrief or lesson identification process, one cannot know in advance if the material might be relevant to any subsequent proceedings. As a lessons' manager, your role is focused on identifying the lessons that can be learned for future application – you are not responsible for speculating or determining potential liability arising from a particular incident*." (AIDR 2019, p37).

   Thank you for considering this submission, and we are available for further consultation.

   Yours sincerely.

Ian Brown
Secretary
Independent Bushfire Group

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