



ACT Government Solicitor

**INQUEST INTO THE DEATHS OF DOROTHY MCGRATH, ALISON MARY
TENER, PETER BRABAZON BROOKE AND DOUGLAS JOHN FRASER
AND
INQUIRY INTO THE ACT FIRES OF JANUARY 2003**

**SUBMISSIONS ON BEHALF OF THE AUSTRALIAN CAPITAL
TERRITORY**

The submissions of counsel assisting to which this submission is a response, have urged the Coroner to make findings assigning responsibility for such shortcomings to a small number of senior ESB officials. They have also sought to argue that these shortcomings were a cause of the fires which impacted on the urban edge of Canberra on 18 January 2003.

It is the position of the ACT that it is wrong in principle and unfair in the context of the events which occurred in January 2003 to isolate the actions of a limited number of individuals and make findings of blame against them. That error is compounded if the proposed findings of causation are made.

Despite the course of these proceedings, the Coroner should not overlook the contributions of a large number of ACT employees and volunteers whose significant efforts during January 2003 have not been properly acknowledged.

Immediately after the events of 18 January, the Chief Minister publicly expressed support for "each and every member of the Emergency Service Bureau, ... every member of our fire service, our police service, our volunteers, our rural service, all those NSW officers that were part and parcel of the defence of Canberra."

In his report *Inquiry into the Operational Response to the January 2003 Bushfires in the ACT*, Mr R McLeod stated:

The individual government officials, employees and volunteers spared nothing in terms of their personal commitment during a long and difficult crisis ...

Any criticism directed at individuals because of the role they were required to perform is in no way intended to question their integrity or their honesty in doing what they felt in the circumstances was the right thing to do at the time

The ACT wishes to acknowledge that all ACT employees and volunteers involved in the January 2003 Bushfires, carried out their duties honestly and with a commitment to doing the best job that they could in the difficult circumstances in which they found themselves.

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THE INQUIRY

1. The taking of evidence in the abovementioned Inquest and Inquiry commenced on 7 October 2003 and continued until 16 October 2003. It resumed on 16 February 2004 and continued until 25 October 2005, when the taking of evidence was completed.

2. It is proposed in these submissions, for reasons of convenience, to refer to witnesses and other persons involved in this event by surname only. No disrespect is intended to anybody by reason of this approach.

THE CORONERS ACT 1997 (ACT)

Inquest into Deaths

3. The Inquest is authorised under the *Coroners Act 1997 (ACT)* (“the Act”). Section 13(1)(a) requires a coroner to hold an inquest into the manner and cause of death of a person who is killed. Section 52(1) requires a coroner holding an inquest to find the identity of the deceased, when and where the death occurred and the manner and cause of death. A coroner may comment “*on any matter connected with the death ... including public health or safety or the administration of justice*”: (s.52(4)). A coroner may report to the Attorney-General on an inquest held by the coroner (s.57(1)) and may make recommendations to the Attorney General “*on any matter connected with an inquest ... including matters relating to public health or safety or the administration of justice*”.

4. A coroner may, at any time before concluding an inquest, make an interim finding on any matter connected with the inquest: s.53. On 15 October 2003, your Honour made a number of interim findings with respect to the deaths of the four deceased persons.

5. Insofar as s.52(4) allows a coroner to comment “*on any matter connected with the death*” and s.57(3) allows a coroner to make recommendations “*on any matter connected with an inquest*”, it is useful to refer to authority where the words “*connected with*” have been considered in a coronial context. In Harmsworth v State

Coroner [1989] VR 989, consideration was given to similar provisions in the *Coroners Act 1985 (Vic)*. Nathan J said (at 996):

“The power to comment, arises as a consequence of the obligation to make findings: see section 19(2) [the Victorian equivalent to s.52(4)]. It is not free-ranging. It must be comment ‘on any matter connected with the death’. The powers to comment and also to make recommendations pursuant to s.21(2) [the Victorian equivalent of s.57(3)] are inextricably connected with, but not independent of the power to inquire into a death or fire for the purposes of making findings. They are not separate or distinct sources of power enabling a coroner to enquire for the sole or dominant reason of making comment or recommendation. It arises as a consequence of an exercise of a coroner’s prime function, that is to make ‘findings’.”

This passage was quoted with approval by the Full Court in R v Doogan; Ex parte Lucas-Smith (2005) 158 ACTR 1 at 12 [41].

Inquiry into Fires

6. Section 18 of the Act provides as follows:

- “(1) A coroner shall hold an inquiry into the cause and origin of a fire that has destroyed or damaged property, if-*
- (a) requested to do so by the Attorney-General; or*
 - (b) the coroner is of the opinion that an inquiry into the cause and origin of the fire should be held.*

In this case, your Honour stated that you held the opinion that an inquiry should be held for the purposes of s.18(1)(b) of the Act.

7. Subsections (2) to (4) of s.52 of the same Act provide:

- “(2) A coroner holding an inquiry shall find, if possible-*
- (a) the cause and origin of the fire or disaster; and*
 - (b) the circumstances in which the fire or disaster occurred.*

- (3) *At the conclusion of an inquest or inquiry, the coroner shall record his or her findings in writing.*
- (4) *A coroner may comment on any matter connected with the death, fire or disaster, including public health or safety or the administration of justice.*

8. Finally, as noted above, s.57(1) provides that a coroner may report to the Attorney-General on an inquest or an inquiry into a fire held by the coroner. Section 57(3) permits a coroner to make recommendations to the Attorney General “*on any matter connected with an inquest or inquiry, including matters relating to public health or safety or the administration of justice*”. Reference has already been made, at paragraph 4 above, to the meaning of the words “*connected with*” in ss.52(4) and 57(3) of the Act.

9. It may be seen that the issues upon which the coroner must focus are:

- (a) the manner and cause of death of the four deceased persons;
- (b) the cause and origin of the fires; and
- (c) the circumstances in which the fires occurred.

In addition, as s.52(4) indicates, the coroner may make comments on any matter connected with the fires including, inter alia, public health or safety. Further, the coroner may make recommendations to the Attorney-General on such matters under s.57(3) of the Act.

“Cause and Origin” and “Circumstances” of Fires – General Principles

10. In Queensland Fire and Rescue Authority v Hall (1998) 2 Qd R 162, Lee J had cause to consider the extent of the inquiry mandated by s.8(1) of the *Coroners Act 1958 (Qld)* which gave the coroner jurisdiction to inquire into “*the cause and origin*” of fires which had endangered or destroyed property or human or animal life. Section 7 of the same Act conferred powers on a coroner to inquire into “*the cause of the death and the circumstances of the death of a person*”.

Lee J observed at 170:

“There seems to be little doubt that the scope of the inquiry under s.7 is wider than that under s.8. ... The very terms of s.7 itself ... are obvious pointers to a wide-ranging inquiry. ... It may be noted that s.7 first refers to ‘cause of the death’ itself as the ultimate focus of the inquiry, i.e. the death, but there is added the requirement of ‘... and the circumstances of the death’. The death is the actual event and the cause of it is the process of happening which brought the death about and is the cause of it, whereas ‘the circumstances’ obviously covers a much wider area of inquiry as the word itself conveys and as the various sections of the Act referred to indicate. Circumstance means ‘time, place, manner, cause, occasion, etc, surroundings, of an act or event’: Concise Oxford Dictionary.”

11. Lee J observed at 171 that the concept of “*cause and origin*” included in the context of that case, such matters as where the fire originated; who started it and who caused it to start and whether it was initiated by the original cause or by reason of back-burning put in place by fire fighters. If the fire originated from back-burning, Lee J observed at 172:

“... it may be said that the prevailing circumstances at the time it was started by them (the fire fighters), as well as their training and experience, are potentially relevant to the cause of the fire...”

12. In WRB Transport Pty Ltd & Ors v Chivell [1998] SASC 6937 (9 November 1998), Wicks J considered the concept of “*cause or circumstances*” of death within the *Coroners Act 1975 (SA)* and after making reference to the passage in Hall, above, at 170, continued at paragraphs 17-21:

“17. Section 12 of the Coroners Act 1975 was discussed in R v von Einem (1991) 55 SASR 199. At p225, Duggan J said:

‘The words ‘cause or circumstances’ are of wide import and I disagree with the narrow interpretation which counsel would place upon them by emphasising the word ‘cause’.”

18. In my opinion, the requirement of s12 of the Coroners Act to ascertain the cause or circumstances of a death

involves the notion of 'relevance'. What is relevant to the cause or circumstances of death depends on the facts and circumstances of each case and cannot readily be the subject of generalisation. It is a question of judgment and degree. In some cases it is useful to test the relevance of evidence by applying the notions of causation and remoteness. These concepts are well known and generally applied in the context of the law of negligence. It does not follow, however, that they should become touchstones to determine what is or is not relevant in the context of a coronial inquiry. They will have application in some cases but not in others.

19. *It is generally for the Coroner to determine what is relevant for the purposes of his inquiry. In carrying out this task he should not be confined in the way in which a trial judge is confined in assessing the relevance of evidence in the conduct of civil litigation. He must be given a reasonable degree of latitude. There may be differences of opinion between Coroners as to the relevance of evidence to be led in respect of a particular inquiry. It is only when one reaches the point that no reasonable person could regard the evidence as relevant that a question of jurisdictional error arises.*

21. *The concept of relevance is broad and in the context of a coronial inquiry it should not be restricted by the use of other concepts."*

13. On appeal in the Full Court (Prior, Mullighan and Lander JJ), similar observations were made - WRB Transport & Ors v Chivell [1998] SASC 7002 (23 December 1998). Lander J (Mullighan J agreeing) stated at paragraphs 19-26:

"19. *Clearly enough, the 'cause and the circumstances' must be two different things. If it was otherwise there would be no reason for Parliament to have included both words.*

20. *The cause of a person's death may be understood as the legal cause. In determining those events which may be said to give rise to the cause of the death, the Coroner is not limited by concepts such as 'direct cause', 'direct or natural cause', 'proximate cause' or the 'real or effective cause'. Nor is the Coroner limited to a cause which is reasonably foreseeable. The cause of a person's death in respect of the Coroner's jurisdiction is a question of fact which, like causation in the common law must be determined by applying common sense to the facts of*

each particular case; Mason CJ, March v E & M H Stramare Pty Ltd (1991) 171 CLR 506 at 515.

21. *The Coroner, therefore, has to carry out an inquiry into the facts surrounding the death of the deceased to determine what, as a matter of common sense, has been the cause of that person's death. The inquiry will not be limited to those facts which are immediately proximate in time to the deceased's death. Some of the events immediately proximate in time to the death of the deceased will be relevant to determine the cause of the death of the deceased. But there will be other facts less proximate in time which will be seen to operate, in some fact situations, as a cause of the death of the deceased. That is a factual inquiry which only has, as its boundaries, common sense.*
22. *Not only does the Coroner have jurisdiction to determine the cause of a deceased's death, he also has jurisdiction to determine the circumstances of the death of any person.*
23. *That jurisdiction must be in addition to the jurisdiction given to determine the cause of the death of the deceased.*
24. *There may be some circumstances surrounding the death of the deceased which, although not operating directly as a cause of the death of the deceased, are relevant for the coroner's inquiry.*
25. *Those circumstances might explain the origin of the causes of the death of the deceased or the interaction between a number of causes of death.*
26. *The circumstances surrounding the death of the deceased may be important, for the purpose of the coroner adding to his or her findings, recommendations which might prevent or reduce the likelihood of a recurrence of a death."*

14. His Honour then referred to the passage in Hall, above, at 170, and continued:

"30. I agree, generally, with the distinction that his Honour makes between cause and circumstance. Specifically I agree that the circumstances to be inquired into cover a much wider area of inquiry than the cause.

In my opinion, the jurisdiction given by the Act to the coroner is quite extensive. It is not limited, as suggested, to a particular inquiry into the direct cause of death of the deceased. The coroner has a jurisdiction and, indeed, an obligation to inquire into all facts which may have operated to cause the death of the deceased and as well to inquire into the wider circumstances surrounding the death of the deceased."

15. The Full Court in R v Doogan approached the construction of s.52(2) of the Act consistently with these authorities: see 8-12 [22]-[40]. It first drew a distinction between the terms “cause” and “origin”: (at [23]). It then elaborated on the concept of causation (at [24]-[27]) in passages which are substantially extracted by counsel assisting at paragraph 1083 of their submissions. We will return to deal with these passages in the context of relevance later in these submissions. The Court then turned to the construction of the term “circumstances” in s.52(2)(b) of the Act. In particular, the Court said:

[37] The requirement to find, if possible, not only the cause and origin of the fire but also the circumstances in which it occurred, is not augmented by any conferral of jurisdiction to inquire into such circumstances. The section only requires the Coroner to make such findings to the extent permitted by the evidence adduced at the inquiry conducted under s.18(1), seen as relevant in the legal sense, to the ‘cause and origin of the fire’.

[38] It is clear, both from the language in which the provision is expressed and from the fact that the power must be exercised in relation to an inquiry under s.18(1), that the ‘circumstances’ to which the provision is directed are circumstances that are related to the cause and origin of the fire.

[39] ... The word ‘circumstances’ has a wide meaning and the concept referred to in s.52(2)(b) of the Act is broader than that referred to in s.52(2)(a) of the Act. Nonetheless, the word must be construed by reference to the statutory context within which it appears. The Coroner is not authorised to make findings in relation to any circumstances arising from the fire, but only in relation to the circumstances in which the fire occurred. The distinction between a cause and a circumstance may essentially be one of degree ...”

“Cause and Origin” and “Circumstances” of the 2003 Fires

16. At paragraph 208 of their submissions, counsel assisting assert that five factors “*can be said to have played a part in the cause and origin of the fires*” that burnt into Canberra on 18 January. Those are said to be:

- a. “knowledge of issues concerning fuel management and the state of the fuel loads at the time of the fires”;
- b. “community awareness of risk and appropriate preparations”
- c. “pre-planning of aircraft and heavy plant”
- d. “issues of access to fires” and
- e. “recognition of the importance of rapid aggressive response”.

17. If what is meant to be conveyed by the notion of “*playing a part in the cause and origin of the fires*” is the proposition that the Coroner is authorised to make findings about these matters, then the ACT submits that this is an erroneous construction of s.18 of the *Coroners Act*.

18. The ACT disputes that any of these matters so stated, can be said to be the origin of the fires. The first, second and fifth factors appear to refer to the state of mind or state of knowledge of unspecified persons. For the purposes of this submission, it is assumed that the first and fifth factors relate to the knowledge of senior ESB officers; and the second factor relates to unspecified members of the Canberra community.

19. The factors do not encompass any act or omission relating to the suppression or control of the fires; nor do they encompass any decision to do or refrain from doing an act in the course of that activity. The focus appears to be on the motivation for such acts or omissions. It is difficult to see how a state of knowledge of persons reflected in the first, second and fifth factors, can be characterised as a cause and origin of the fires on 18 January.

20. The third factor relates to the failure to ensure the pre-season acquisition of plant and equipment and the fourth factor appears to relate to the failure to maintain fire trails. It may be conceded that if these things had been done (assuming that they were practically achievable), it may have facilitated aspects of the fire fighting effort and have assisted in the containment and control of the fires.

21. The ACT accepts that it is a proper exercise of the Coroner’s jurisdiction to inquire into what was or was not done but any further inquiry into the reasons for or

policy behind such acts or omissions, is not authorised. It is submitted that these antecedent matters cannot be correctly characterized as a cause of the fires. If it were otherwise, then as a matter of logic, other remote matters such as the positioning of roads within the National Parks would be relevant; so too would the maintenance plans of the heavy equipment which broke down or required service during the fires. It is submitted whilst matters of this kind might be thought to have some relevance, they are too remote to be a cause of the fires of 18 January.

22. At paragraph 17, counsel assisting submit that it is appropriate for the Inquiry (for the purpose of determining the cause and origin of the fires) to examine of the evidence of the state of fuel loads in the affected areas and the previous advice of experts and others about how they should be controlled. The ACT does not dispute that the first matter is a relevant area of inquiry; but submits that the second matter is too remote. It does not relate to what was done or not done between 8 and 18 January; nor to any decision made in that period. Generally it relates to advice proffered some considerable time before 2003 and can only go to the state of knowledge of, presumably, ESB personnel. Accordingly, if relevant at all, the connection of the second matter to the cause and origin of the fire, is remote and tenuous.

23. At paragraphs 105 and following, counsel assisting discuss the relevance of fuel management to the issues to be considered by the Coroner. At paragraph 107 of their submissions, counsel assisting refer to relevant passages in R v Doogan, including paragraph [25]. Counsel assisting state that their outline of evidence and the submissions:

...will not go beyond the first two levels to which the Court referred and which are emphasised above – the fuel loads ... on 8 January 2003 and the fact that several witnesses ... had expressed concern that fuel reduction burning had not occurred to ... (an appropriate) level ...

24. In R v Doogan at paragraph [25], the Full Court indicated that the question of “the thickness of the vegetation at the site where the fire commenced” had causal relevance to the fires in question. Their Honours then proceeded to pose other questions which that observation may evoke, relating in broad terms to the reasons why the vegetation was in that state; whether it involved a failure of some government

agency; whether that failure was due to lack of resources, conservation issues or other reasons and so on.

25. Reference is made at paragraph [27] of the judgment, to “*the suggested issues*” that could not be said to be irrelevant but were “*somewhat remote from cause and origin of the fire*”. Their Honours suggested that an inquiry into such matters is not authorised by s.18(1). “*The suggested issues*” can only be sensibly understood to refer to all the questions evoked from the initial observation. It follows therefore that counsel assisting’s submission which implies that the Full Court sanctioned an examination of “*the first two levels to which the Court referred*” is erroneous and the only issue within jurisdiction is the state of the fuel loads, not how and why they got to be in the state they were in.

26. The issue is revisited at Section 2.2 of counsel assisting’s submissions – Fuel Management and Fuel Loads. Counsel assisting state at paragraph 130, that the purpose of this part of their submissions, is “*to summarise the evidence that shows what that (fuel management) regime was and the state of the fuel loads that existed at the time of the fires*”. The ACT submits that whilst the second matter is clearly within jurisdiction, the first involving as it did a historical analysis of events in 1994 as set out in the McBeth Report, is not. It might be thought that having regard to the concessions made by Lucas-Smith, Graham and McRae about their knowledge in 2002/3 of the fuel loads, the introduction of historical evidence was unnecessary.

27. In any event, far from dealing with the regimes of fuel management in place at that time, the extracts of the McBeth Report that counsel assisting choose to quote relate not to the state of the fuel loads, but entirely to the asserted unpreparedness of the Canberra public for bushfires and the significant damage such a “*conflagration fire*” would cause when it inevitably occurred. The apparent purpose of the reference to the McBeth Report is to adopt the view of the author who was “*critical of the lack of fuel management planning and practices in place in the ACT*” in 1994.

28. The ACT submits that such matters are not within your Honour’s jurisdiction, and that your Honour’s Inquiry should not extend beyond that issues such as the state

of fuel loads in the fire areas, the nature and extent of the initial response and the state of the access to the fires.

The Relevance Test at an Inquest or Inquiry

29. A coroner is not bound to observe the rules of procedure and evidence applicable to proceedings before a court of law: s.47(1) *Coroners Act 1997 (ACT)*. Section 47(1) does not go on to say that a coroner may inform himself or herself of any matter in such manner as he or she thinks fit. This additional provision is not uncommon where an inquisitorial or investigatory tribunal or body is not bound by the rules of evidence: cf *Medical Practice Act 1992 (NSW)*, Sch.2, cl.1 (Medical Tribunal); *Zaidi v Health Care Complaints Commission* (1998) 44 NSWLR 82 at 90G-91A, 92G-93C; s.17(1) *Independent Commission Against Corruption Act 1988 (NSW)*. The absence of these words is suggestive of a more circumscribed evidence-taking function for a coroner in the ACT.

30. In *R v Doogan*, the Full Court dealt at length with the question of the extent of the Coroner's jurisdiction with particular attention being paid to the concept of causation: see 7-11 [16]-[34]. Some parts of the reasoning bear restatement in full:

[28] *Section 18(1) does not authorise the Coroner to conduct a wide ranging inquiry akin to that of a Royal Commission, with a view to exploring any suggestion of a causal link, however tenuous, between some act, omission or circumstance and the cause or non-mitigation of the fire ...*

[29] *A line must be drawn at some point beyond which, even if relevant, factors which come to light will be considered too remote from the event to be regarded as causative. The point where such a line is to be drawn must be determined not by the application of some concrete rule, but by what is described as the 'common sense' test of causation affirmed by the High Court of Australia in *March v E & M H Stramare Pty Ltd* (1991) 171 CLR 506 ... The application of that test will obviously depend upon the circumstances of the case and, in the context of a coronial inquiry, it may be influenced by the limited scope of the inquiry which, as we have mentioned, does not*

extend to the resolution of collateral issues relating to compensation or the attribution of blame.

[31] *There will, of course, be many cases in which the issue of causation will necessary involve an examination of a person's conduct. A coroner conducting an inquest into the death of a person may be obliged to consider whether the death was attributable to accident or homicide. ... If that situation does not arise, the Coroner will be obliged to make findings as to the nature of the acts and/or omissions that caused the death, even if they reflect adversely on the reputation of one or more people involved in the relevant incident. Hence, a coroner might well hear evidence suggesting that a cyclist's death had been caused not merely by a collision with a motor vehicle, but also by the antecedent conduct of the driver of that vehicle in failing to stop at a stop sign adjacent to an intersection. However, the limited jurisdiction conferred by section 18(1) would not authorise the Coroner to inquire into any perceived failures in relation to general policy relating to the sighting of stop signs or the enforcement of traffic regulations. The particular sighting and design of the relevant intersection may be a different matter. The application of the common sense test of causation will normally exclude a quest to apportion blame or a wide ranging investigation into antecedent policies and practices."*

31. It is evident from these passages that, when the issue of causation arises in an inquiry, many potential causes will be suggested by the evidence. They will range from immediate to remote. Causes will only be relevant if they meet the "*common sense*" test. As the example provided by the Court in [31] and other examples provided at [25], [26], [27] and [30] make plain, in the context of the *Coroners Act*, the relevance line will be drawn much closer to the immediacy end of the range than to the remoteness end.

32. It is also clear that the Court considered that there were many potential causes identified on the "issues list" prepared by counsel assisting which were not relevant in the necessary sense: see *R v Doogan* at 11 [34]. As counsel assisting observed (at paragraph 1087 of their submissions) the Court did not particularise those issues which fell outside the coronial jurisdiction. Whilst the Court was prepared to accept that some latitude was necessary, especially during the early stages of the Inquiry, in determining what evidence should be received, that latitude did not necessarily extend

to the making of findings and recommendations based on such evidence once the Inquiry was completed. Thus, for example, although the existence of a heavy fuel load in the areas where the fires commenced and developed would be a causally relevant factor, other issues on the list which would go further and ask why the vegetation was in that state, whether Government agencies had contributed to it being in that state, whether policy or resource issues impinged on the state of the vegetation and so on could not be the subject of findings by the Coroner: cf. R v Doogan at 8-9 [25]. It is also instructive to note the observations of Callinan J in Travel Compensation Fund v Tambree (2005) 222 ALR 263 made after referring to the oft-cited passage of Mason CJ (Gaudron J agreeing) in March v Stramare at 285 [81]:

“... It would be a delusion to think that a disputed question of causation can be resolved according to an invariable scientific formula, and without acknowledgment that common sense, that is, the sum of the tribunal's experience as a tribunal, its constituents' knowledge and understanding of human affairs, its knowledge of other cases and its assessment of the ways in which notional fair minded people might view the relevant events, is likely to influence the result. Of course it is possible to say, sometimes with force, that tribunals may on occasions tend to become remote from the community and its values, indeed that there is not a community value as such, but a multiplicity of community values, themselves shifting from time to time, and that one person's common sense may sometimes be another's nonsense. But all of that is to say no more than that perfect justice, the availability of a perfect test for liability, is beyond human reach. But tribunals of fact have to do the best they can. And that which has to be done is better done with candour, and candour demands the acknowledgment by any tribunal or any judge called upon to resolve a matter, of the use of his or her common sense in determining causation. Value judgments may sometimes be inescapably involved, but that they may, does not justify the division of the question into a "but for" test and a further inquiry whether a defendant should in law be held responsible for a plaintiff's damage. (Emphasis added)

33. Counsel assisting contend (at paragraph 1095 of their submissions) that your Honour is obliged by the Act to make findings if “*satisfied that the actions or inactions of an agency or a person were a cause of any of the deaths or of the fires ...*”. Whilst there may be some debate as to whether s.52(1) of the Act imposes an obligation to make such findings in an inquest it may be accepted for present purposes that a power to make such findings exists. Of greater significance is the caveat that

the contention is only sustainable if the word “*cause*” is understood (as we expect it was intended) in the sense referred to by the Full Court in R v Doogan at 9-10 [29].

Nature of Coronial Inquest and Inquiry

34. It has been accepted that the rules of procedural fairness apply to an inquest: Maksimovich v Walsh (1985) 4 NSWLR 318 at 327; Annetts v McCann (1990) 170 CLR 596 at 598; Director of National Parks and Wildlife v Barritt (1990) 102 FLR 392 at 401. This is further emphasised by the provisions in s.55 of the Act.

In Musumeci v Attorney-General of NSW (2003) 57 NSWLR 193, Ipp JA (Beazley J agreeing) observed at 199 (paragraphs 33-34):

*“Courts have often found it difficult to characterise the precise juristic nature of an inquest. For my part, I do not think it necessary to embark on that exercise. I think it sufficient to note, firstly that it is a hybrid process containing both adversarial and inquisitorial elements. Secondly, coroners exercise judicial power, notwithstanding the executive nature of their functions. Thirdly, the proceedings in the Coroner’s Court involve the administration of justice: see R v South London Coroner; Ex parte Thompson (1982) 126 Sol J 625 (cited in Annetts v McCann (1990) 170 CLR 596 at 616 by Toohey J); Fairfax Publications Pty Limited v Abernethy [1999] NSWSC 826 per Adams J; Maksimovich v Walsh (1985) 4 NSWLR 318 at 327-328 per Kirby P and at 337 per Samuels JA; Mirror Newspapers Limited v Waller (1985) 1 NSWLR 1 at 6; Herron v Attorney-General (NSW) (1987) 8 NSWLR 601 per Kirby P at 608.
The nature of an inquest differs from that of a fundamentally investigatory process such as a Royal Commission.”*

35. Although these observations were made concerning the *Coroners Act 1980* (NSW), they are equally pertinent to the ACT. The present Inquest is not a type of Royal Commission into bush fire fighting and fuel and land management in the ACT: see R v Doogan at 9 [28].

Limits upon the Coronial Jurisdiction

36. Unlike its predecessor Act (s.56(1)(d) *Coroners Act 1956 (ACT)*) the *Coroners Act 1997 (ACT)* does not require or permit a finding that a person “contributed to” the cause of death or the cause of a fire. This statutory change is most significant. It emphasises the fact that the coronial jurisdiction does not extend to attribution of blame and findings of contribution.

37. Lord Lane CJ in *R v South London Coroner; Ex p Thompson* (The Times, 9 July 1982) said:

“Once again it should not be forgotten that an inquest is a fact finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a trial where the prosecutor accuses and the accused defends, the judge holding the balance or the ring, whichever metaphor one chooses to use.” (emphasis added)

38. This passage has been relied upon in *Annetts v McCann*, above, at 616 per Toohey J, *Civil Aviation Authority v Australian Broadcasting Corporation* (1995) 39 NSWLR 540 at 546 per Kirby P, *McKerr v Armagh Coroner* (1990) 1 WLR 649 at 655 per Lord Goff of Chieveley, *Moles* (1994) 77 A Crim 360 at 372-3, *Green v State Coroner of NSW* (Sully J, 19 November 1997, BC9708037 at page 7) and *Perre v Chivell* (2000) 77 SASR 282 at [52].

39. Although s.52(4) allows a coroner to comment on any matter connected with the death or fire, and s.55(1) acknowledges that there may be “a comment adverse to a person”, there is no power in the Act to make findings of contribution, blame or guilt. Adverse comment may occur in a secondary or incidental way only: *R v Doogan* at 6 [12] and 9-10 [29], [31].

The Coronial Function - Learning Not Blaming

40. A fundamental purpose of the coronial jurisdiction is to identify the cause of death and the origin and circumstances of a fire to enable lessons to be learned for the future. In this way, the community learns and can improve processes and systems to reduce the prospect of similar tragedies.

41. In approaching this task, the Coroner discharges an important public function. An analogy may be drawn between the Coroner and the function performed by a body such as the Australian Transport Safety Bureau (“ATSB”) under the *Transport Safety Investigation Act 2003 (Cth)*. Section 7 of that Act provides as follows:

“Objects of this Act

- (1) The main object of this Act is to improve transport safety by providing for:*
 - (a) the reporting of transport safety matters; and*
 - (b) independent investigations into transport accidents and other incidents that might affect transport safety; and*
 - (c) the making of safety action statements and safety recommendations that draw on the results of those investigations; and*
 - (d) publication of the results of those investigations in the interests of transport safety.*
- (2) Another object of this Act is that during the investigation of a transport safety matter under this Act, there be co-operation between the Executive Director and any other Commonwealth agency or person having powers under another law of the Commonwealth to also investigate the matter.*
- (3) The following are not objects of this Act:*
 - (a) apportioning blame for transport accidents or incidents;*
 - (b) providing the means to determine the liability of any person in respect of a transport accident or incident;*
 - (c) assisting in court proceedings between parties (except as expressly provided by this Act);*

- (d) *allowing any adverse inference to be drawn from the fact that a person is subject to an investigation under this Act.”*

42. Prior to the enactment of the *Transport Safety Investigation Act 2003 (Cth)*, the ATSB investigated aviation accidents under the *Air Navigation Act 1920 (Cth)*. The object of such investigations, emphasised again in the 2003 Act, was expressed in the following terms in the ATSB’s Aviation Safety Investigation Report of April 2004 entitled “*Bankstown Mid-air Collision*” (page 5):

“Under the Air Navigation Act 1920, it is not the object of an investigation to determine blame or liability. However, it should be recognised that an investigation report must include factual material of sufficient weight to support the analysis and conclusions reached. That material will at times contain information reflecting on the performance of individuals and organisations, and how their actions may have contributed to the outcomes of the matter under investigation. At all times the ATSB endeavours to balance the use of material that could imply adverse comments, with the need to properly explain what happened, and why, in a fair and unbiased manner.”

43. The ACT submits that a similar approach ought be adopted with respect to coronial proceedings and reporting. It is not the role of the coroner to make findings of contribution, blame or guilt. Indeed, the removal of the power to make findings of contribution, which occurred with the enactment of the 1997 Act, emphasises the limits upon the coronial jurisdiction in this respect. It is for the coroner to make findings, comments and recommendations as permitted by the Act. The rationale for this is, in effect, similar to the *Transport Safety Investigation Act 2003 (Cth)*. The true facts may be found more readily when the court approaches its task without engaging in apportionment of blame. Although s.55 of the Act envisages possible adverse comment in coronial findings, such comment is incidental only. The removal of the power to make findings of contribution with the enactment of the 1997 Act reinforces the limited nature of adverse comment which is permitted.

44. It is submitted, with respect, that your Honour correctly identified the nature of the coronial jurisdiction in the following statement made to Mr Castle (T1742.20):

“I am sure you know the purpose of this inquiry is to try and find out what happened and importantly why it happened. The

reason for that is so that we, as a community, can prevent anything like this from happening again."

45. It is noted that Mr Lasry QC, Senior Counsel Assisting, stated at one point (T4832.36):

"Rather than analyse it word by word, I can only say for my part I thoroughly reject the implications in the submissions that have been made about slants being put on evidence or witnesses being called in - of course witnesses have been brought here, have been questioned and several witnesses who are accountable have been asked to be accountable and they have been examined in that context."

46. In the same way as it lies outside the coronial jurisdiction to find contribution, blame or guilt, the notion of accountability likewise is excluded from coronial purview. If the observation of Mr Lasry QC is to be taken as meaning nothing more than that witnesses who are able to give relevant evidence concerning the events under inquiry have been asked to give that evidence, the observation is unremarkable. If, however, Mr Lasry QC is seeking to import into these proceedings a notion of accountability as a basis for passing judgment concerning persons, such an approach would involve legal error.

47. The ACT submits that your Honour will approach the discharge of your coronial jurisdiction by confining attention to the questions posed by the Act.

No Issue of Criminal Conduct

48. At no stage during the course of the Inquest or Inquiry has your Honour raised the question of s.58 of the Act, being the procedure to be followed where a coroner has reasonable grounds for believing that, having regard to the evidence given at an inquest or inquiry, a person has committed an indictable offence. Nor have counsel assisting adverted to this section or made any submission that it arises on the evidence. The ACT submits that such an approach is entirely correct. The evidence is incapable of constituting reasonable grounds for a belief that a person has committed an indictable offence. The demanding nature of manslaughter by criminal

negligence is well known: R v Lavender [2004] NSWCCA 120 at [61]-[62], [108]-[109], [161ff], [297ff]. No such question arises in the present Inquest or Inquiry.

49. If a s.58(1) issue did arise, it would be necessary for the Court to consider the admissibility at trial of the evidence given at the inquest or inquiry on which the coroner may base the relevant opinion: s.58(2)(a).

50. Reference should be made to s.48 of the Act:

“48. Evidence

(1) For the purposes of an inquest or inquiry, a coroner may take evidence on oath or affirmation and, for that purpose –

(a) the coroner may require a witness either to take an oath or to make an affirmation; and

(b) the coroner, registrar or other appropriate officer of the court may administer an oath or affirmation to a witness.

(2) A coroner may

(a) require a witness to answer a question put to the witness; and

(b) where a person appears before a coroner pursuant to a summons require the person to give evidence or produce a document or thing specified in the summons.

(3) Except in relation to proceedings under part 7, a record of evidence made for the purposes of an inquest or inquiry is not, by reason only that it is such a record, admissible in any court as evidence that any person made the depositions included in that record.”

51. Section 48(3) gives a measure of protection to witnesses at an inquest. Except in relation to proceedings under Part 7 of the Act, which contains a series of offences including refusal to be sworn or give evidence (s.80) and giving false evidence (s.81), a record of evidence made for the purpose of an inquest or inquiry is not admissible in any court as evidence that any person made the depositions included in that record. Section 48(3) appears to give a form of use protection to the witness: Ganin v NSW Crime Commission (1993) 32 NSWLR 423 at 433; Rogan v Hyde (1995) 84 A Crim

R 519 at 524. It appears that s.48(3) applies automatically to the evidence of a witness at an inquest. A claim of privilege against self-incrimination is not required to trigger the section.

52. On its face, s.48(3) would render inadmissible in any civil or criminal proceedings against any person evidence given by witnesses at the Inquest. The only exception to this prohibition would be prosecutions for offences under Part 7 of the Act.

53. The use protection given by s.48(3) of the Act would extend to prevent reliance by an expert witness in any civil or criminal proceedings upon evidence given by a witness at the Inquest: McMartin v Newcastle Wallsend Coal Company Pty Limited and Ors [2003] NSWIRComm 392 and 393.

54. The ACT submits that no occasion arises in this Inquest or Inquiry for consideration of possible offences under the *Occupational Health & Safety Act 1989 (ACT)* ("OHS Act"). Indeed, counsel assisting appear to be critical of a number of operational decisions made upon the basis that they were not sufficiently aggressive from a fire-fighting point of view, even though issues of worker safety were taken into account in determining what action should be taken: see their submissions at paragraph 1151. The ACT submits that no question arises as to any possible breach of ss.27ff of the OHS Act.

55. Section 35A of the OHS Act provides as follows:

"35A Commencement of Prosecution in Magistrates Court

- (1) If a coroner's inquest or inquiry is held and it appears from the coroner's report or from proceedings at the inquest or inquiry that an offence has been committed against this part, a prosecution for the offence may be begun in the Magistrates Court at any time before the third anniversary of the day the findings were recorded, or the report was made, whichever occurs later.*
- (2) Subsection (1) applies to an offence against this part whether it was committed before or after the commencement of this section."*

56. The ACT submits that there is no foundation in the present Inquest or Inquiry for the relevant "appearance" of an OHS Act offence, as understood for the purpose

of OHS legislation: Page v Walco Hoist Rentals Pty Limited (1999) 87 IR 286 at 292. Accordingly, the occasion does not arise in the present Inquest for consideration of the OHS Act.

The Benefit of Hindsight

57. An inquiry such as the present involves a close and detailed examination of events following lengthy investigation. As Cheney readily agreed (T480-481), he has had the opportunity to examine and review relevant events with an abundance of material not available to the contemporaneous decision makers, and with knowledge of the outcome of the events. The Court is in a similar position. In these circumstances, it is critically important that the Court realises the substantial advantages which it has over those who were called upon to make decisions in January 2003.

58. In a number of decisions, Courts have emphasised the need for caution in examining events with the benefit of hindsight. In Rac v Broken Hill Pty Company Limited (1957) 97 CLR 419, Fullagar J said at 422:

“As I observed in that case, there has been a tendency in cases of this type to forget the legal standard of reasonable care, and to regard the standard employer as a person possessing super-human qualities of imagination and foresight. When it is said in such cases that it is easy to be wise after the event, what is meant – and all that is meant – is that the matter should be judged from an a priori, and not from an ex post facto, point of view. The fact of the happening of the accidents is, of course, itself a relevant consideration, but, in considering whether it ought to have been foreseen, it is wrong to take as the standard of comparison a person of ‘infinite resource and sagacity’.”

59. In the same case, Taylor J said at 430:

“Accordingly the first question in this case is whether, upon the facts, a jury would have been entitled to say that the plaintiff was exposed to a risk of injury which by the exercise of reasonable care might have been foreseen and avoided. But in pursuing such an inquiry it is a simple matter to permit hindsight to take the place of foresight and to see, after the occurrence of an accident, that appropriate safeguards might have been provided which would have ensured safety. But as has been said so many times, this is a completely erroneous

approach to the problem. No doubt in many cases where an employee has sustained an injury in the performance of his daily work a relevant breach of duty may frequently be readily detected but, in general, the mere occurrence of an accident is not itself indicative of a breach of a duty to take care."

60. In Rosenberg v Percival (2001) 205 CLR 434, Gleeson CJ said at 441 [16]:

"There is an aspect of such a question which may form an important part of the context in which a trial judge considers the issue of causation. In the way in which litigation proceeds, the conduct of the parties is seen through the prism of hindsight. A foreseeable risk has eventuated, and harm has resulted. The particular risk becomes the focus of attention. But at the time of the allegedly tortious conduct, there may have been no reason to single it out from a number of adverse contingencies, or to attach to it the significance it later assumed. Recent judgments in this Court have drawn attention to the danger of a failure, after the event, to take account of the context, before or at the time of the event, in which a contingency was to be evaluated. This danger may be of particular significance where the alleged breach of duty of care is a failure to warn about the possible risks associated with a course of action, where there were, at the time, strong reasons in favour of pursuing the course of action."

61. In Grynbeg v Muller; re Estate of Bilfeld [2002] NSWSC 350, Hamilton J said at [48]:

"Arguments were put to me in detail as to why the plaintiffs and the Popovtzers must have known that the proceedings would fail, or must have known facts which, properly assessed, made it inevitable that the proceedings would fail. These submissions focus the bright light of hindsight. Hindsight sings a siren song of which Judges must be cautious. There have been many judicial warnings as to its dangers in different contexts. The Court of Appeal has recently drawn attention to the dangers of hindsight in determining foreseeability in cases of personal injury caused by negligence"

62. These considerations are equally relevant in the coronial jurisdiction, when the Court is called upon to consider the actions of persons in dealing with a difficult and dynamic event such as a bushfire. Arthur described a bushfire as *"effectively this is a battle scene"* (T4554.46).

The Need for Practical Reality

63. Before embarking upon detailed submissions concerning the January 2003 fires, a number of general submissions are pertinent. The events of January 2003 are being examined in close detail in the present Inquiry, and properly so. It is clear that much has already been learned from the tragic events under consideration.

64. It is useful to observe the evidence of Koperberg, Keady and others concerning the significant lessons learned in New South Wales from the tragic 1994 bushfires. In any field of human endeavour, it cannot be expected that all organisations and persons will be ready to deal with any eventuality. It is no different in the field of bushfire fighting, in the ACT or elsewhere.

65. Lucas-Smith had been the Chief Fire Control Officer (“CFCO”) in the ACT since 1987 (T769). He said in evidence (T782-29):

“1985 was the last round of what I would refer to as major fires. And in my curriculum vitae I think I refer to a major fire being a fire in excess of 5,000 hectares. And the December 2001 fires were not in excess of 5,000 hectares.”

66. The 2001 fires had been the largest fires experienced by Lucas-Smith in the ACT (T1200.24). The 2003 fires were clearly beyond his prior experience. The ACT experience had involved, for two decades, relatively small fires which were capable of being controlled and extinguished, usually by early and direct attack.

67. The December 2001 fires challenged the ACT resources but were controlled within 52 hours. Multiple fires were involved, probably resulting from arson, and fires burnt in and threatened the urban edge. The Inquiry into the 2001 fires, conducted by Chief Coroner Cahill in January 2004, acknowledged that these fires were effectively fought. Although areas of improvement clearly arose in a number of areas, as is inevitable in the operational setting of bush fire fighting, the ACT authorities performed well.

68. In some respects, it may be that the satisfactory performance in the December 2001 fires gave rise to undue confidence in dealing with the January 2003 fires. In

particular, the widely held perception that any fires reaching the urban edge of Canberra may behave and appear like the fires of December 2001 has featured in the evidence of a number of witnesses (including Castle T1776.40, Bennett T1958 and 2000, Harvey T2451).

69. Persons should not be blamed or criticised for having such thought processes. They accord with the practical reality and with human experience in this area. The evidence of Koperberg supports this view (T2117.45-2118.24):

“Q. What did you mean by that last answer, Mr Koperberg? Was Canberra defensible to a degree?”

A. It is a sort of strange question, of course, “was Canberra defensible”. Whatever we do as a matter of course in New South Wales is as a result of an evolution of procedures and practices, invariably as a result of having suffered a major catastrophe, such as 1994, with the loss of many, many houses and 2001/2002, with the loss of some 204 structures and life, and procedures evolve, and lessons are learnt and remedial actions are taken. It is unrealistic for anyone to suppose that the ACT authorities should have automatically assumed all of the procedures and methodologies that someone else uses because this was a first-time event and therefore they did not have the advantage of previous experience.

So when I answered that question it was in the context of someone employing hindsight and saying, “Well, if we knew then what we know now, we would have done X.” But it does not follow that, not having had to deal with a similar experience in the past, things which evolve as a result of experiencing similar circumstances automatically are employed.” (Emphasis added)

70. Koperberg emphasised that New South Wales has learned as *“a direct result of many bitter experiences and losses”* and pointed to the importance of hindsight in learning from, but not judging, the past (T2214.13):

“Q. Are you saying to Her Worship, “The ACT authorities had enough time to warn these people and they didn’t do it in my opinion”?”

A. *I think the ACT authorities had every right to make a judgment on the potential impact and the resulting consequences on their communities. I don't think I can make that judgment.*

Q. *You are not saying then, are you, that they didn't do enough?*

A. *It depends on whether I speak with the benefit of hindsight or - -*

Q. *With the benefit of the hindsight obviously - -*

A. *Obviously no.*

Q. *But if we assume people should only be criticised for things that they should and could have done, without the benefit of hindsight, are you saying that, what could have been foreseen, enough was done by ACT authorities to warn residences?*

A. *One is in danger of making the error of assuming that what we do in New South Wales, which is a direct result of many bitter experiences and losses, automatically translates to the ACT which does not have that experience, and I don't want to do that."*

71. In the same way that the January 2003 fires were beyond the recent experience of the ACT community, an inquest and inquiry into such events in Canberra is equally novel. In these circumstances, it is submitted that it is all the more important that a realistic view be taken of events insofar as the assessment of the performance of individuals and organisations is concerned. It would be unfair, unrealistic and inappropriate to measure the performance of persons and individuals in the ACT by reference to a benchmark or measuring stick formulated upon the basis of experience in other jurisdictions, or by reference to the extraordinary and catastrophic forces that struck Canberra on 18 January 2003.

72. Koperberg confirmed Lucas-Smith's proven track record in the ACT (T2145.14):

"I think Mr Lucas-Smith has a proven record in the ACT over many years of dealing with circumstances which are normal in the ACT. I have already submitted that this event was extraordinary."

THE EXTRAORDINARY EVENTS OF 18 JANUARY 2003

73. The summary of facts referred to in paragraph 7 of the submissions of counsel assisting and contained in later Chapters, includes little, if any, evidence of the size and scale of the fires on 17 and 18 January 2003 as actually experienced by the fire fighters and other ESB personnel on those days. Indeed as paragraph 4 makes plain, the only evidence which the submission intends to address, is the evidence “relevant to the two issues identified above (initial response and warnings)”.

74. The ACT submits that in order to duly discharge the duties under ss.18 and 52 of the Act to make findings as to the cause and origin of the fires and circumstances surrounding them, your Honour should make findings about the size and scale of the fires on 17 and 18 January. This is to ensure that the findings and recommendations reflect an accurate account of the fires and also to ensure that the shortcomings of the ACT authorities asserted by counsel assisting are considered in the context in which they occurred. To this end, the ACT provides below a summary of the evidence given by a sample of fire fighters which it submits should be included in the Coroner’s report (with any necessary alterations and/or additions) to give colour and dimension to the experiences of many on 18 January 2003.

75. The ACT submits that if the report of the Coroner merely adopts counsel assisting’s narrative, there will be an incomplete and inaccurate account of the fires which impacted on the Canberra urban edge on 18 January. The narrative is also incomplete since the fires did not end on 18 January but continued until approximately 30 January.

76. Regrettably, the approach of counsel assisting in paragraph 4, appears to be focussed upon finding facts to identify shortcomings and to attribute blame to individuals. There can be no objection to the identification of shortcomings because that is necessary to initiate improvements; but the second objective does not accord with principle. This approach should be rejected.

77. It is acknowledged that at Section 3.7.3, counsel assisting summarised the evidence of several residents regarding their experiences on 18 January and

emphasised the unexpected speed with which events unfolded on the afternoon of 18 January 2003. Speaking broadly, a lack of expectation regarding the speed and ferocity of the fires was a uniform experience that afternoon by all concerned, including the firefighters.

78. The ACT submits that your Honour should record the experiences of at least a sample of firefighters in a similar manner to what counsel assisting have done regarding residents. This record ought to reflect both their experience of the events and their expectations of what might occur. The ACT submits that your Honour's report should therefore contain the following summaries, subject to any additions or alterations that your Honour might wish to make.

79. The extraordinary nature of the events, and the relevance of hindsight, were touched upon by Koperberg (T2191.45-2192.31):

"Hindsight would dictate that there would have been dozers, if not hundreds, of things that might have been done by many, many people, but they were not. Based on the information that was available to a whole range of people, I should say that the magnitude of what occurred in the western suburbs of Canberra could not have been foreseen by anybody. The fact that impact was likely or inevitable, I believe, could have been foreseen. The magnitude, the intensity could not have been foreseen by anyone."

Hindsight of course could say, "Well, you should have seen foreseen that and you should have done this and you should have done that," but these assertions are invariably made with the benefit of little more than hindsight."

Q. I accept that. The speed of the progress of the fire on the 18th is one of the things which would have been virtually impossible to predict; wouldn't it?

A. As would be the consequence of fire activity beyond the immediate interface. One could not have contemplated, for argument's sake, the strength of wind being capable of removing or tearing off the platelets which constitutes the bark and pinus radiata and hurling thousands of burning bits of timber into the streets behind the interface strip. That could not have been foreseen. The weather forecast was for winds of 60 to 80 kilometres per hour. It blew well in excess of that."
(Emphasis added)

80. Koperberg observed that the fire on 18 January 2003 travelled three or four times faster than was expected “being driven by winds blowing at a velocity higher than originally forecast, as a result of all sorts of phenomena which occurred, not the least being the collapse of the convection column between the various fires generating tremendous energy release and creating gale force winds” (T2193.17). According to Koperberg, “the magnitude and velocity could not have been foreseen” (T2193.35) and the New South Wales authorities, like the ACT authorities, were taken by surprise with the destruction of the NSW Rural Fire Service base camp at Mt Stromlo.

81. Koperberg observed that “*no one could have foreseen the effect of both the forecast and the prevailing weather conditions on the behaviour of those fires*” (T2204.1).

82. Koperberg agreed that the area in the vicinity of Warragamba Drive contained “*very good set backs*” (T2206.38) and that “*under normal circumstances in this particular scenario one could have reasonably expected [the set backs] to be quite useful in terms of fire fighting*” (T2207.10). He “*would certainly have had that confidence [to hold out any break outs] in those circumstances*” (T2207.28).

83. Cheney commented favourably about the setbacks in his report of 7 June 2004 (page 18.7):

“In my opinion, the condition of the fuels adjacent to the urban areas of the ACT, setback distances from forest vegetation and the compact nature of ACT urban development provided Canberra with the safest interface of any city within the equivalent or higher rainfall zone anywhere in Australia. Other fire experts agree.”

84. Julie Crawford, Queanbeyan Area Manager for the NSW National Parks & Wildlife Service (“NPWS”) possessed very extensive bush fire-fighting experience extending back some 24 years before January 2003 (T4418.27). Her perception of the possible movement of the McIntyre’s Hut Fire into the ACT, and the possible consequences of such movement, is most pertinent. She acknowledged that there was a “*real and genuine prospect*” as at 8 January 2003, and thereafter, that the McIntyre’s Hut Fire may burn into the ACT (T4470.15). But how likely was that

prospect and what might reasonably be expected if it did, in fact, occur? She was asked (T4470.47-4471.47):

Q Up to 10 January, had you heard anyone discuss the possibility that, if the fire went that far, it might well affect the Canberra suburban area?

A No.

Q Had it crossed your mind?

A No. Canberra was a long way away. Canberra - it was more than 10 kilometres to Belconnen; it would be more than that. There was cleared paddocks. We were in drought. There was no fuel in the paddocks. And even to Duffy from McIntyre's was more than 15 kilometres. You have got rivers, major bitumen roads, drought, paddocks - no.

Q When was the first time that it occurred to you that this fire might actually hit the suburbs of Canberra?

A Probably - I suppose there's a difference when it might hit the suburbs of Canberra, which might be the surrounds of the suburbs --

Q No, I mean --

A -- but not damaged. I never thought of damage to houses in the suburbs until it was late in the Saturday when it was actually happening.

Q So --

A To the actual urban edge probably earlier on the 18th - but not damaging the houses. Canberra has had fires to the urban edge before, and experience has shown they have an excellent record of holding fires on the urban edge. And 2001 was a perfect example against an arsonist of being able to hold them on the urban edge.

Q So on these days around the 9th, 10th, 11th and even 12th of January, the possibility of Canberra suburbs being directly affected by fire hadn't crossed your mind?

A No.

Q And it hadn't been discussed with anyone?

A No.

Q As far as you are aware or as far as you can recall?

A No."

85. Unlike Koperberg, Crawford said that as at 12 January 2003, she regarded the prospects that the McIntyre's Hut Fire may breach its containment lines as a possibility only, and not a probability (Crawford T4481). This evidence is significant given that Crawford had a day-to-day involvement with the McIntyre's Hut Fire from 8 January 2003. As a person in a command position at Queanbeyan, substantial weight should be attached to her contemporaneous opinions and perceptions over several days concerning the possible movement of the McIntyre's Hut Fire.

Counsel assisting asked Crawford concerning warnings (T4509.21-4510.11):

Q Perhaps before I go to the question I originally asked you: do you recall any discussion from Mr Lucas-Smith, Mr Castle or anyone else around that time in which they were informed that they should consider warning residents in the ACT and suburban Canberra about the potential of the McIntyre's fire?

A That's for the agency to decide based on all the other information that they have. The ACT has always had an excellent reputation in holding fires on the urban edge. 2001 was an excellent example, and there have been other examples right throughout. They have very good setbacks, very good management around the urban edge of Canberra. I think only those who are within the ACT ESB that have the full picture know when it is appropriate to warn the residents.

Q Is it right to say, though, that you don't warn residents at a point where the damage to be done by a fire is imminent; you warn them well before that, surely?

A I don't know whether - when you do know when it is imminent. It is actually happening then. So you have got to tell them something then. You don't want to panic people. There is always an issue of - we would often promote people stay with their houses because they have got a much better chance of protecting their property if they stay with their house. But there are other people who come from the point of view that, yes, people are all game. They are going to save their house. But once they start choking on the smoke and things get dark and they get scared, then they ring the police and say, 'Come, quick, come and get us out,' and it is too late then".

86. That the timing and wording of warnings to an urban community with respect to bushfires is not a straightforward, black-and-white issue is well illustrated by this evidence from Crawford.

87. Likewise her evidence to the following effect (T4512.15):

"Q At what point is it appropriate to provide that information to the people who are likely to be affected by it?

A. *It is different for each different situation. It depends where it is; it depends on all the other agencies as well. Really it is not one single person can decide it, it is based on a meeting between people. If you warn people, you can't just say it is coming. You have got to give them directions, 'Are you going to evacuate; are you not going to evacuate. If you are going to stay, what are you going to do?' If you are going to evacuate, where are they going to go? The worst thing you can do if [sic] put everyone out on the roads with nowhere to go. It is a huge decision. It has to be based on all agencies agreeing.*

Q. *Yes. One of the benefits, I take it, of early warning to people who are residents and potentially affected by a fire is to be able to give that warning in circumstances where you know there has been some education as to what they should do with the information?*

A. *Yes, and also you don't want to cry wolf either. You don't want to go too early. I mean, then by the time the fire comes, everyone is sick of it – it is coming; it is coming – and everyone ignores your warning. You have to time it. The timing is very critical.*

Q. *And obviously, it almost goes without saying, you don't want to leave it too late either.*

A. *That's right."*

88. Crawford acknowledged that it was difficult in hindsight to express a view as to whether reasonable persons within the ESB ought to have given evacuation advice at 1.00 pm on 18 January 2003 (T4513-4). In answering this question, she said (T4514.12-4515.10):

"They also would have the fact that the ACT has had an excellent reputation of holding fires on the urban edge of Canberra. They have really good setbacks. I can remember right back in the early '90s where we actually evacuated some people from O'Connor but, from my memory, no residences actually burnt down. People snuck back anyway. You can't stop that. You get them out and they go over the back fences and head back into their properties anyway.

I think the ACT worked out that it wasn't going to hit until 6 o'clock that night. But if you just look at it, there is the Murrumbidgee River to cross, there is a huge amount of rural paddocks which were in the middle of drought. There were no fuels in them. A lot of them were just dust bowls.

The night of the 17th, Dr Cheney was out there on the fire ground at that area. He spoke with my divisional commander. My divisional commander said, 'What do we do? It is in the timber.' The advice I got back through my divisional commander was 'There is nothing you can do once it is in the timber. Once it gets out in the cleared country, that's when you hit it'. That's what you would expect. When it came out into the cleared country is when you would attack the fire and when you would be able to get it. At least the rate of speed would drop.

What happened when it came out into the cleared country, from discussions I had with people who were there at the time, they couldn't believe it – it hit the cleared country and just took off. It was a wall of flame across paddocks that had nothing in them. The rate of spread was far more excessive than what people expected. You were also then having where fires were combining and things so you get this much more erratic fire behaviour. You would have to work out, 'Well, it is there'. What are you going to tell the people of Canberra? That it is coming and, yes, you will get it in the cleared paddock, which is what everyone was hoping would happen."

89. Crawford emphasised that, when the McIntyre's Hut Fire crossed the border, "We stayed with it". She said (4515.23):

"I don't think anyone expected the fire to get to the urban area in such a short time. When it did get there, I think we all had the same confidence that we have had for a long time, which is the ACT fire services have such a fantastic ability to hold it on the edge."

90. Crawford said that she was part of the decision-making process that led to the establishment of the NSW RFS base camp at Stromlo on 14 January 2003 (T4518-9). She said (14518.37):

"I was out at the base camp on the morning of the 17th and never felt any threat to the base camp."

91. Bruce Arthur possessed decades of experience in bushfire fighting and was the appointee under s.44 *Rural Fires Act 1997 (NSW)* for the Queanbeyan Area, including the McIntyre's Hut Fire (T4544-6). He was asked about his thought processes concerning the prospect of the McIntyre's Hut Fire breaching containment lines on 12 January 2003 (14574.47-4575.12):

“Q What conclusion did you come to about what the consequences of the fire breaking its containment lines, particularly to the east, were?”

A. I guess on the 12th I’m working on what I may have thought at the time – if it went over the containment lines it would cross the border and be into the pine forests. From there, it would probably descend down along the Murrumbidgee River and onto the flatlands. Our consideration at that time was that, if it hit the grasslands, given the degree of overgrazing and the bareness of the paddocks, we had a very good chance of dealing with it once it came down off the hills.”

92. Arthur did not believe, as at 12 January 2003, “that it would go as far as or into the suburbs of Canberra ... I had in the back of my mind that a containment break could take it into the ACT” (T4577.34; 4578.1). He confirmed that the Stromlo base camp was set up from 14 January 2003 with “one of the primary driving factors” being “whether or not that site might be affected by fire” (T4583.3). The view had been taken that it would not be so affected.

93. With respect to the possibility of breakout of the McIntyre’s Hut Fire as at 15 January 2003, Arthur said (T4590.9):

“I never considered it inevitable; I considered it possible. I made a statement earlier and I will stand by it that I didn’t go into this to lose, and therefore we had a plan in place and it was coming the way we wanted. I believed on the 15th that we would achieve containment and we were going to work very hard to try and contain it. It was possible that it could come out.”

94. Using descriptive and compelling language, Arthur stated (T4611.5):

“We were trying to control nature, yes. I believe every man on the ground and every agency put every effort into this but in the end it beat us”.

95. Arthur confirmed that the McIntyre’s Hut Fire was almost on the Stromlo base camp on 18 January 2003 when it was decided to evacuate it, with equipment worth about \$1.5 million being lost (T4621). He was asked (T4621.25):

“Q. I take it that occurred simply because the fire was on you before you in fact had any capacity to do anything to save that equipment?”

A. At that stage we were aware the fire was coming through the pines. There were crews stayed in situ to defend the asset. They were simply overwhelmed. They were still there after the fire had gone.

Q. Was it the intention of New South Wales, if the fire came over the border, to provide some fire fighting capability in the ACT?

A. We did, sir.

Q. Could you just tell us what you did in an effort to deal with the fire?

A. When the fire started to move, say late Friday night and Saturday, all of the resources and manpower and vehicle and aircraft resources assigned to the fire backed down with it. In other words, they came back in front of the fire attempting to hold it. That was all of the way back down across the river and into the flatlands. They never left the fire at any stage.”

96. Arthur agreed with Crawford’s view that “*it is a very fine balance as to when you*” warn people to leave their homes (T4622.24).

97. The evidence of Crawford and Arthur, both very experienced New South Wales bushfire fighters, is central to an understanding of the perception of the McIntyre’s Hut Fire. It may be stated fairly that both Crawford and Arthur considered that there were reasonable prospects that the McIntyre’s Hut Fire would be contained and, if it broke containment lines (which was only a possibility), that any threat to the Canberra urban edge was a remote prospect. In essence, this view accords with that held by Lucas-Smith, Castle and others up to 18 January 2003.

Arthur Sayer

98. Mr Sayer is among the most experienced fire fighters in the ACT. At the time of the fires, he was a Deputy Chief Fire Control Officer with approximately 37 years

of firefighting experience. He has always lived in the Tidbinbilla Valley and has for many years been a member of ACF Parks Brigade.

99. Sayer gave evidence about his role in the firefighting effort, including his experiences on 18 January 2003. Sayer was with his brother, Wayne Sayer, in a light unit accompanying a tanker on the afternoon of 18 January 2003, carrying out property protection work in the Tidbinbilla Valley. He gave the following evidence:

“My brother parked the backhoe in a burnt area of the first spot fire and got into my car to travel out of Tidbinbilla property. He then opened the gate and I drove through followed by the tanker. Before my brother could get back into my car and shut the door the fire was over the top of us. The fire had travelled about 1.7 kms in the time it had taken us to get through the gate. He managed to get in and we sat in the car for approximately 20 minutes in a burn over situation. I am pretty sure I relayed that to the Command Centre so it should be all on tape.

The fire was a wall of flames somewhere between 60 to 100 feet high and of maximum intensity. I estimate that the wind was now at about 150 kilometres per hour. The fire and wind were lifting our vehicle up so that both drivers' side wheels were well into the air. I remember hanging on to the steering wheel and door handle and looking down onto my brother in the passenger seat. I could see the tanker and knew that it was full of water because we had only just filled it up from the dam. The tanker was rocking from side to side. The feeling was unbelievable helplessness and fear as we just sat contained in the vehicle. We were running out of oxygen and I remember my younger brother saying, we're going to die, and I said don't be an idiot” (GSO.GSO.0500.0388 at paragraphs 58, 59)

100. In oral evidence, Sayer said the winds lifted his vehicle “*probably 2 foot... nearly a metre off*” the ground (T3975). The tanker was full of water and yet it also was “*getting lifted fairly well – rocking fairly well*”. Sayer added in his 37 years of fire fighting he had “*never seen anything like that before*” (T3975).

101. Regarding the speed of the fire, Sayer said that the fire travelled the estimated 1.7 kms in “*less than a minute*” (T3974), and that he had “*never experienced [in his] entire fire fighting career*” a fire travelling that fast (T3979).

102. McNamara was another experienced fire fighter with over 10 years experience in fighting bushfires. In January 2003, he was a Deputy Captain of ACT Parks Brigade. McNamara led various fire fighters in an arduous but ultimately unsuccessful endeavour to fight the Stockyard Spur fire on 9 January 2003.

103. In January 2003, McNamara lived with his family in a Departmental cottage in the Tidbinbilla Nature Reserve. On the night of 17 January 2003, he fought the fires in the Tidbinbilla Valley before returning to his home at about 6am to get some sleep. At about 10am his wife woke him concerned about the fires then crowning over the top of Fishing Gap about 6-7kms to the west. McNamara described an “*amazing wall of fire coming through*” (T3808). McNamara described 3 main fronts of fire burning towards his home. He gave the following evidence about events from approximately 1:30pm that afternoon:

“Michelle had done a fantastic job in preparing our home to the best of her abilities. She had cleaned out all the gutters of leaves and sticks along with blocking the down pipes with rags and filling them with water. This water was now cascading over the top of the gutters. In addition, Michelle had soaked down the house and lawn which was quite green. All windows had been closed with the curtains drawn. Our house was not surrounded by heavy forest, but rather open grassland with tea tree, and now with a grader line around it. In light of Michelle's preparation and the grader line break, I was reasonably confident of protecting our home.

I positioned the Light Unit in the backyard, as the fire front from the Church Rock (due west) came towards us. I determined, due to the prevailing wind conditions, the lack of combustible fuel and containment line close to the house, that this particular fire front would pass by heading up towards Wallaby Rocks. It did. We did experience spotting from this fire which we attempted to suppress, but unfortunately we could not stop it before it took hold of the chook shed. Conscious of the need to conserve our limited water supply, I directed the light unit crew to stop attacking this fire as it posed no direct threat to the house, the wind was blowing it away.

By this stage another fire front from the north west (Block 60 Pine Plantation) was roaring up on us. The sound of the fire was deafening, the winds cyclonic and the ember attack unrelenting. Wayne Sayer and I

attempted to position the Light Unit to the north of our home so as to fight this front.

Wayne was inside the light unit and I was trying to fight the fires spraying water. I had no idea where the other two guys were. At this stage we were inside a horrific firestorm... absolute chaos, it was frightening. My main concern was to get Wayne out of the vehicle, as flames were coming over the top of my head I couldn't get near the vehicle due to the intensity of the fire as it came over the top of the Light Unit, I could see that he was trapped inside. I remember looking through the windows and not seeing Wayne. I assumed that he was lying down with what I thought was a blanket over the top of him. I tried to smash on the glass with the nozzle of the hose to get him out, but he was not going to go anywhere. I could not breathe at this stage, there was no oxygen in the air just a massive amount of dust, embers and flame. I was knocked over by the intense winds hitting my head and losing my helmet. As I got up, I recall my dampened face cloth and mask now burning. I can remember peeling off my goggles and trying to get the face-cloth off. I was being hit in the face with burning embers and dust. I am not sure how I got out. I got down behind the back of a tree, I think, and just got down very low and crawled, eventually finding my way around the back of the house to get out of the flames and severe and intense heat. The heat was incredible. I recall vividly crouching behind the house thinking that Wayne was dead and that I was going to die. I saw the picnic table burning because of the intense radiant heat - there was no flame near it. I wanted to see my family again.

I crawled inside the house thinking this is not going real well. I found the other two chaps there. They were standing near the computer pouring milk over their face. The electric water pump was not working so they were trying to get smoke out of their eyes by pouring the milk over their faces. I recall thinking that Michelle would not be pleased about the milk being spilt all over the computer and carpet. Wayne was still in the vehicle and I really thought he had been cooked.

The fire was roaring all around us and I spent the time walking up and down the house, from the study down to the kitchen window. It was a large kitchen window above the sink, which faced due north, so I had a very good view of the firestorm from the north/north west. As I was looking out, and seeing this fire all around me, my work vehicle (Holden Rodeo twin cab utility) caught alight. It was amazing how quickly it burnt. The gardens were all mulched and the embers were landing in it. The house was now entirely engulfed by fire. The kitchen window blew open where I was standing and the only way I can describe it was like a hungry monster. Once the oxygen was sucked out, the fire raged through. I remember quite vividly looking up at the kitchen clock it was 3:10 pm and feeling the heat on the back of my neck as I walked out.

As I walked down the corridor the curtains were alight in the dining room and my little girl's bedroom was well ablaze. The bed was quite a

distance from the window but was well and truly alight I got back to where the guys were standing in the study and said "I think its time to get out". In a somewhat orderly fashion we just walked out of the house from the laundry door and out behind the chook shed, an area we had previously identified as our safety zone. A fire front from the Church Rock area had previously burnt through this area and it was now a blackened safety zone.

I considered that if my vehicle had been totally engulfed by fire, that the light unit with Wayne inside would not survive. The Light Unit was in close proximity to my vehicle. I genuinely feared for his safety. We sat outside in the safety zone and watched my house being totally engulfed by fire and burn, destroying all of my family possessions and household contents. An experience I would not recommend to anyone. The light unit was still very much in the front of this fire. After probably 10-20 minutes we worked our way around to the front of the house where we could see the light unit. The fire had by now passed through. Wayne Sayer was sitting there in the Light Unit with a big of a smile on his face and I was totally relieved to see him. We all sat for a while and watched the fire burn the rest of my house we were all in absolute shock. Then I realised my face had been badly burnt. I had burns to the nose, cheek and ears. We could see the fire going over the top of Gibraltar Rocks towards Birrigai, and knew that the education centre would be history. If it burnt us out the way it had done, nothing was going to stop it by that stage. Canberra was in real trouble."(GSO.GSO.0500.0219 at paragraphs 125 – 132).

Neil Cooper

104. Cooper is another experienced ACT firefighter, his experience extending back to 1977. He has been involved with every large fire in the ACT since 1982 (ESB.DPP.0001.0206, paragraph 5; T4794-4795). Cooper played a major ongoing role during the 2003 fires.

105. On 18 January 2003, Cooper went to the Uriarra Forest area to provide reconnaissance information. He gave the following evidence about his experiences that afternoon:

"At about 14:30 hrs I caught up with Simon Katz (Rivers 1). We were separated from the other Rivers Units as we tried to help the manageress of Huntly (I can not recall her name) muster cattle out of the path of the fire. The fire was roaring up the roadside vegetation (which was acting as

a wick) and our only choice at the time was to retreat into the heavily grazed paddock on the southern side of the Uriarra Crossing Road. I radioed in to say we were in a bit of trouble because we were now caught between fire fronts with one front to the north, a front to the south and another coming up from the west.

In desperation I tried to burn a patch of ground to give us an area of safety but there wasn't enough fuel to light a new fire and the winds were too strong actually picking up rocks with enough force to break car windows. The on-coming flames driven by heat and wind were up to 2 meters high. I remember they were as high as the aerial on my vehicle. The flames had a depth of greater than 100 metres, which is a lot deeper than normal grass fires. I could not believe the height and depth of the approaching flame front given that it was burning across heavily grazed and bare ground. We were probably 70 or 80 metres from the road and the flame front was coming right at us.” (ESB.DPP.0001.0206 at paragraphs 66 and 67)

106. In oral evidence, Cooper agreed that he “*had never seen anything like that before*” (T4785). He then gave the following evidence about what then occurred:

“Our only option was to face the vehicles in the direction of the flames and leaving it to the very last minute, I drove straight through the fire with the Rivers Command Unit driving next to me. I couldn't see anything and so I just kept the steering wheel straight, heading through to where I thought the gate was. Luckily we both came out exactly where the gateway was and we made it onto the bitumen road. By this time my vehicle's dashboard was smoking and all the engine warning lights had come on. The radiator hoses underneath had melted and the temperature gauge was way off the dial. Rivers I was okay although his offsider in the vehicle was slightly stressed. I then checked to see if the other Rivers Units were okay which at that time they were. I later learned that some had been air lifted out by helicopter as they had suffered smoke inhalation when trying to defend the homestead and rescue the landowner. All this had happened in less than 10 minutes and it was probably about 14:20 hrs when I headed back to Stromlo depot to get some repairs done on my vehicle by the mechanic who I knew was still at the depot.”(ESB.DPP.0001.0206 at paragraph 68)

107. Notwithstanding what had occurred, Cooper went back to the depot where he intended to leave his vehicle for repair. Cooper stated:

“Even in all my experience and what I had just witnessed, I still did not even think that the depot was about to burn down. I left my wallet and other valuables in my car at the depot.” (ESB.DPP.0001.0206 at paragraph 70).

108. Not until Cooper had driven to Eucumbene Drive did he appreciate the extent of the fire. He then returned to the depot to evacuate the mechanic, Paul Graham, only to find the depot and all its vehicles well alight. (ESB.DPP.0001.0206 at paragraph 72; T4786).

109. Cooper gave further evidence about returning to Weston Creek and along Eucumbene Drive *“which was totally engulfed in flame and smoke. Visibility was now less than 2 metres.”* (ESB.DPP.0001.0206 at paragraph 74).

Various fire fighters

110. The ACT Fire Brigade deployed considerable resources along the urban edge of Canberra to extinguish expected spot-fires or low-level tongues of fire that may approach the suburbs. On 18 January 2003, various officers of the Fire Brigade had been directed to Eucumbene Drive in Duffy to set up stand pipes and hoses for this purpose. The evidence makes plain that events unfolded very differently to what was expected. The ACT submits that the experiences of at least some of the firefighters should be recorded.

Lance Buckley

111. Mr Buckley is a senior firefighter with the ACT Fire Brigade. He gave a statement in which he wrote:

“By now the place was getting dark and had a really orange eire look and feel to it, I received a radio message from Delta 4 that “Fellas; in five minutes there is going to be thirty feet of flame hitting us. On hearing this I put my over pants, fire-fighting tunic and gloves on. I decided at this stage that I will stay at this position and dampen down as much as I can. I was putting as much water on the trees lawns and houses as was humanly possible in the immediate vicinity.

The winds had picked up and the place was getting darker and the orange tinge was worse. The fire was not far now, the noise was scary, I could only just here the helicopter overhead.

The next thing I remember all hell had hit the place. The winds were gale force, there was a wall of flame, fireballs going in all directions, I could not see the top of it. This was as if I was at the movies, it was all happening in slow motion. The heat at this point was something I hadn't encountered in my thirteen years as a fire fighter. I attempted to get into the ute, the fire was too hot and I got down on the nearside of the ute, remembering the ute was petrol I retreated toward the houses, but it was too hot the air was burning my throat every time I took a breath. I went and picked up the hose and turned the branch on and put it on spray and sprayed it over me. Putting the branch up to my face to allow me to breath cool air. At a moment there I thought I was a goner. I was thinking somewhere at this point that I don't get paid enough to do this. I just could not believe this was happening.

After the main front of the fire had passed through the wind was unbelievable, with the flaring embers whirling around in tornado like fashion, there were explosions and banging noises coming from everywhere. Everything seemed to be bursting into flames.

After getting over the initial shock of what was happening I tried to put the fires out. I proceeded to hose the house nearest me, there were explosions coming from all over. I was alone and horrified at what was unfolding in front of me, being a fire fighter and not being able to stop the fires at all, not even putting a dent in it.”(ESB.AFP.0024.0128)

Paul Fixter

112. Mr Fixter is another senior firefighter with the Fire Brigade. He gave a statement in which he wrote:

“At sometime around 1300hrs we received a call from Comcen to go to Eucumbene Drive in Duffy. Upon arrival we were met with Bravo 5, Bravo 7, Kambah 10 & 20 as well as our District Officer, Darrell Thornthwaite. (I believe Bravo 3 arrived later when the fire front was just about to hit.)

In the briefing with the District Officer, I believe we were told the fire may head towards the suburbs and that we were to set up standpipes and hose lines along Eucumbene Drive. After this task was completed we met again at the corner of Eucumbene Drive and Warragamba Avenue. Bravo

5 were set up on this corner. We then saw the fire in the pines at the top of the ridge a few kilometres away. The flames were well over twice the height of the pines at this stage. We were talking to the District Officer and he advised that the fire was coming towards us and that we were to stop it from crossing the street...

...As we were wetting down houses it became very dark very quickly and when I looked towards the fire it had jumped the grass paddock in front of Bravo 5 and was heading quickly up into the pines that were opposite us. The closest pines to us were around 10

to 25 metres away. I remember a large amount of embers hitting us first, followed by extremely strong winds and very thick smoke. The wind was strong enough to stop you from walking about freely. It soon became extremely hot and hard to breathe. F/F Morton and myself were wearing dust masks and SFQ Clyde-Smith was wearing a full-face mask.

Within some seconds it became apparent that we were in a very bad way, as it was extremely difficult to breathe or even move. At this stage SFQ Clyde-Smith had the hose reel and quickly put it to full fog spray facing away from us to try and offer some protection. We were now sheltering on the passenger side rear wheel, as it became extremely hard to move or even breathe.

F/F Morton, who was still on the 70mm line 4 metres away, joined us at our position while we tried to wait the fire out. SFQ Clyde-Smith told me that he could not breathe and replied that I was struggling as well.

The radiant heat was also becoming a problem down below and I remember looking down and seeing flame from underneath the tanker on the bitumen as well as above our tanker. I then put my left arm up towards a short hose line that was preconnected above me on the tanker and grabbed it and quickly turned it on full fog spray, covering the three of us in a shower of water. This provided a little relief but not enough to stay in that position for much longer. I remember grabbing my portable radio with my right hand with the intention of sending a MAYDAY message but the radio was not functioning. I said to the other two firefighters that we have to get out of here, as it was apparent by this stage that we were starting to suffer asphyxiation.

F/F Morton who was the driver tried to run to the driver's door but only got two metres and was forced back by the fire and smoke. We then had two attempts to all jump in the passenger side door, which was only two metres away. On the second attempt we all piled in the cabin which was very hot but more livable than outside. SFQ Clyde-Smith and I told F/F Morton to just drive as fast as he could south along Eucumbene Drive. The visibility was less than two metres and our vehicle was driving through the flames and heavy embers.

The fire seemed to be following us south at our speed because we tried to stop after 300 to 600 metres to try and make a stand but when we got out of the vehicle the fire overwhelmed us again. We got back in the tanker

and kept driving through the smoke, as I believe that had we remained where we were the radiant heat would have burnt our tanker, which had been our lifeline.” (TSB.AFP.0045.0118)

Philip Canham

113. Mr Canham was an Acting District Officer with the Fire Brigade. On 18 January 2003 he attended the 9:30am planning meeting at which planning officers predicted the fires would reach the urban edge that day. Later that morning, Canham went to the Mt Stromlo Observatory and in particular to the Red Belly Black restaurant and the Mt Stromlo visitors’ centre to find out how many diners and visitors they would be expecting that afternoon in the event that evacuation became necessary. In the event, no visitors came due to the closure of Cotter Road.

114. Canham gave some “*minor advice*” to the restaurant manager about property protection and returned for Curtin for lunch and to monitor fire conditions. It then “*became apparent that the fire conditions were deteriorating and the fire was possibly going to impact the Duffy area.*” Canham gave evidence that he received a call about a spot fire that had started near the Lower Molonglo Treatment Plant. Canham requested the Fire Brigade’s utility to collect equipment from the store at Kambah. He intended to return to Fyshwick to collect fire-fighting hose but only managed to collect equipment from Kambah before the fires impacted upon the Weston Creek area.

115. Canham went to Eucumbene Drive and was there told that a state of emergency had been declared. He observed fire on both sides of the Cotter Road and considered that the houses fronting Warragamba Avenue might be under threat.

116. Canham then gave an account of driving along Warragamba Avenue and Dixon Drive. His vehicle was completely surrounded by fire and visibility was reduced to about 5 metres. On Warragamba Avenue, Canham counted 16 houses completely engulfed in fire and a fire appliance - Bravo 3 - burning on the side of the road in Warragamba Avenue. Canham was also involved in attending to the elderly

parents of the Fire Commissioner, who were still at their home on Warragamba Avenue.

117. Canham observed that the Fire Brigade “*were completely overwhelmed by the current situation and that all [they] could do was continue [their] current level of property protection.*”

118. Canham had been a permanent firefighter for over 20 years. He felt he was as prepared as he could be for what occurred on 18 January 2003, but that the ferocity of the firestorm was something he had never experienced or had knowledge of prior to that day. In his view, the Fire Brigade was completely overwhelmed, and it was beyond their control to significantly have much impact on the prevention of what happened.

DELAY IN THE CORONIAL PROCESS

119. In Chapter 1.2, counsel assisting deal with the Course of The Inquest. References are made to the ACT seeking leave to appear and counsel assisting's misgivings that separate representation might be required for some individuals or entities. That issue was revisited when reference was made to Phase 2 of the Evidence. The separate representation of Lucas-Smith, Castle, Graham and McRae are noted.

120. The ACT approached the Inquiry on the basis that it would be conducted consistently with long-standing principles that the attribution of blame was not part of the coronial process. For that reason there were only limited prospects that separate representation would be required. The opening of counsel assisting made it clear that the two central issues were, firstly, the Initial Response and, secondly, Warnings and Community Information. They suggested that in both respects what was done was inadequate. Both these issues had been identified in the McLeod Report and their inadequacy commented on. The ACT has fully implemented recommendations regarding warnings and initial response.

121. What was not evident until Phase 2 began was the intention of counsel assisting to move beyond identifying the shortcomings to attributing blame to various senior officers. That approach was not articulated in the Opening, nor was it ever conveyed informally by counsel assisting to the ACT representatives. In a manner not dissimilar to the approach adopted to supplying the working documents of Cheney and Roche, counsel assisting elected to "play their cards close to the chest" and to conduct the Inquiry essentially in an adversarial manner.

122. To the extent that any delays were occasioned from the need for witnesses to obtain separate representation, this approach of counsel assisting contributed in a material way. Another matter which contributed to the need for separate representation was counsel assisting choosing to pit one witness against another. This only became evident in the early part of Phase 2 of the Inquiry, and inevitably led to

delay. It would have been quite different if the intended approach had been made clear in October 2003.

123. For example, at T950-1 it was put to Lucas-Smith that “... *Mr Cooper doesn’t agree with you*”. The alternative but equally effective approach would have been to put in general terms that it has been suggested that certain shortcomings existed. That would have achieved the result of having the witness respond to the alleged shortcomings without bring him or her into direct (and it is submitted unnecessary) conflict with another witness.

124. In various parts of their opening chapter, counsel assisting refer to delays which were occasioned during the Inquiry. Generally speaking, the consistent approach in those submissions, is to be critical of the delays said to have been occasioned by the actions of the ACT and to downplay any delays occasioned by counsel assisting and their witnesses.

125. Examples of the former are at paragraphs 31, 98, 102 and 103; an example of the latter is the disingenuous way in which the delay occasioned by Roche failing to meet the time appointed for the delivery of his report (originally expected on 4 June 2005 but received on 14 July 2005) was dealt with at paragraph 33:

Following the adjournments in late March and early April 2004, the evidence proceeded essentially uninterrupted until 4 June 2004, after which there was a delay of some four weeks to allow parties sufficient time to consider the reports ... which had not then been completed in the time originally anticipated.

126. The fact is that no delay would have been occasioned if the report had been served on time, and the suggestion that the delay was to accommodate the needs of the parties is misleading.

127. The suggestion by counsel assisting in paragraph 98 that the application to the Coroner that she should disqualify herself was made on short notice “*with a view to gaining some kind of forensic or other advantage from the element of surprise*” is untenable. No such advantage was or could have been obtained. The need for the

application to be made on short notice arose from the dictum of the High Court in Vakautu v Kelly (1989) 167 CLR 568 at 572 to the effect that a party who perceives bias may not sit by but must make a prompt application for disqualification.

128. In paragraph 99 reference is made to the Coroner declining to disqualify herself when asked to do so on 19 October 2004. No mention is made of the fact that the Coroner failed to provide any reasons for her decision. Had such reasons been provided there may well have been no application to the Supreme Court. As the Court subsequently held in R v Doogan at 41 [172], the Coroner's failure to provide reasons constituted an error of law.

129. In paragraph 101 it is said that the Full Court concluded that the applications were made prematurely. Reliance is placed on certain observations appearing at 45 [188]. Fairness and balance required counsel assisting to quote the opening words of paragraph [188], namely:

"While we understand the considerations that led to the Prosecutors seeking prerogative relief at this stage rather than waiting for notification under section 55 of any adverse comments proposed ..."

and the earlier observations (at [103]) that:

"We accept that counsel for the Prosecutors faced a difficult dilemma. A litigant who has reasonable grounds for seeking prerogative relief based upon apprehension of bias will be expected to act promptly. They will not be permitted to allow the proceedings to continue in the hope that they may be resolved in his or her favour and then apply for such relief should that hope not be fulfilled. On the other hand, a litigant who does raise the relevant issues promptly may find the application dismissed as premature if the facts reveal only contingent grounds for apprehension."

130. Plainly, the court did not hold that none of the evidence on which the disqualification application was based could support such an application if and when notices issue under section 55 of the Act. It is, therefore, not correct for counsel assisting to assert (as they do in paragraph 103) that the court held that the evidence "*clearly could not establish the required grounds for apprehended bias ...*". The

problem, as far as the Court was concerned, was that the application had been brought prematurely. Some, at least, of the evidence may well be found to support a perception of bias if the tentative concerns are confirmed by events later in the Inquiry: R v Doogan at 26 [103].

131. At paragraphs 102 and 103 counsel assisting refer to “*the delay of the kind resulting from the applications in this case*”. If the implication is to criticise those applications or those who brought them, then that implication should be peremptorily rejected. It is a remarkable submission that a party who approaches a superior court to ensure that proceedings below are fairly conducted and succeeds in that application (the proceedings before Whitlam J) should be criticised for occasioning delay. One would have thought that it was the obdurate refusal of counsel assisting to accord fairness to the parties that was the real cause of the delay.

132. Even in the proceedings before the Full Court in which the application was dismissed, an order nisi was granted by Crispin J and the matter was considered of such importance that it was referred to the Full Court. To the extent that delay was occasioned by those proceedings, it was in no small measure contributed to by the actions of counsel assisting and their witnesses which were the basis of many of the complaints before the Full Court. Furthermore, it was for the convenience of counsel for the DPP in the second proceedings, that those proceedings commenced in February 2005 rather than November 2004.

133. We here add that counsel assisting assert repeatedly and wrongly (paragraphs 5, 17, 26, 98, 99, 101, 1082, 1084, 1090, 1093, 1103 and 1105) that the disqualification application was pursued in the Court of Appeal. It was not. It was heard by a Full Court of the Supreme Court: see R v Doogan at 4, 5 [6].

It is not only counsel assisting who impliedly assert that the ACT and other parties bear the major responsibility for the delays in the Inquiry. That sentiment has been repeated by the Coroner on many occasions during the Inquiry, the last occasion being the directions hearing on 16 June 2006. The ACT annexes to this submission a Table of sitting days for the Inquiry. That Table records the days the Inquiry did not sit and the reasons for that. The largest delay was due to the two Supreme Court applications (274 days); the next longest delay was 137 days due to unavailability of witnesses and

reports and preparation of submissions; and then 40 days for the convenience of counsel other than ACT counsel.

134. Even if the view be taken that the ACT should bear responsibility for delays occasioned by the need for separate representation (which is disputed), the Table shows that only 10.75 days were lost.

135. The ACT accepts that none of these matters have any relevance to the jurisdiction that the Coroner must exercise in the Inquiry. However, the matter was raised in counsel assisting's submissions and publicly ventilated by the Coroner. In these circumstances, the ACT has considered it necessary to address these matters.

136. In paragraph 104 of their submissions counsel assisting recommend that the Coroner recommend certain legislative changes to the Attorney-General. The proposed amendments would impose a leave requirement before any application could be made to the Coroner or the Supreme Court which might cause a material delay to an inquest or inquiry.

137. The ACT submits that the Coroner does not have jurisdiction to make a recommendation of the kind contemplated under the *Coroners Act* or at all. In any event, no such recommendation should be made. Section 52(4) of the *Coroners Act* confers a power on the Coroner to "*comment on any matter connected with the ... fire ... including public health or safety or the administration of justice*". Section 57(3) of the Act is in materially identical terms and there is no warrant for it being construed differently from s.52(4). The power to make comments is "*inextricably connected with, but not independent of the power to enquire into a ... fire for the purposes of making findings*": *Harmsworth v State Coroner* at 996. Any comments must be **based on the evidence** adduced at the inquiry: *R v Doogan* at 12 [43]. (Emphasis added). They are observations about relevant issues in the inquiry such as recommendations as to steps which might be taken to prevent or reduce the risk of future harm: *R v Doogan* at 12 [41]. Recommendations about the form of legislation under which such inquiries are conducted or to which they are subject are not comments of the kind comprehended by s.52(4). They are not inextricably linked to the power to make findings and are not based on evidence taken for this purpose.

LAND MANAGEMENT ISSUES & THE CORONIAL JURISDICTION

138. Commensurate with the approach adopted during the Inquiry, the submissions of counsel assisting raise land management issues briefly and as a secondary issue. However, the combined effect of the main submissions by counsel assisting and their submissions concerning recommendations, is a broad coverage of a significant range of land management issues and policy matters.

139. It is submitted that, for two reasons, any findings, comments and recommendations touching upon land management in this Inquiry should be confined.

140. Firstly, the ACT submits that land management issues are of limited relevance to the Inquiry. The judgement of Full Court of the ACT Supreme Court in R v Doogan provides a statement as to the proper jurisdiction of a Coroner with respect to the issue of fuel management. It is clear that the jurisdiction is a narrow one.

141. Counsel assisting referred, at paragraphs 17 and 105 -108 of their submissions, to the judgment in R v Doogan and the question of jurisdiction concerning fuel management. The ACT submits that counsel assisting have misunderstood the judgment in an important respect.

142. Counsel assisting state at paragraph 17 of their submissions that the Full Court made clear that “*fuel management and associated issues*” were likely to be too remote from the concept of cause and origin of the fires to justify detailed examination and they proposed to restrict their examination:

... to what the evidence shows about the state of the fuel loads in the affected areas and references to the advice which had previously been given by a variety of people who might be described either as experts or stakeholders about how they should be controlled. In our submission, this aspect of fuel loads issue is important to understanding the condition in which the fires started and then developed, and is therefore not remote from the issue of cause and origin.

143. At paragraph 107 of the submissions, counsel assisting stated:

It will be apparent from the conduct of the proceedings that, ultimately, no exhaustive analysis was conducted, presented and cross examined about

concerning fuel management. The outline of the evidence and these submissions will not go beyond the first two levels to which the Court referred and which are emphasised above the fuel loads that were actually in evidence at the time of the commencement of the fires on 8 January 2003 and the fact that several witnesses including experts and personnel from ESB had, putting it broadly, expressed concern that fuel reduction burning had not occurred to the level where a benefit would be obtained in the event of a serious conflagration as occurred on and shortly before 18 January 2003. Such evidence, in our submission, is well within the test of the concept of cause and origin of the fire to which the Court referred in its discussion of s.18(1) of the Act.

144. A proper reading of the judgment of the Full Court in particular at paragraph [25], shows that the only matter their Honours considered to be within jurisdiction was the fuel load in the areas of the fires i.e. the first level to which the Court referred. The highlighted portions in the extracts above are, in our submission, outside the jurisdiction of the Court in this Inquiry.

145. Counsel assisting's reasoning for seeking to include those matters is elusive. They state that the evidence is recorded in order to understand the conditions in which the fires started. This would be true, but only if the evidence concerned the state of fuels and the access trails – nothing more. Yet counsel assisting seek to go much further. The ACT submits that the approach suggested by counsel assisting will lead the Court into error. Their approach seeks to broaden the matters upon which a Coroner may make findings (and consequent comment and recommendations) beyond the matters approved by the Full Court.

146. It is clear from paragraph [25] of the judgment in R v Doogan, the Full Court had in mind as within jurisdiction one matter:

To take but one example, it may be thought that the thickness of the vegetation at the site where the fire commenced had some causal relevance and, if the first respondent came to that view, then she would clearly be entitled to make a finding to that effect. However, that observation may evoke other questions
....”

147. The first sentence of the extract above delineates the extent of the jurisdiction of the Coroner with respect to fuel management. Of all of the matters referred to by the Full Court *after* the extract above, the Full Court suggested at paragraphs 27 and 28 that they were:

... somewhat remote from the concept of the cause and origin of the fire, and any adequate investigation of them would involve not only substantial time and expense, but also delving into areas of public policy that are properly the prerogative of an elected government rather than a coroner or, indeed, any other judicial officer

Section 18(1) does not authorise the coroner to conduct a wide-ranging inquiry akin to that of a Royal Commission, with a view to exploring any suggestion of a causal link, however tenuous, between some act, omission or circumstance and the cause or non-mitigation of the fire”.

148. Accordingly, there is no support for the inclusion of any of the questions referred to in judgment at paragraphs [25] and [26] and the only issue that is within the jurisdiction of the Coroner is the “*thickness of the vegetation*” at the site of the ignition. The reasons given by the Full Court for this view are sound, namely that it would be very expensive, it would take a good deal of time to *adequately* examine all the issues, and such an examination would involve policy matters upon which a Coroner ought not to comment. This point underpins the second reason for why any findings, comments and recommendations regarding land management issues should be confined.

149. The problem with the submissions by counsel assisting is particularly stark when considering the second of the matters they propose as relevant to the Inquiry, namely:

“the fact that several witnesses including experts and personnel from ESB had, putting it broadly, expressed concern that fuel reduction burning had not occurred to the level where a benefit would be obtained in the event of a serious conflagration as occurred on and shortly before 18 January 2003. ... Further, findings about those matters will provide a proper jurisdictional foundation for any comments and recommendations Your Honour is minded to make on fuel management practices in place at the time of the fires and how those practices might be improved for the future”. [paragraphs 107 and 108 of the submissions of counsel assisting].

150. The submissions invite comments and recommendations concerning complex matters involving the balancing of a significant range of competing factors. There was no adequate examination of those factors in the Inquiry which was understandably directed to the issue of fire suppression. These competing factors involve matters of public policy and allocation of funds. To make meaningful and balanced

recommendations on this issue would require the kind of wide-ranging inquiry which the Court made clear in R v Doogan forms no part of the Coroner's jurisdiction.

151. Counsel assisting state at paragraph 130 that their "*purpose ... is not to examine and comment on policy decisions and other matters that may have resulted in the fuel management regime at the time of the fires (but to) ... to summarise the evidence that shows what that regime was and the state of the fuel loads that existed at the time of the fires as a consequence of that regime.*" They continue "*It also confirms what the senior officers at the ESB knew about the (sic) those issues which, once again, can be assumed to have been part of their thinking and decision making ...*"

152. If the knowledge of ESB officers is relevant, the question is not what information "*can be assumed to be part of their*" decision-making but what information was. The knowledge of ESB officers concerning the fuel management regime is irrelevant to the Inquiry. With respect to their knowledge of fuel levels, no assumption ought to be made about what was or was not part of the "*thinking and decision making*" by officers of ESB. Counsel assisting examined officers of ESB during the course of the Inquiry and counsel assisting ought to rely on the evidence available in relation to knowledge on the part of any particular officer concerning fuel levels and not other confirmatory evidence. This is especially so when none of the officers denied the proposition that there were very heavy fuel loads in the areas of the fires.

153. The proposed factual review of fuel management is entirely historical and on the 'wrong side of the line' of the Coroner's jurisdiction as delineated by the Full Court. The problem is apparent from the narrative in the submissions, which includes the following comment by counsel assisting at paragraph 134 :

"The report by Mr McBeth is notable not only because he is critical of the lack of fuel management planning and practices in place in the ACT at the time of his report, but also identifies in unequivocal terms the inevitability of what he describes as a conflagration fire disaster in the ACT and on its urban rural interface ..."

154. The reference to the McBeth report is made for the apparent purpose of including the critical views of a person who has strong views in support of broad scale fuel reduction. When read in conjunction with paragraphs 17, 107 and 108, the commentary by counsel assisting in the extract above clearly invites critical comment from the Coroner concerning the fuel regime at the time of the fire, rather than a finding as to the fact of the fuel levels. This is done in circumstances where the Court has no jurisdiction to make those findings or comments, and it would be improper for a Coroner to do so.

155. Another land management issue raised by counsel assisting in their submissions (at paragraphs 251 to 255) relates to fire trail maintenance. The ACT submits that the state of relevant tracks at the time of the fires in January 2003 is within the jurisdiction of the Court, but that the trail building and maintenance regime is, similar to fuel management regimes, outside that jurisdiction. Those matters are one step removed from an inquiry under s18 of the Act.

156. By way of example, counsel assisting refer to the issue of use of east-west trails being better for fire suppression (see paragraph 255). There was no evidence as to the relevance to this Inquiry of the north-south orientation of many tracks. More importantly, the reasons for development of tracks and trails in this way and the resource issues associated with changing the line of trails are not matters that are within the jurisdiction of this Court. These matters are not proper matters to be the subject of findings or comments.

157. Similar to fuel management, access trails is a complex area that requires consideration of many competing factors, including public policy decisions which ought not be reviewed by the Court.

158. Counsel assisting draw the Court even further into error in their submissions concerning Recommendations. Those submissions contain several comments and recommendations concerning detailed land management obligations. Those recommendations cannot properly be made in the light of the findings in R v Doogan.

159. The second reason for why any findings, comments and recommendations by a Coroner in this Inquiry touching upon land management issues ought to be confined arises from the way that the issue was dealt with during the Inquiry. Counsel Assisting spent a very limited amount of time looking at land management issues. It is a complex topic which was not fully ventilated during the Inquiry. Meaningful recommendations require an:

“... adequate investigation ... (which) would involve not only substantial time and expense, but also delving into areas of public policy that area properly the prerogative of an elected government rather than a coroner, or, indeed, any other judicial officer”.

160. There are a large number of competing ideologies and practical considerations which underpin the issue of land management in the ACT. Land is managed for many differing purposes. Apart from urban or rural development, these are not limited to, but include:

- Conservation and wilderness values;
- Recreation (ranging in their effect on the land from walking to rally car driving);
- Water catchment and quality;
- Fire management.

161. Two experts gave evidence touching on land management issues. Both of them, McBeth and Cheney, hold a particular view concerning conservation land management objectives, and indeed elevate fire management over other objectives.

162. At T7044.10 – 44, Cheney gave the following evidence:

Q. Could I just show you a document that is drawn from the documents produced pursuant to your Worship's order the other day. Volume 1, part 1, tab 2 is said to be the draft land management report of 4 June 2004, according to the schedule, with proofing marks made by H. Drew. Could I take you to page 27, which is there, Mr Cheney.
A. Page 27?

Q. I think the front page is just there to identify where it is coming from. Page 27 is the second page. About two-thirds down the page:

"In the past a popular way of managing access is to declare areas wilderness. Wilderness is an outdated '70s concept and it is dangerous. It is dangerous because in its pure form it prohibits pro-active management in the area. It is elitist because it denies the elderly and infirmed and at least some of the physically handicapped people access to areas of our natural heritage."

It seems that part of what is said there is deleted as the document shows. Is it fair to say what was in the draft indicates your actual views on the wilderness issue?

A. Good job you didn't get an earlier draft.

Q. It was even hotter, was it?

A. Oh, yes.

THE CORONER: Just make no admissions, Mr Cheney.

163. The evidence of McBeth and Cheney represents only one part of the equation and without the other part, their evidence is not helpful to arrive at a balanced approach to this issue.

164. Although Cheney has much experience and helpful advice to provide on fuel management matters, this Inquiry did not fully ventilate land management issues in order to support balanced and thoughtful comment and recommendations that may be useful to the Territory. The evidence of others with similar viewpoints only served to emphasise the difficulty for the Coroner, not alleviate it.

165. Counsel assisting, at paragraph 130 of their submissions, state that they intend to provide a factual narrative and not comment on policy matters. If the factual narrative had been confined to the state of the fuel and access trails, this would have been appropriate. However, the approach in their submissions is at odds with this statement. The issues raised by the narrative at paragraphs 131 to 141, and some of the issues at 142 to 145 and 251 to 255 would require very detailed and careful consideration of the broader obligations and objectives with respect to land management in the Territory. Those paragraphs concern the McBeth Report, the Glenn Taskforce, the Cheney review of the 2002 Bushfire Fuel Management Plan, the

McRae “Phoenix Imperative”, and part of the comment on the state of fuels, fire trail maintenance and access to fire. Such a careful inquiry and analysis was beyond what was undertaken during the Coronial Inquiry (as well as being beyond jurisdiction).

166. This issue becomes particularly acute when considering the recommendations made by counsel assisting in their submissions concerning recommendations dated 5 May 2006. They make detailed recommendations for how land management matters ought to be dealt with (paragraphs 12 to 26 of the recommendations submission). These are issues clearly outside the jurisdiction of the Coroner and no such recommendations can or should be made by the Court.

167. The pitfalls of the approach by counsel assisting are made plain when considering some of the recommendations. In particular, counsel assisting comment in detail about the SBMP, including both its virtues (paragraph 14 and shortcomings as they perceive them (paragraphs 15 and 16).

168. The difficulty that counsel assisting profess to have in understanding the detailed and careful work which has been undertaken in the development of the SBMP (which incorporates fuel management) underlines the inappropriateness of their recommendations. Counsel assisting recommend that the Coroner reserve her comments upon the SBMP, and advances in fuel management works in the Territory, until she has seen the BOPs. BOPs have been prepared and can be provided if requested. However, the allocation of funding for further development of the SBMP, the emphasis given to various matters in the SBMP and the practical implementation of that Plan through BOPs is the result of weighing up by the government of competing calls on public funds, lengthy consideration by the Territory of a huge number of competing views and many differing land management objectives. The resulting approach to land management is a public policy matter and a matter upon which the Coroner has no jurisdiction to comment. The same can be said for the BFMPs that existed before the 2003 fires and their implementation.

169. The recommendation by counsel assisting at paragraph 19 of their Recommendations submissions is particularly dangerous. To adopt the wisdom of

counsel assisting, gained from their assessment of the limited evidence before the Inquiry, in substitution for the careful consideration of:

- a range of land management objectives;
- the weight to be given to fuel management and other matters within various differing parcels of land;
- resource allocation; and
- other public policy matters,

by experienced fire and land managers is wholly inappropriate and outside the Coroner's jurisdiction. The ACT submits that no such recommendation ought to be made.

170. The ACT also submits that the recommendation by Roche that land managers ought to be the first responders to fire on their own land is not appropriate for the ACT. The ACT submits that the closest brigade vehicles ought to undertake the initial response, supported by an IMT (if one is required) consisting of staff from the land management agency upon whose land the fire is located. The aim should be in the first instance to get the vehicles closest to the fire to suppress it – not have land manager crews drive further than other crews who would be readily available to fight the fire. The combination of:

- the DUS MOU,
- the Agency Representative arrangements,
- access agreements, and
- stand-up arrangements,

mean that land managers will most often be initial responders to fires on their own land (as they were in January 2003), and where they are not, proper supportive arrangements are in place. The point is that the closer vehicles ought not be precluded from being responded initially to provide for a timely firefighting response.

171. The lack of jurisdiction on the part of the Coroner does not affect the fact that careful consideration has been given to land management issues that came to light as a result of the experience of the 2003 fires in the ACT. The land management issues raised by the McLeod Inquiry have been addressed. The Government continues to weigh up its competing obligations and address these important issues within the

resources available to the Territory. This includes, but is not limited to, the development of the next version of the SBMP, setting of practical targets in Bushfire Operations Plans, audit of fuel management tasks and development of policy and practical changes surrounding access to forests and conservation areas.

OPERATIONAL PREPAREDNESS FOR THE 2002-2003 FIRE SEASON

172. Following the December 2001 fires, ESB gave consideration to areas of improvement in operational fire fighting. Evidence of this was given to Chief Coroner Cahill in January 2004 during the Inquiry into the December 2001 fires. Mr Lucas-Smith gave evidence in the present Inquiry on this point (1776-778).

173. A number of improvements had been made by January 2003. In general terms, the ACT authorities had a good record in fighting bushfires within their jurisdiction and in working cooperatively with NSW authorities.

174. At this point, it is pertinent to contrast the size of the NSW and ACT Bushfire Services. The NSW Rural Fire Service is comprised of the Commissioner, some 120 Fire Control Officers, some 2,200 Rural Fire Brigades and approximately 69,000 volunteer fire fighters (RFS.AFP.0093.0006). In January 2003, the ACT Bush Fire Service comprised 4 full-time persons –Lucas-Smith, Graham, Ingram and McRae. There were only 3 departmental brigades and 9 volunteer brigades (ESB.AFP.0111.0236 at 0259). In effect, the ACT bush fire brigade was comparable to the bush fire personnel in a district or shire within NSW.

175. Counsel assisting have explored with a number of witnesses the question of increased operational preparedness leading into the 2002-2003 bushfire season. It is clear that there were finite resources in the form of appliances and facilities available to the ACT authorities. Likewise, there was a finite number of permanent and volunteer fire fighters available. It could not reasonably be suggested that a significant increase in numbers of experienced fire fighters could have been achieved in the 13 month period between December 2001 and January 2003.

176. Counsel assisting have referred to a document prepared by McRae in early 2002 entitled "*The Phoenix Imperative*". In that document, McRae proposed fuel management and hazard reduction activities. In his evidence, McRae made clear that

these were not actions which were capable of achievement within a matter of months. Rather, he was speaking of longer term actions which needed to be taken.

177. Counsel assisting have raised with witnesses the possible pre-deployment of bulldozers and other heavy equipment within national parks and in remote areas. Although this concept has a theoretical appeal, a critical issue is identification of the location where such heavy appliances would be placed. There would be a significant element of chance in placement of equipment – how would you determine where to place it? Whether it was close to or remote from a fire would depend upon the location of the fire. Practical and financial considerations also militate against such pre-deployment. As Crawford observed, *“we don’t pay to have dozers on standby ... if you pay to have a dozer on standby, I could have a dozer on standby in Queanbeyan, but the fire could be in Young or Crookwell Shire”* (I4434.33). Lucas-Smith said that he had access to ACT Forests heavy plant under a memorandum of understanding (I789).

178. Lucas-Smith was aware that the 2002-2003 fire season may be a bad one. The evidence indicates that he had been informing the ACT community of this concern. Realistically, no further steps could have been taken to better prepare the ACT authorities to deal with the January 2003 fires.

PREPLANNING OF AIRCRAFT AND HEAVY PLANT

179. At Section 2.5.3 of their submissions, counsel assisting adopt the comments of Roche, and implicitly the latter's criticisms regarding lack of pre-planning by the ESB in specified respects – see paragraph 247. Roche's criticisms appear at pp.38-9 of his report and are prefaced with the comments that:

Despite this recognition of the expected severity of the 2002/3 fire season, the evidence suggests that little if anything, was done in the lead-up to the season by either ESB or the DUS over and above normal pre-season preparations.

180. Thereafter, Roche listed “*the actions that should have occurred*”, which list comprised 11 items.

181. Counsel assisting purport to summarise Roche's evidence about these matters at paragraphs 211 to 216. The ACT submits that this evidence may be relevant to the making of recommendations for the future, but has marginal if any relevance to the cause and origin of the fires. The latter issue encompasses what did or did not occur from the point that the fires were ignited to their ultimate extinguishment; but does not include what might have happened if things had been done differently before the fires commenced.

182. It is significant to note that of the 11 actions which the Roche report asserted should have been done, only three matters were deserving of mention in the submissions of counsel assisting. No doubt this was so because Roche was extensively cross-examined about the manner in which he came to these conclusions; in particular the evidence upon which he relied to do so. It appears that that he assumed there had been inactivity by reason of the absence of evidence in the brief, rather than a reliance upon any evidence that things had not been done.

183. At T7573, Roche was asked whether he was asserting that none of the matters at p.39 of his report were attended to and he said:

From the evidence available to me there was no indication that they were.

184. This was an approach that Roche adopted in respect of other matters in his report. There are a number of examples in his evidence. At T7557/8, he was questioned about criticisms he made at p.53 of his report asserting inadequate training, situational analysis and poor command, involving the burn over of Fire Brigade pumpers. He stated that it was not his place to have arranged for anybody in authority with intimate knowledge of the issue to be spoken to. Accordingly, his opinions were “*based on the evidence that was put before the Court*” or “*evidence that formed part of the brief*”.

185. In the context of pre-preparation for the impending fire season, Roche gave evidence that arrangements should been made for an increased access to aircraft - however, until the receipt of Ingram’s second statement, he did not know “*the number and the specifics ...*” of available aircraft (T8014).

186. The weight of Roche’s opinion is reduced by reason of the fact that whilst he asserted the negative proposition, he would not be drawn on the specifics of what arrangements could and should have been made. So much is demonstrated at T8015, where he said:

“in my view, arrangements should have been made to secure or to ascertain ... the availability of additional aircraft. Now what number to me is irrelevant at the time.”

187. Similarly when Roche made the same criticism about the unavailability of heavy plant, he did not know whether the nine pieces of heavy equipment listed in Annexure DI3 of Ingram’s second statement were available or not (T8016-18).

188. Rather than concede that the reliability of his opinions might be affected by these omissions (as a truly objective expert witness would have done), Roche rejected the proposition that it was impossible to criticise the ACT and to suggest they should have had increased access to aircraft when he did not know what they had (T8016).

189. Having regard to these matters, Roche’s reliability as an expert witness is called into question. Not only did he not qualify his report by stating that he was forming opinions on the assumption that what was contained in the brief represented the true facts, but he also did not take any steps to satisfy himself of the true position.

Nevertheless Roche was prepared to proffer critical comments adverse to senior ESB personnel.

190. At paragraph 7 of the submissions, counsel assisting make the claim that chapters 2 and 3 “*contain an accurate summary of all the evidence*” which is relevant. The cross-examination of Roche is referred to in paragraphs 212 to 215 in chapter 2. Passing reference is made to Roche’s lack of knowledge of these facts; but no mention is made as to any impact this might have on Roche’s reliability as an expert witness yet counsel assisting did not show such reluctance in commenting on the credibility of the evidence of other witnesses e.g. Keady’s evidence at paragraph 556. Furthermore, nowhere in the submissions is there reference to the extensive attack on Roche’s credibility or what effect that attack should have on the evidence given by him.

191. The ACT submits that this approach of counsel assisting lacks detachment and objectivity – it treats Roche as a favoured witness. The ACT submits that the Coroner should reject such an approach and consider Roche’s evidence in the same way as other witnesses. The reliability of his evidence and the weight to be attached to it should be measured by the well accepted rules relating to the evidence of expert witnesses.

192. At paragraph 247, counsel assisting submit that nothing was done “*over and above ESB’s usual pre-season preparations*” in the lead up to the subject fire season in relation to weight of response; pre-planning or pre-positioning of resources or arrangements in respect of aircraft.

193. It is accepted that nothing extra was done in relation to the specified matters. It might be thought that a significant degree of hindsight is implicit in the proposition – the line of thinking being that it should have been foreseen that any fire or fires which ignited would (without the preparations suggested) result in uncontrollable fires.

194. The ACT submits that in a jurisdiction of the size of the Territory, it is not unreasonable to deploy resources in accordance with a standard operating procedure which seeks to take into account the potential seriousness of the fire situation.

Furthermore in the context of the ACT, it is not reasonable to expect that resources should be deployed in greater numbers than the weight of response requires, to remote fires which have not been assessed. Personnel and resources are not limitless; and deployment of resources can only be responsibly done by having regard to the ability to have sufficiently rested crews available in the event that the fire continues past a number of working shifts.

195. It is also incorrect to say that nothing was done at all. Ingram in his statement of 15 October 2005 (FSB.DPP.0013.0196) at paragraph 5, summarises the actions he took in preparation for the fire season as follows:

- i. the 2002 Pre-season Workshop was conducted. This included an exercise involving fires in Namadgi National Park and required complex fire management considerations;
- ii. the preparation and circulation of phone lists;
- iii. the preparation and circulation of Call Sign lists;
- iv. the development and distribution of Duty Coordinator and DCFCO and Group Officer Rosters for 2002/3;
- v. helicopter arrangements with regular contractor HeliAust were in place; but radio and buckets arrangements for the season were finalized and air observer kits were available and checked; as was the helicopter support trailer;
- vi. the fire tower contracts were in place and operative;
- vii. the reviews of primary personal protective equipment and other stores were conducted in July and August 2002 and were regularly reviewed;
- viii. a new initiative in COMCEN training which enhanced communication capabilities and protocols specifically for bush fire related duties was undertaken in 2002;
- ix. liaison with Bureau of Meteorology regarding fire matters was completed in 2002;
- x. there was regular liaison between ACT Bushfire Service staff and Yarrowlumla RFS staff; and
- xi. a review of stock of maps and ICS forms for the up-coming season, was conducted.

196. Ingram confirmed the steps he took in preparation for the 2002/3 fire season at T3522; he indicated they went through the normal checklist and it was no different to any other fire season (T3523). Further at T3523, Ingram referred to the Memorandum of Understanding between the ACT Bushfire Service and the land management agencies, which was signed of on 9 January 2003 (– AUS.AFP.0036.0001, albeit the MOU was informally in place earlier in the season). Section 5 of the MOU made provision for the supply of heavy plant by ACT Forests to the Bushfire Service and associated matters.

197. Ingram confirmed that the ESB did not own or lease bulldozers; at the start of the season, suppliers were contacted to see what machinery was available; there was an MOU with ACT Forests that any machinery they had was available on request (T3527– T3528). Ingram confirmed that ESB had lists available to source additional aircraft apart from what was on contract to them (T3528).

At T789/790, Lucas-Smith referred to the MOU that ESB had with the land management agencies *“as we went up the readiness scales, ... heavy plant would become on standby and are available to us ... it moved the floats in close proximity to where the machines were working so they could be readily accessed and transported.”* He stated that such occurred on every orange and red readiness day in ACT.

198. Lucas-Smith was asked about preparedness of heavy equipment and said that he did not have the equipment available and to do so would involve a *“logistics exercise for four or five months ..., which is quite extensive and very expensive”* (T791). It is noteworthy that neither counsel assisting, nor Roche in his report, pursued the issue of what practical and financial limitations existed if attempts were made to try and implement Roche’s suggestions.

199. The allocation of funds was not a matter under the control of the ESB; nor is it an issue which is a legitimate area of concern for this Inquiry. If criticism is to be levelled at individuals for asserted failures in this area, it would be quite wrong to do so when a significant reason for such failure as might be inferred from Lucas-Smith’s evidence, namely a lack of funds, was outside his control. It is one thing to say by recommendation that it is desirable in extreme fire seasons to have available aircraft

and heavy plant – it is quite another to be critical of persons for not having that availability, when it may not have been in their capabilities.

200. In summary, the ACT submits that your Honour should reject Roche's criticisms in this regard. This is because Roche conceded that his opinions concerning some of the asserted omissions were based on an absence of evidence in the brief rather than information that things had not been done. Secondly, Roche gave no consideration to whether the things he suggested were achievable in the available time frame (August 2002 to January 2003); and finally he gave no consideration to issues such as how many aircraft or heavy appliances were required or the cost of them – see Roche T8015.

201. Having regard to these matters, any criticisms based on his views must be compromised and further any recommendations based upon them, are of limited utility if the Court is unable to conclude that they could have been achieved or afforded.

THE INITIAL RESPONSE TO THE FIRES

202. The facts pertaining to the Initial Response to the three ACT fires are set out in Chapter 3 of the submissions of counsel assisting. Counsel Assisting raise questions concerning the adequacy of the initial response to all fires in the ACT and about the manner in which the decision to withdraw from the Bendora fire was made.

203. The ACT acknowledges that in hindsight the question of overnight firefighting at the Bendora fire only, and the manner in which that decision was made, could have been handled better. However the ACT submits, for the reasons set out below, that the response of the officers of the ACT Bushfire Service was a reasonable one having regard to the prevailing circumstances. When determining whether individuals should be criticised, it must be borne in mind that fair judgment can only be made by acknowledging that individuals act within the constraints of their knowledge, training and experience and in the circumstances in which they find themselves.

204. The ACT is a small jurisdiction with more limited personnel and resources than its neighbouring State. The pool of persons experienced in large fire events in the ACT is also not comparable to larger jurisdictions. Accordingly, any judgment concerning the response of ACT authorities to the fires of January 2003, should be judged with those constraints in mind. It is also almost inevitable that in events of this kind, tasks will sometimes not be carried out in the best manner and mistakes will be made; this is so even in large and well-resourced jurisdictions. Invariably one of the core reasons is a failure to appreciate the potential of the fire or disaster in question.

205. An example of such a failure is exhibited in the response of US authorities to Hurricane Katrina. The Final Report of the Select Bipartisan Committee into that event was released on 15 February 2006 – at p.131, the Committee observed:

Similar to the troubled national responses to Hurricanes Hugo and Andrew in 1989 and 1992 respectively, the federal government failed to recognise the magnitude of the situation presented by Hurricane Katrina prior to landfall, adequately project future needs, fully engage the President, and respond in a proactive and timely manner.

despite there being:

...plenty of advance warning by the National Weather Service, and the consequences of a category 4 hurricane striking New Orleans were well documented.

206. This example serves to illustrate that even in a larger, very well resourced jurisdiction which had warning of what was about to occur, the system did not function well.

207. The Committee concluded at p.359 that

... all people involved, at all levels of government, were trying their best to save lives and ease suffering, their best just wasn't good enough.

208. Consistent with that conclusion, the approach adopted in that Inquiry is summarised at p359 as follows:

We have not sought to assign individual blame, though it is clear in our report that some were not up to the challenge that was Katrina. Rather we have tried to tell the story of government's preparation for and response to a massive storm, and identify lessons learned.

209. The Committee noted the difference between having enough information to find institutional fault and having information to assign individual blame and stated at p.359:

It's the former that's important if the goal is to be better prepared the next time. This was not about some individual's failure of initiative. It was about organizational and societal failures of initiative.

210. The nature and scale of the events involved in ACT in January 2003 bear no close analogy with what occurred in New Orleans; however, there are common issues concerning the perception of the authorities as to the nature of the disaster and how they responded to those perceptions. Accordingly, the ACT submits that the Coroner should adopt the approach of the US Select Committee i.e. to eschew ascribing individual blame and to identify the lessons learned so that the ACT may better be prepared for future wildfires.

211. In this context, it is also useful to note the Concluding Remarks of McLeod in his *Inquiry into the Operational Response to the January 2003 Bushfires* in the ACT at p.239 that, whilst large destructive fires are not unique:

... the event was unique in the experience of the residents of Canberra and its surrounds and probably of all the fire fighters because fires of this kind have never before cause such damage to the region. A house has not been lost to bushfire in suburban Canberra since 1952.

212. In making your findings and recommendations, your Honour should acknowledge that it was in the context of that experience (to be contrasted with the experiences of others who gave evidence (e.g. Koperberg at 12214 and 2117-2118), that the various individuals made judgments concerning the fires in January 2003 and acted on those judgments.

213. The ACTI submits that, based on the evidence led in this Inquiry, your Honour should make findings consistent with those of McLeod who stated at p.243:

*“The individual government officials, employees and volunteers spared nothing in terms of their personal commitment during a long and difficult crisis ...
Any criticism directed at individuals because of the role they were required to perform is in no way intended to question their integrity or their honesty in doing what they felt in the circumstances was the right thing to do at the time”*

214. It is not in accordance with proper principles to single out individuals for blame for the acts done and decisions made within systemic constraints (see Nature of Coronial Inquest & Inquiry above). It must also be borne in mind that on 8 January 2003 the individuals concerned were called upon to make decisions based upon their knowledge and expectations at the time, without the input of expert opinion in a situation where they faced competing priorities and calls upon their resources. These issues have received more detailed consideration in the submissions above (“The Benefit of Hindsight” and “The Need for Practical Reality”).

215. Counsel assisting have made various submissions (which are addressed more specifically below) to the effect that specified omissions which occurred on 8 January were relevantly a cause of the fires which impacted upon Canberra on 18 January

2003. Your Honour should reject that proposition. The principles relating to causation in this context have earlier been dealt with in these submissions.

216. In this respect, it is submitted that the better approach is to recognise that although a *chance* to extinguish the fires was lost in the first 24 to 48 hours after the lightning strikes on 8 January 2003, the number of variables and underlying circumstances make it inappropriate to state with any certainty that a different final outcome would have been achieved had a more vigorous approach been undertaken. The ACT submits that the course adopted by Mr McLeod at page 242 of his report provides a sound approach:

“The Inquiry considers ... that there was a chance to extinguish the fires if the opportunity to put them out in the first 36 to 48 hours after the lightning strikes had been grasped more vigorously. The ACT fire authorities are criticised for not coming to this realisation quickly enough and for failing to immediately attack the fires with all the aggression they could muster. Had this occurred - while this Inquiry is not in a position to conclude unequivocally that it would have made a difference in the absence of the fullest response that was potentially available – the doubt remains that the fires that originated in the ACT could have been stopped. ...” (emphasis added)

217. Reference has already been made to observations made by the Full Court in *R v Doogan* at 9-10 [28], [29] and [31] as to the limits of this Court’s powers when making findings as to causation. In particular, attention was directed to the tempering effects of common sense and reasonableness. These observations are consistent with dicta in a number of High Court cases, for example in *Allianz Australia Ltd v GSF Australia Pty Ltd* (2005) 215 ALR 385, McHugh J at 394 [41] emphasized the part that notions of common sense play when considering causation:

The common law concept of causation is concerned with determining whether some breach of a legal norm was so significant that, as a matter of common sense, it should be regarded as a cause of damage.

218. The ACT submits that greater difficulties generally arise in the application of the test for causation when factors such as those set out below exist in combination as they do in the present Inquiry:

- in issue is inaction rather than an act;
- the inaction relates to an unpredictable phenomenon, namely a wildfire;

- that phenomenon is affected by another unpredictable factor, such as the weather;
- the inactions were removed temporally and in distance from the point where the loss or damage occurred – in other words there was an issue of remoteness. The inaction involved:
 - a. a claim that a person, and in this case the Chief Fire Control Officer, should have identified the lack of experience of another officer and replaced him with someone more qualified;
 - b. a further claim that the first mentioned officer should have become much more involved in the decision whether to fight the fire, and in this case the Bendora fire at night; and
 - c. uncertainty as to what would have occurred, had crews undertaken a different course, and in this case overnight suppression tasks;
- the absence of equipment, and in this case bulldozers that might have undertaken suppression tasks; and
- a claim that the inaction was a cause of the later loss and damage, and in this case damage occasioned by fires which commenced a considerable distance from the urban edge of Canberra after 10 days had elapsed since ignition and despite numerous intervening events.

219. At each stage of this sequence of events, several alternative outcomes may have occurred depending on a number of variables, for example a change in weather or the ability or inability of crews to maintain the rate at which they carried out suppression work and equipment or other events. In addition, the loss and damage resulted from a combination of fires, the largest of which - the McIntyre's Hut fire - was being dealt with by NSW RFS. That fire was arguably also a cause and therefore, another variable related to the capacity of NSW RFS to suppress that fire.

220. In the light of these variables, to contend that the omissions of the ACT individuals on 8 January, removed in time and distance from 18 January, were a cause of the fires at the urban edge of Canberra misapplies the common sense test of causation. Their omissions were too remote from the events on 18 January to constitute causes in the necessary sense.

221. It is submitted that the more accurate finding is that an opportunity was lost to contain and perhaps then to control the Bendora fire. Whether that would have affected the events of 18 January 2003, cannot be determined.

222. The ACT concedes that, in relation to the Bendora fire, an opportunity was lost to contain that fire when the crews were withdrawn on the first night, but submits that no finding of causation of the fires that impacted on the urban edge of Canberra on 18 January 2003 is open.

223. In relation to Stockyard Spur, the ACT submits that, having regard to the matters below, there was no real opportunity for crews to access the fireground and therefore, whilst there existed a theoretical opportunity for rapid containment and control on 8 January, no actual opportunity existed.

So far as the Mt Gingera fire is concerned, there was no practical opportunity for rapid initial response due to the late hour the fire was reported and the inability of crews to have gained access before nightfall.

224. The following more specific submissions are made concerning the Initial Response of the ACT firefighting authorities to the three fires which commenced on 8 January 2003.

Bendora Fire

225. The fire was first detected at 15.41 by Mt Coree fire tower. Firebird 7 had been deployed for aerial reconnaissance at 15.30 as a result of other smoke sightings. Following a report from Ingram in Firebird 7 at 16.02, Graham at 16.03, directed units to the fire. Stevens, travelling alone in a command vehicle, arrived at the fire ground at 17.50 ahead of the two Forest Brigade units. Odile Arman, who was responded a little later, arrived in her command vehicle at about 18.50 along with the Parks Brigade crew and fire suppression vehicles. It is submitted that these resources were dispatched to the fire in a timely fashion.

226. The incident controller, Arman, was of sufficient competence and experience to make a decision whether to stay or not, having regard to her experience and practice. Her firefighting experience commenced in 1984 and included some remote forest firefighting experience. She had been a Group Captain since 1997/8 and was the local incident controller for the Bruce Ridge fire in 2001, that being a fire in a forested area of about 50 hectares in size (ESB.AFP.0111.0001 at paragraphs 10-18 and Annexure A)

227. The size, intensity and location of the Bendora fire were not such as would put fighting that fire outside her range of experience. It was her opinion at the time that the fire would not expand rapidly overnight and she concentrated more on the immediate situation than the long term (Q227-8 TROC DPP.DPP.0004.0021). It may be that her ability to foresee the longer term potential of the fires was affected by her experience – but does not detract from her capabilities competently to assess the fire on 8 January and decide whether it could be safely attacked.

228. It must be remembered that this was the 92nd fire to have commenced that fire season, and response capability had proved reasonable. (Lucas-Smith T802). The ACI submits that it is only because this fire ultimately caused substantial destruction that Arman's experience has come under such scrutiny.

229. Arman's decision to withdraw was made on a reasonable basis, having regard to the safety of the crews and their fatigue. It is by no means certain that others more experienced would have made a different decision – since those persons were not in a position to assess the capacity and fitness of the crews or the degree of danger involved in the fire fighting exercise that night. Even if more experienced persons might have made a different decision, that fact by itself does not detract from the reasonableness of Arman's decision.

230. The circumstances in which the decision was made were conceded by those involved in making it to be less than "ideal" – and that is an appropriate description. The manner in which the incident controller conveyed her decision was not decisive – she neither asked for advice (cf Q226 TROC) nor did she state a concluded decision.

One contributing factor to this indecision was Arman's uncertainty regarding who had the authority to make the decision (Q.236 TROC). She also considered that if senior officers at ESB had wanted the crews to stay, they would have said so (Q.246). The circumstances of the discussion leading to the decision, gave scope for ambiguity. In the event, Arman agreed that she would have been happy to act differently if her decision had been overruled; but that position was not conveyed in the exchange between her and Graham (Q.244 TROC). (Arman TROC DPP.DPP.0004.0021)

231. The acceptance by Graham of her decision without further question was not an appropriate response; the opportunity to discuss and, if appropriate, reconsider the decision, for example, providing a second opinion to the incident controller in the field, were thereby lost. The manner in which such decisions are made in the future can and should be improved.

232. The manner in which the decision was made reflects a miscommunication or misunderstanding between Arman and Graham. Whether or not this was a reflection of the experience of the persons involved, is debatable. In the event, their past experiences of successful suppression of fires with which they had been involved, may have contributed to the belief that there was sufficient opportunity to contain the fires at first light the following day. Moreover their small size and their remoteness supported the view that the potential threat posed by them to valuable assets was not great. There was, no doubt, a failure to realise the potential consequences of allowing such fires to take hold, thereby making later suppression more difficult.

233. The ACT submits, however, that any finding as to what might have occurred on 18 January 2003, had the crews stayed at the Bendora fire, is highly speculative. Any linkage appears to rely, in part at least, upon the proposition that the fire could have been contained within the first 24 hours with the crews and equipment which were deployed to Bendora on 8 January. If it was not contained before the afternoon of 9 January, the prospects of subsequent successful containment diminished considerably. The notion of containment within the time frame, depended on two further factors -- the use of the Bendora Break as a containment line (obviously before it was breached on 8 January or in the early hours of the morning of 9 January 2003) and the availability of heavy equipment to assist in the containment process.

234. The incident controller on 9 January was Rick Hayes who was a fire fighter of considerable experience. That experience dated back to 1987 (ESB.AFP.0108.0002 at paragraph 6). At paragraph 38, he described the deterioration of conditions as follows:

... during the day fire activity increased to what was really an amazing intensity by the evening of 9 January 2003.

He confirmed this observation in his evidence at T3902, where he stated that the significant deterioration of conditions occurred at 16.00 on 9 January 2003, such that the crews had to be withdrawn.

235. That on-ground experience was confirmed by the Bureau of Meteorology which noted in its submission (BOM.AFP.00092.0001) at p.20 that:

The fire danger on 9 January rose to High on the McArthur Scale but only very briefly rose into the Very High range as a wind change moved through the area

236. The ACT submits that the window of opportunity to contain the fire, closed substantially on the afternoon of 9 January and unless the fire was substantially contained by then, its subsequent escape could not have been prevented due to the deteriorating conditions.

237. The most proximate potential containment line to the north or north-west of the fire was the overgrown Bendora Break. No bulldozers were (or could have been) deployed to Bendora on the night of 8 January. Any attempt to build a break to contain the fire in that period would have required construction of containment lines by hand. The evidence disclosed that the fire crossed the Bendora Break late on 8 January or in the early hours of 9 January 2003. Accordingly, the task of completing secure containment lines needed to be completed before the Bendora Break was breached. It is by no means certain that this was achievable by hand line construction without the assistance of bulldozers. The number of crew available at Bendora on the night of 8 January 2003 was reasonable. Even though the configuration of vehicles sent to the fire was not exactly in accordance with the SOP, the number of crew and vehicles was in excess of the SOP. However, there were too many variables (fatigue, experience, nature of the terrain, fire behaviour, weather, the need for crew members to undertake watchout and water-locating activities, injury) to reasonably conclude

that a successful rake hoe line could have been achieved. The development of the fire into fingers overnight on 8/9 January 2003 would also have contributed to the difficulties in constructing containment lines (ESB.AFP.0108.0002 at paragraph 23)

238. Even if a hand line had been achieved, a real question arises as to whether the fire could have been contained when conditions deteriorated on 9 January. As events transpired, no D4 or D6 bulldozer was available until 10 January 2003. At paragraph 39 of his statement, in the context of dealing with what might have been achieved on 9 January had a bulldozer been available in the morning, Hayes stated:

It's very difficult to say what could have been achieved during the day, especially as the difference in fire activity between the morning and the afternoon ... was quite extraordinary.

The ACT submits that, in resolving questions such as these, your Honour should accord significant weight to the views expressed by experienced fire fighters who were actually present at the fire ground.

239. Accordingly, it cannot reliably be concluded that the fire could have been prevented from crossing Bendora Break overnight – on 8/9 January 2003 and have been controlled before the onset of the worsening conditions on the afternoon of that 9 January 2003.

240. The suggestion by Cheney and Roche that containment would have been successful and control achieved over the ensuing 10 days should not be accepted – it represents one view based upon a number of variables which may or may not have occurred. In the light of such observations, the issue of control of the fire in the ensuing 10 days is entirely speculative.

Stockyard Spur Fire

241. Smoke at the Stockyard Spur location was detected at 15.25. Helicopter surveillance was undertaken at 15.57 and Graham activated crews at 16.03. The incident controller, Dennis Gray was contacted by ESB at 16.18 (ESB.AFP.0180.0230 at paragraph 10) . The ACT submits that these resources were dispatched in a timely fashion.

242. The evidence of the incident controller was that he and his crew were unable to reach the location of the fire and were thereafter withdrawn. It was Gray's evidence that it took at least one and a half hours for him and his crews to reach the Mt Ginini carpark i.e. they arrived after 18.00 (ESB.AFP.0180.0230 at paragraph 11). The radio transmissions (between 19.13 and 19.14) confirm that, based on the assessment of both Gray and Firebird 7, Gray was about 3 and a half to 4 kms from the fire at that point. [see p.79 of the merged transcripts ESB.DPP.0002.0001 at page 51]

243. The fire was not accessible by vehicle and the estimated walking time was about 2 to 3 hours. Accordingly, the crews would never have been able to access the fire ground before nightfall. In these circumstances and in the absence of air transport, no fire suppression activities were able to be carried out on the night of 8 January 2003. Even if the crews been able to access the fire, there was very little realistic prospect of the fire being contained overnight – see evidence of McNamara referred immediately below.

244. Furthermore, even if heavy equipment had been available that night, the evidence suggests that it could not have been transported to the fire. The question of whether it was practical to deploy heavy equipment was the subject of conversation between Graham and McNamara on 9 January. In his statement at paragraph 41 (ESB.AFP.0103.0052), McNamara estimated that, had such equipment been available, it would have taken between 3 and 5 hours to get to the fire.

245. The evidence discloses that there was a significant deterioration of conditions evident at the Stockyard Spur fire shortly after 14.00 on 9 January. At paragraphs 43 to 44 of his statement, McNamara said that the wind picked up at about 2.30 pm and that at about 4.00 pm, fire behaviour changed with increased flame height due to increase in wind strength, and temperature and a drop in humidity – McNamara confirmed this in evidence at T3728 (see also Radio Transcript ESB.DPP.0003.0002 at p.40).

246. The fire was not reached by crews, and could not reasonably have been reached, on the night of 8 January. Heavy equipment was not available to be deployed

on 8 January (or until 10 January) and even if it had been, there were no practical means of transporting it to the fire site. The opportunity for earlier containment and control had greatly diminished by 14.00 on 9 January.

247. It follows that the contention that this fire could have been contained and sufficiently controlled by an initial aggressive response before the onset of these conditions, is built upon a false premise, namely that firefighters and suitable equipment could access the fire.

248. It is also entirely speculative to conclude that such a response was likely to have altered the events of 18 January. In the absence of any realistic suggestions of steps that might have been taken on 8 and 9 January to overcome these problems, the conclusion that the fire could have been controlled is not open.

Mt Gingera Fire

249. No access was gained to the Mt Gingera fire on the night of 8 January and indeed the aerial report at 18.01 which followed the fire sighting, was to the effect that there was “no easy access” to this fireground. The following day, the reports were that it would have taken in the vicinity of two and a half to three hours (from Tidbinbilla Nature Reserve) to access the fire ground.

250. The evidence of Lucas-Smith establishes that this fire was accorded the least priority of the fires then under ACT responsibility. This decision was made on the basis that, on the best estimates, crews could not have accessed the fire before nightfall and only by approximately 21.00, and that the fire was small and inaccessible. An additional matter of significance for Lucas-Smith was the fact that the location of this fire raised issues of safe ingress and egress for fire crews along the Mt Franklin Rd – see Statement of Lucas-Smith ESB.AFP.0110.0551 at paragraph 28.

251. In order to justify a reasonable conclusion that containment and control of this fire could have been achieved had crews attended, it is incumbent on those who so contend to demonstrate how crews and equipment should have reached the fire

ground and in what time frame. In the absence of relevant evidence, any assessment as to what might have been achieved cannot reliably be made.

McIntyre's Hut Fire

252. The ACT makes no submissions concerning the Initial Response of NSW authorities to the McIntyre's Hut fires. It is pertinent to observe however that it was this fire which impacted upon the Weston Creek area of Canberra (see paragraph 1 of the submissions of counsel assisting) – with the qualification that the effect of the coalesced fires undoubtedly increased the rate of spread and the nature of the impact on the some parts of urban edge. It may well be observed that this fire, unaffected by the ACT fires, could have itself impacted upon Canberra, albeit at a different time and with less drastic consequences.

253. The ACT submits, for the reasons set out below, that it is speculative at best to contend that, had the ACT authorities acted as suggested in the submissions of counsel assisting, the impact would not have occurred – that result is but one potential result. Such a contention depends upon a number of propositions, none of which could be advanced with certainty. If a conclusion that a certain outcome would have occurred depends upon a number of factors occurring and occurring in a certain sequence, the greater the number of factors, the greater is the uncertainty of any ultimate conclusion.

Summary of the Evidence of Peter Lucas-Smith

254. Lucas-Smith provided a statement to the Inquiry (ESB.AFP.0110.0551). At paragraph 4, he stated that he had been the Chief Fire Control Officer in the ACT since July 1996. His Curriculum Vitae - ESB.GSO.0005.0421 – indicates that he had been involved in 10 major bushfire events (fires exceeding 5000 hectares) and 4000 minor and medium bushfire events. He had not experienced any major bushfire event during his tenure in Canberra.

255. At T1200, Lucas-Smith stated that he had had successful experiences with fires up until 2003. In the 16 years he had been the CFCO, the Service had responded to 3000 fires, 6 of them significant and had sustained no serious loss. His thinking in the course of these fires was:

*... I had a fair bit of confidence we could do something ...
(and) ...a reasonable expectation that some suppression effort would be successful and there would be some amelioration of the impact on the ACT.*

256. At paragraph 14 of his statement Lucas-Smith stated that, at 16.00 on 8 January 2003, he became aware of a large number of reports in quick succession, they being of multiple lightning strikes. He spoke to Graham about whether there had been an appropriate response. Lucas-Smith stated that he left the task of responding to the calls to Graham because “all these fires were small and resources were in the process of being responded”.

257. At paragraph 15, Lucas-Smith stated that the SMT was formed comprising himself as controller, Graham as Operations officer and McRae as Planning officer. Ingram who would normally have been included as Logistics Officer was involved in helicopter reconnaissance.

258. At paragraph 16, Lucas-Smith stated that the prime tasks of the SMT were to verify reports of smoke and report all fires to the responsible control centres and then to deploy ACT resources to ACT fires.

259. The reports by helicopter and other sources were that there were five sightings (three were reports of fires in NSW) two of which were relevant to ACT authorities - namely fires at Stockyard Spur and a fire at Bendora Creek. The report regarding Stockyard was that “*there was no vehicle access to the fire edge*” (paragraph 17).

260. At paragraph 19, Lucas-Smith said that, once there had been positive grid references fixed for the fires, the responding units were advised. “*Given the remoteness and the ‘Orange’ readiness level of the day, the response was made in accordance with our SOPs, which is designed to maintain adequate coverage of the*

ACT should it be required” especially having regard to recent arson activity and “the potential for additional lightning strikes to emerge”.

261. At paragraph 20, he stated that the Parks Brigade Captain (Odile Arman) was dispatched to the Bendora fire with 2 tankers and 3 light units and a command unit; the Parks Brigade Deputy Captain (Dennis Gray) was dispatched to Stockyard Spur fire with 2 tankers and 1 light unit *“although access for those units was not yet evident”*. One light unit was sent to report on the McIntyre’s Hut fire.

262. Lucas-Smith noted that, as there were protracted travel times associated with remote area response to the ACT fires, water bombing by helicopter was employed on the Bendora and Stockyard Spur fires. During this time, a further lightning strike fire at Mt Gingera was reported (paragraph 21). In addition, a grass fire 1 km south of Tharwa and 8 small fires at Paddy’s River Road (apparently started by a faulty motor vehicle) were reported (paragraph 22).

263. At paragraph 23, he stated that, by around 17.00, the following reports were in: two very large smoke plumes at McIntyre’s Hut and Yarrangobilly and six smaller plumes at Stockyard, Bendora, Gingera, Mt Morgan, Mt Urialla and Broken Cart. Lucas-Smith commented that *“Experience suggested there was a significant possibility of other lightning strike fires still emerging, which had not as yet produced any smoke. This meant the threat of additional fires was significant.”*

264. A post trough wind change was expected and this *“always created safety risks for field crews.”* It became evident that the Bendora fire was the only fire *“that could be reasonably accessed using 4WD trails”*. The main access to Stockyard Spur and Gingera was the single access Mt Franklin Rd and *“safety factors had to be considered in regard to the threat from other known and unknown fires ... that might affect crew safety and egress”* – paragraph 24.

265. Lucas-Smith made further reference to these safety concerns at paragraph 38 (albeit in relation to events on 9 January) where he stated that there were problems with the remoteness and access to those fires. He continued:

We were also concerned with the orientation of Bendora and the Stockyard Spur fires, as they were on east facing aspects with the slope running uphill towards the Mt Franklin Rd. Although the prevailing winds were light, they were in that same direction as the slope and so both wind and terrain were going to influence the fire behaviour and fire spread to the west, putting the Mt Franklin Rd under threat. At that time, this road was our only access to the Stockyard Spur and Mt Gingera fires and therefore our only route for retreat if required by crews working on both those fires. The northern end of Mt Franklin Rd also provided us with the only access to the Bendora fire at that time ... We therefore needed to suppress the fire from spreading to the west to keep Mt Franklin Rd open, being very conscious from a safety perspective that we didn't expose our crews to an uphill fire run along the Mt Franklin ridge.

266. Lucas-Smith concluded that over the last two decades the majority of firefighting deaths have occurred in similar circumstances.

267. The difficulty in gaining access to the fires on 8 January was recognised by other experienced fire fighters. Graham Blinksell (a person with at least 30 years of firefighting experience - paragraph 9, ESB.AFP.0108.0089) said in his statement at paragraph 14:

After the lightning strikes on 8 January, I knew from the location of the smoke plumes and my personal knowledge of the area, that there would be difficulty in gaining quick access to the initial fire sites while the fires were still small.

268. At paragraphs 26 and 27 of his statement, Lucas-Smith noted that, during his absence, Graham had a conversation with Arman concerning whether the crews would stay overnight and, having regard to the inherent risks of fire fighting in the dark, a decision to withdraw was made.

269. When he made his statement, Lucas-Smith did not recall the telephone conversation he had with Graham at 19.42 on 8 January 2003, a transcript of which he later produced and became Exhibit 0020(T820/1 ff) It is submitted that the fact that he volunteered the transcript indicates that, he did not wish to conceal any information; and wanted to assist the Inquiry. This is a matter which weighs heavily in favour of Lucas-Smith's credibility.

270. It is evident , that the exchange of information between Lucas-Smith and Graham occurred whilst Lucas-Smith was in a vehicle travelling to Qucanbeyan. The

situation did not provide an opportunity conducive to informed decision-making. Lucas-Smith sought information about whether any firefighting could be done that night and there was a provisional expression by Graham that he was “*very doubtful*” that there could. A short discussion followed as to redeployment of crews the following day; then Lucas-Smith commented that care was required not to over commit their resources which might be required for the ACT to support the McIntyre’s Hut effort.

271. In the course of giving his evidence, Lucas-Smith made a number of statements concerning his thinking in relation to the Initial Response of ACT authorities. At T794, he said that, on 8 January, he saw the potential for fires to involve ACT and NSW, and at least to have the potential to threaten assets in the ACT but not to threaten urban Canberra. At T794, he stated:

I certainly had confidence in our ability to be able to have some intervention, and therefore ameliorate some of the impact.

272. Lucas-Smith stated that he did not recall the conversation in which Bartlett offered his services, but conceded that Graham may have said that ESB would not commit additional resources until there had been confirmation from on-ground incident controllers about the fires (T795-7).

273. Lucas-Smith’s approach is not materially dissimilar to the approach urged by Roche in connection with the Baldy Range fire. Roche stated at T7840 there is nothing wrong with developing an interim strategy but “*not to actually start doing anything one way or another*” or “*not to make that commitment necessarily until corroborative information was received*” i.e. to deploy personnel and machines to various places to do various tasks. “*The physical commitment of resources on a fire line should not have been committed until a position was well and truly established*” (T7841). This comment applied to all fires being considered at the Queanbeyan meeting(T7842). At T7851, Roche stated that “*the firm strategy should not have been implemented*” until the corroborative information had come back.

274. In relation to the issue of overnight firefighting, Lucas-Smith stated that whether or not it should occur depended on an assessment of the terrain; the environment the fire was burning in; the accessibility; the prospects of achieving a result by direct attack; and risk of safety of firefighters— (T798). At T812, he further gave evidence that so far as overnight firefighting on 8 January was concerned:

... we were still seeking advice and information ... and I was not prepared to make any decisions or judgments ... (regarding effective strategies) until we had that information.

275. At T815, he stated that he:

...had some concerns in relation to the night-time firefighting exercise ... The potential existed ... for a number of safety issues to arise. However, it is the advice from the people in the field that make that determination, not ... Curtin.

276. A further element in Lucas-Smith's thinking was that on 8 January, the fires were

... a long way away from the urban edge of the ACT ... (T803)

and that at the time he considered that the McIntyre's Hut fire was the fire which had the potential:

... to impact on the ACT not the urban edge ... (T804)

but that the risk to Canberra was:

... a pretty long bow at that particular time ... (T805_

SUBMISSIONS IN RESPONSE TO THE MATTERS RAISED IN CHAPTER 5 OF COUNSEL ASSISTING'S SUBMISSIONS

277. Counsel assisting assert, in paragraph 1116, that, with the exception of some measures taken by ACT Forests, “*ESB and ACT land management agencies made essentially no preparations for this particular fire season over and above any preparation made in any normal year*”. If this assertion is taken to mean that ESB did nothing in preparation for the 2002/3 fire season, then the ACT submits that the submission should be rejected. We refer to the “Operational Preparedness” and “Preplanning of Aircraft & Heavy Plant” sections above, and to the supplementary statement of Ingram referred to within those paragraphs.

278. If on the other hand, the criticism is directed at the omission to engage aircraft and heavy plant, any such criticism is unwarranted without a consideration of what financial and other constraints existed for ESB personnel to do so.

5.1.3 Rapid Aggressive Response

279. At paragraph 1117, counsel assisting submit that with “*a rapid and aggressive response to all fires, there was a strong likelihood of containment of all fires within the first 24 hours*” and that this would have led to good prospects of successfully controlling and suppressing the fires before the onset of extreme weather. At paragraph 1119, the term “*rapid aggressive response*” is stated as requiring, as a “*minimum*”:

- a. an immediate response to all fires with ESB’s standard weight of response, with crews equipped and trained to undertake remote area firefighting;
- b. standing up of all available resources “*to be deployed as soon as reasonably practicable after first arriving crews are on scene*”;
- c. ascertaining the availability of heavy plant and arranging for deployment “*to all fires at the earliest opportunity*”.

280. This is a submission of considerable generality. your Honour should not make findings of this kind for the following reasons.

281. Firstly, it is a broad ‘text book’ proposition of ‘best practice’ which overlooks the particular limitations and difficulties which existed on 8 January. In this regard, the formulation does not take into account the fitness, training and experience of the ACT crews that were deployed and the fact that some of them had been working since the early hours of that day. It pays no regard to the fact that two of the fires, Stockyard Spur and Mt Gingera, were inaccessible by means then available to ACT authorities.),

282. Secondly, it also ignores the potential ‘cancelling’ effect on any progress in containment and control of the fires as a result of the weather change that occurred between 1400 and 1600 on the following day (9 January).

283. Thirdly, it ignores the breach of the fire line at Bendora Break late on 8 January or in the early hours of 9 January before there was any possibility of a dozer reaching the Break to construct a containment line.

284. Finally, the formulation of the term “*rapid aggressive response*” contains numerous variables:

- (i) There is no indication of what constitutes “*immediate response*” having regard to the location of each of the three fires.
- (ii) Assuming that there were RAFF crews of sufficient number available at that time, there is no consideration of whether those that were available were able to complete a full shift having regard to many of them having been on duty since the morning.
- (iii) There is no indication of how and in what time frame, the stood up resources should, or could have been, deployed – in this context, the question of when “as soon as reasonably practicable after first arriving crews are on scene” is left open.

- (iv) The definition does not grapple with the issue of what heavy plant was available, whether what was available was suitable to deal with each of the fires and in what time frame could they be deployed – in other words, there is no indication of what constitutes “*at the earliest opportunity*”. Regarding the last of these variables, Lucas-Smith (T788) stated that the ACT authorities had arrangements with a NSW Government Department to have available to them two bulldozers (T791 and 864/5).

285. The availability to the ACT authorities of heavy plant on 8 January 2003 is dealt with in the statement of Peter Beutel, the agency representative for ACT Forests (ESB.AFP.0108.0215). It appears from his statement that the two available bulldozers were a D9 and a D4 bulldozer.

286. At paragraph 6 of his statement, Beutel said that on 8 January in the afternoon, he was asked by Neil Cooper to begin sourcing bulldozers. At about 4.30pm, he arranged for a D9 bulldozer to be available for making firebreaks at north-west side of Uriarra forest and to assist in the firefighting effort in the Brindabellas. He stated that the D9 was delivered to the Blundells/Brindabella Rd intersection at 8.30pm. It appears to be the case that this bulldozer would not have been able to be deployed to any of the fires before nightfall on 8 January – and furthermore, it was too large to be of use in any of the three ACT fires at that time. The limitation relating to deployment of the D9 dozer is that it needs to be taken on the float as close as possible to the area where it is required to be used and then ‘walked’ in. The size of the float is such that it cannot get down smaller roads. After a dozer comes off the float it is ‘walked’ in – a process which is generally kept to a minimum because it is slow (between 2 and 3 km per hour) and because of the wear and tear on the dozer and the possibility of damage. These constraints were generally the subject of agreement between Cheney at T336 and Lucas at T788.

287. The closest a float could have taken a D9 to the Bendora fire on the night of 8 January 2003 was Bulls Head on Mt Franklin Rd. The distance from Bulls Head to

the Bendora fire is about 7.5 to 8km. The closest a float could have taken a D9 to the Stockyard fire on 8 January was a little further along Mt Franklin Rd than Bulls Head. It is about 25 km from Bulls Head to the Stockyard fire.

288. At paragraph 8 of his statement, Beutel stated that the D9 bulldozer “*required track repairs for most of the day*” – being 9 January. It was running by 6pm that day. On 8 January, Beutel contacted a Mr D McMillan to organise D6 replacement for the broken-down D4 bulldozer. McMillan organised for a bulldozer to arrive from Bathurst the next day. The D6 bulldozer left Bathurst at 1pm and reached Belconnen at 7pm. In relation to both bulldozers on 9 and 10 January, there was only one operator for each bulldozer so only the day shift was worked (paragraphs 8 and 9). Subsequently on 10 January, a D6 bulldozer was obtained from Soil and Conservation at Goulburn; and D7 and D8 bulldozers from Captains Flat (paragraph 9). Beutel also noted that the D6 bulldozer which had been deployed to Bendora on 11 January had a transmission problem at 3.15pm “*and was not used much while being fixed.*” The same piece of equipment was stopped due to a radiator leak on 12 January (paragraph 11). The evidence of Ingram at T3553 confirms the breakdown of two bulldozers.

289. Therefore, as events stood on 8 and 9 January, it would not have been possible to have had heavy equipment at any of the firegrounds before the evening of 9 January and, more likely, not until the morning of 10 January. Whether this comes within the formulation of “*at the earliest opportunity*” is not made clear.

290. These circumstances illustrate that speculation about likely outcomes based on ‘best practice’, without regard to unforeseen setbacks, and is of limited value. Invariably, predictions of the course of events in a situation differ from how events actually unfold in the real world where not everything goes to plan.

291. In the present Inquiry for example, the evidence disclosed that plans were disrupted in various ways. Equipment failed; various accidents occurred e.g. the helicopter accident on 13 January involving Lucas-Smith – paragraph 67 (ESB.AFP.0110.0551) of his statement; a tanker fell through a bridge on Lick Hole Road on the afternoon of 16 January 2003, thereby frustrating the entire evening’s

backburning plan. This problem was compounded when the ESB had access to dozers to clear the trail, but not the keys to the dozers. (statement of Sayer - ESB.AFP.0111.0262 at paragraphs 39- 42). There was a significant change of weather conditions on the afternoon of 9 January.

292. In addition, when predictions are made as to the capacity of individuals to perform tasks at specified rates, it is not uncommon that such people can be afflicted by injury, fatigue or unexpected terrain so as not to perform to expected requirements.

5.1.4 Operations Officer Role on 8 January

293. At paragraph 1120, counsel assisting state that the choice of officer responsible for decisions about strategies and resource deployment at initial response is most -important and submit that it should have been evident to Lucas-Smith and Graham that:

- the person with that role should be the next available officer to Lucas-Smith with expertise in fighting and managing remote area wildfires and
- that person was not Graham.

294. The premise upon which this submission is made is that the person entrusted with the task should have foreseen the potential of the fires to escape and ultimately become campaign fires - in other words a hindsight view of what occurred. It may be true that a more cautious or pessimistic person may have acted differently; however the ACT submits that what was required in that task of operations officer, was a competent and experienced officer and that Graham was such an officer. He had been performing the role of Operations Officer for many years and in response to 92 previous fires that bushfire season without mishap.

295. It was always likely that the operations officer at ESB would rely upon the incident controller in the field to provide accurate information about the location and circumstances of the fire and connected safety issues. Furthermore, the incident controller would have been singularly well placed to give an opinion about the matters as to which professional judgment might be required e.g. the size, spread and intensity

of the fire; the terrain; the fuel loads; the experience and fitness of the crew; an assessment of what might be achieved if the crews remained and issues connected with safety of the crews.

296. Accordingly, of equal significance was the expertise of the incident controller at the site of the fires, because the responsibility lay with that person to assess the fire and determine what could be done and whether it could be done within the constraints of Occupational Health and Safety requirements.

297. At paragraphs 1121-1125, a comparison is made between the more limited experience of Graham in managing and fighting remote area wildfires and that of Bartlett, Cooper and Sayer. Graham accepted that he did not recognise the same level of concern as the others but did not accept that he was not sufficiently experienced. It is submitted that it is one thing to say that a more experienced officer may have acted differently; it is quite another to assert that the less experienced officer failed to act reasonably. There is no basis for the latter submission.

298. Graham acted as Operations Officer throughout the rest of this event and did so in a manner that receives no criticism. He was constantly making operational decisions concerning these same fires over that period. The fact that someone else may have made the initial decision differently to Graham is insufficient cause to say that he was not a suitable person for the Duty Officer role. He had performed the role with success for 5 ^{1/2} years. It is unreasonable to say that a person who has successfully filled the role for that period ought to have recognised at the time this event began that it was a particular event in which he ought not play his regular role.

5.1.5 Relevance to Cause

299. At paragraph 1126, counsel assisting submit that your Honour should conclude that Graham's lack of experience contributed significantly to the poor decision-making on the first night of the fires and the following morning. The ACT submits it is unfair to characterise the decision-making as "*poor*"; although agrees that it might have been done better.

300. In any event, Graham at 13018/9 stated that if the matters of concern to the incident controller (as noted in paragraphs 52 and 53 of her statement) had been put to him he would still have decided not to leave news on the fireground overnight:

No, if its Arman had passed on all of that information on to me before the decision had been made whether or not for crews to remain overnight, I certainly believe it was a dangerous situation that they were facing and the risk (to the firefighters' safety and lives) was too great.

301. He expressed the view that it was difficult to second-guess an incident controller:

... when a person is stuck in an office some miles away.

302. Further, the proposed finding does not relate to any act or omission in starting the fire, suppressing or containing the fire at any stage between 8 and 18 January 2003 or any decisions on the fire ground relating to these matters. Nor is it a finding about the actual decision to remain overnight or not, putting aside the question of whether Graham or the incident controller made the decision. The finding relates to the experience of a decision-maker removed from the fire ground and it purports:

... to explor(e) ... (a) suggestion of a causal link, however tenuous, between some act, omission or circumstance and the cause or non-mitigation of the fire.

It is therefore submitted that the proposed finding is so remote from the cause or non-mitigation of the fires on 18 January 2003 that it is not within the jurisdiction of the Coroner to make it.

303. Similar considerations apply to the proposed finding based upon the evidence of Lucas-Smith, Bartlett and Roche that, had an officer of Bartlett's expertise and experience been in that role, the matters listed would have occurred. The proposed finding in relation to the location and responding of heavy plant ignores the fact that this was done by the agency representative Beutel.

304. The proposed finding appears to be based upon the evidence of Bartlett (Q.74-5 IROC, DPP.DPP.0004.0023), yet Bartlett prefaced his response by stating that it was “a difficult question” because he was not given the role and he preferred to answer the question hypothetically as if he were assigned the role of the incident controller. In summary, he stated that his proposed course of action would have been to assess the location and knowledge of the fires; to assess what resources could be deployed immediately and how best to get them quickly to the fires; “*to use whatever mechanism was most efficient to*” deploy all available resources onto the fires; and to start the planning process. Furthermore, at T5947 Bartlett stated that he would have deployed RAFT crews and made arrangements for bulldozers.

305. It is important to note that Bartlett was speaking hypothetically; accepting that he might have taken the steps that he indicated, it does not follow that he would have taken those steps had he been the Incident Controller at the fireground on 8 January, or that those steps would have been successful, or that the expected outcomes would be achieved.

306. As previous and later discussion shows, there were problems of access and equipment availability and failure, which Bartlett was not asked to factor into his hypothetical considerations.

307. At paragraph 1127, counsel assisting submit that the Coroner should conclude that, had such an approach been taken to all fires in the ACT on the first night, “*it is likely that initial attempts at containment in the first 24 to 48 hours would have been successful, and a significant degree of control achieved over the ensuing 10 days.*” The effect of the breakouts on 17 and 18 January would have been minimal and a significant part of the damage and destruction of property is likely to have been avoided. It is also contended that it is likely that the tornado would not have eventuated.

308. The proposed finding, asserting as it does that there was a likelihood of success in containment, stands in stark contrast to the finding made in the McLeod Report at p.242 to the effect that doubt remains that the fires could have been stopped.

It is submitted that there are so many variables underpinning the proposed finding that it should not be made.

5.1.6 Proposed Finding

309. At paragraph 1128, counsel assisting submit that the Coroner should find “*that the failure to identify the importance of the role that Mr Graham would be fulfilling that night in the absence of Mr Lucas-Smith and to replace him with an officer with the necessary experience was a serious error of judgment that was a cause of all the ACT fires ...*”. The error was made (so it is said) in the first instance by Lucas-Smith who was in the best position to understand the seriousness of the situation and the importance of Graham’s role. His error was compounded by his declining Bartlett’s offer of assistance.

310. The ACT submits that the Coroner should not make this finding for the following reasons.

311. First, the serious assertion that Lucas-Smith was guilty of a serious error of judgment in this regard was not put to him – and as a matter of procedural fairness, it ought to have been.

312. Secondly, the ACT repeats the submission that the link between the asserted failure by Lucas-Smith and the fires on 18 January is so remote and tenuous that it would be outside the Coroner’s jurisdiction to make such a finding. The proposition may be demonstrated by outlining some of the steps in the proposed chain of causation: firstly that Graham lacked experience in such circumstances; next that Lucas-Smith should have but failed to realise this fact; thirdly, that had he done so, he would have replaced Graham; fourthly, that the replacement would have been a person of greater experience than Graham; fifthly, that the person would have had available to him crews and heavy equipment; sixthly, that the crews and heavy equipment would have been deployed that night to all the fires; and finally that those crews and equipment, assuming they had even reached the fires, would have achieved containment. We submit that the finding is fundamentally speculative.

313. In any event, there is no evidence that Lucas-Smith had proper grounds or even the power to replace Graham. It may be inferred that Graham went through a routine employment process i.e. that he submitted an application, underwent a selection process and was selected based on his suitability for the job. Furthermore, Graham had successfully discharged his job since July 1997 and there was no cause to think that Graham was lacking in competence and would fail to discharge his duties competently.

314. As already noted, the proposed finding involves a number of steps as to how the alleged error of judgment occurred. The term “*error of judgment*” implies an exercise of judgment being a conscious choice between a number of options. There is no evidence of Lucas-Smith thinking on 8 January in regard to whether the Incident Controllers at Bendora and Stockyard Spur may have lacked sufficient experience to determine whether fire fighting should have continued at night; or whether Graham also lacked that experience. Indeed, his knowledge of what was occurring and who had been deployed, but not taking any steps to challenge or counter that course, suggests quite the opposite.

315. Counsel assisting submit at paragraph 1129 that Graham made an error of judgment in declining Bartlett’s offer and that his lack of perception about his inexperience was part of his overall error, but secondary to the error of Lucas-Smith.

316. According to Bartlett, he attended at ESB “*to inquire as to what I could do*”. The offer by Bartlett was made very early in the piece at a time when Lucas-Smith and Graham “*were still trying to confirm the number of fires and their specific locations*”(ESB.AFP.0001.1140 at paragraph 29).. In the light of these matters, it is submitted that it was not unreasonable for Lucas-Smith and Graham to attempt to assess the dimensions of the tasks before taking up Bartlett’s offer of assistance and that neither Graham nor Lucas-Smith made any error of judgment. They had in place, both at headquarters in Curtin and on their way to the known ACT fires, competent and reasonably experienced personnel.

5.1.7 Flaws in SMT Structure

317. Counsel assisting contend at paragraphs 1130-1133 that the entire SMT structure was dysfunctional; and that there was confusion as to roles on the part of the field controllers on 8 and 9 January. It is conceded that Arman indicated such confusion as to the respective roles of Graham and herself. However this was not the case with Gray who gave evidence to the effect that there had never been any problems in the past in interacting with the SMT. He stated that the decision-making would vary between small and large fires – in the former case, that role would be with the incident controller and in the latter, “*the management team at ESB would assume some of the responsibility*”(T3689). However, it is accepted that there was evidence of other personnel that indicated confusion similar to that expressed by Arman; and that improvements in the understanding of those persons would have been desirable (had the system remained in place). None of that, however, approaches a conclusion that the “*entire structure was dysfunctional*”, and your Honour should not draw that conclusion.

318. Further, it is contended by counsel assisting that the key deficiency related to the role of planning and, in particular, that field controllers had no planning support in the field. This may be accepted but, as was pointed out by McRae, considerable steps have been taken to remedy those problems- (T3082).

319. The ACT agrees with the submission that it is difficult to point to any aspect of the “*dysfunction*” of the SMT that could be said to be relevant to the ultimate development and spread of the fires. In the event, it did not contribute to the decision-making, on 8 January, howsoever characterised, because the effective decision was made by the incident controller in the field and Graham would have made the same decision even if he had been further appraised of Arman’s reasons.

320. Of greater significance to the question of whether matters such as Graham’s asserted lack of experience and Lucas-Smith’s asserted errors of judgment were

causes of the fires, is the fact that the problems with the SMT were only relevant to decision-making not to the development and spread of the fires. It necessarily follows that the matters antecedent to the decision-making on 8 January were also not causative.

5.2 Bendora Fire

5.2.1 Response and Arrival at the Fire

321. The ACT agrees with the submission at paragraph 1134 that the non-compliance with Standard Operating Procedure 7 “Weight of Response” “*is not material*” in the case of the Bendora fire. Indeed, as is noted, the number of personnel deployed was 14, which exceeded the assumed number of 11 persons. It is also clear that any shortfall, given the conditions, was not such as to have a significant effect on what was achievable.

322. It should be noted that SOP 7 gives guidance for Initial and Second Responses. As to the latter, it is stated that:

If initial response is found to be insufficient, the Incident Controller may request through COMCEN to the Duty Coordinator the assistance of additional units.

323. The number of units responded will normally be as requested by the Incident Controller but may be modified by the Duty Coordinator based on:

- *competing demands for available resources;*
- *concerns about other on-going incidents;*
- *the risk of further incidents and the time it takes to mobilize additional resources;*
- *considerations regarding back-fill operations ...*

324. Lucas-Smith’s evidence to the Inquiry was to the effect that “*it is the people in the field that make decisions about resourcing*” (T822), and that is a position consistent with the terms of SOP 7. Furthermore, even though the question whether

that approach is best practice is open to debate, ESB officers acted in accordance with Second Response guidelines in making decisions about the deployment of resources in the course of the fires.

5.2.2 The Decision to Withdraw

325. At paragraph 1136, counsel assisting submit that the decision to withdraw raises two issues. First, that the fire burnt unchecked overnight and that, had the crews remained, containment may have been achieved. Secondly, was the decision to withdraw and the process by which the decision was reached carefully considered and appropriate?

326. The ACT submits that, as to the first matter, no firmer conclusion is available on the evidence than that an opportunity to contain the fire was lost.

327. As to second matter, the ACT concedes that the way in which the decision was made was deficient in that:

- a) more information should have been requested from the incident controller about the fire, the conditions and the capacity and the safety of the crews; and
- b) that such information should have received due consideration with a view to assisting the incident controller make an informed decision.

The ACT submits, however, that the process is unlikely to have led to a different decision for the reasons set out in Graham's evidence (13018).

5.2.2.1 The Effect of the Decision

328. The submissions of counsel assisting at paragraph 1137 proceed on the assumption that "*it seems unlikely that the fire crossed the Bendora Break until the early morning of 9 January*". The person best placed to provide this view was the

incident controller for 9 January Rick Hayes - and, as he was not present when that event occurred, his view is to a degree speculative. In his TROC (DPP.DPP.0004.0029), Hayes at Q.428-434 was asked to make comment about Cheney's report of the fire and when Bendora Break was crossed. His answer indicating that it occurred between 11pm and 3am, was put as a possibility, the precise terms being "*Even it could have happened the evening before, say eleven o'clock*". The understandable imprecision of that view provides a very insecure basis upon which to construct predictions as to what might have been achieved in terms of containment.

329. Further, it is assumed that a hand trail or part thereof could have been constructed with support from a bulldozer in the morning of 9 January. That assumption only holds good if bulldozers were available; yet the evidence is that no bulldozers were available until late 9 January or 10 January.

330. At paragraph 1138, counsel assisting refer to the evidence of Roche in relation to the suggestion that no useful work could be done on 8 January in the area of Bendora Break because fire was going to cross Bendora Break regardless, and submit that the suggestion overlooks the fact that the handline "*would have halted the spread of the fire over Bendora Break*". Roche further stated that crews could have cut off sections of the fire which had crossed the line the next morning.

331. Arman described Bendora Break as "*quite overgrown*" (ESB.AFP.0111.0001 at paragraph 31) and recounted the difficulties of clearing the Bendora Break which had - albeit on 10 January - "*quite a few logs across it and had been left to overgrow for some time*" (Q.343-4 TROC DPP.DPP.0004.0021 and ESB.AFP.0111.0001 at paragraph 82). In addition, Lucas-Smith stated at T863 that he doubted that the crews that were there "*at that time would have been able to achieve*" the construction of "*a line right around the fire or maybe even put it out*".

332. These views provide scant support for the conclusion expressed by Roche. Of course, what would have happened can never be determined with certainty - it is by reason of such uncertainty that it would be undesirable (if not impossible) for your

Honour to make findings as to what was “*likely*” to have occurred as distinct from what was possible – and as to the latter, there existed more than one possibility.

333. For similar reasons, it is submitted that your Honour could not reliably conclude that, if crews remained overnight, “*it is likely that a patrollable containment line around the fire would have been established by later on 9 January*” (paragraph 1140 of counsel assisting’s submissions). In relation to the submissions of counsel assisting in paragraph 1141, the ACT accepts that, had the crews stayed overnight, useful work could have been done – but whether that work would have led to the control of the fire before the adverse conditions the following afternoon and whether the fire could have been prevented from breaking out altogether, cannot reliably be determined. The substantial worsening of the weather on the afternoon of 9 January suggests both results are unlikely, in light of the fact that during the afternoon the fire crossed Warks Rd and containment lines constructed by Hayes’ crews that day.

334. It follows that the ACT disputes that there is an adequate evidentiary foundation for your Honour to conclude that, had the activities identified by Roche and Cheney occurred on 8 January and had they been supported by adequate resources the following day, it was “*likely*” that the fire would have been contained and not spread, or at least spread the way it did when the adverse weather arrived 10 days later –(paragraph 1142 of counsel assisting’s submissions). It is submitted that any such conclusion would be highly speculative.

5.2.2.2 The Making of the Decision

335. At paragraph 1143, counsel assisting submit that the manner of making the decision to withdraw left a great deal to be desired. Graham was questioned extensively about this matter. He conceded that he did not discuss with Arman the factors which influenced the decision(T2712). At T2715, Graham, speaking of the decision to withdraw, said:

I believe we could have done better in that respect

336. At T2716, Graham said:

I believe we in the ESB could have taken greater consideration of the information we were getting back from Odile about overnight resourcing and possibly could have questioned her further.

337. At T2717, Graham stated that it was a joint decision between the Incident Controller and SMI. He said that the Incident Controller's decision must be supported but that ESB might have questioned in greater detail the reasons for withdrawing. He conceded that his failure to take that opportunity was a deficiency in the way the matter was handled(T2721).

338. A contemporaneous record confirms that the issue of firefighter safety was the subject of discussion between Graham and Arman at the time of, or shortly after, the decision was made. In a discussion recorded in the radio logs on 8 January at 21.48 (ESB.DPP.0014.0079), Graham told Hayes that "*Odile was saying be wary of big trees that are falling*".

Finally, Lucas-Smith accepted at T825 that:

... there probably should have been a little bit more in-depth consideration (of the decision to withdraw).

This was a comment with which Graham agreed (T2711/2).

339. Graham frankly admitted that the reason he did not consider the importance of hitting the fires quickly was that, in effect, he was distracted by the number of events which were happening at that time – a situation which not infrequently occurs. There were "*several fires*"; there was "*a fair bit going on*"; there were "*discussions with Yarrowlumlá*" and "*just the number of activities going on at that time that not everything was considered fully*"(T2713).

340. Counsel assisting urge a finding in paragraph 1144 that Graham made a statement to Arman concerning the decision to withdraw after the decision had been made. At best, that statement does no more than illuminate the thought process of Graham at the time the statement was made. The ACT submits that such a finding is

neither necessary to the matters about which the Coroner must make findings nor is it helpful in any other respect. It stands in contrast to the statements made by the parties to each other in the lead-up to the decision (as to which there are telephone transcripts and radio logs) which are clearly relevant.

341. The reasons for Arman's decision to withdraw the crews, are summarised at paragraphs 313 to 319 of the submissions of counsel assisting. It is submitted that there were additional matters to which the Incident Controller was entitled to have regard.

342. Firstly, none of the seven members of the crews under her command on 8 January who provided statements to the Inquiry, four of whom had extensive firefighting experience, voiced any objection to the decision at the time: Cliff Stevens (ESB.AFP.0108.0262); Tamera Beath (ESB.AFP.0011.0068); Rebecca Blundell (ESB.AFP.0108.0115); Matthew Brooke (ESB.AFP.0111.0091); Steven Harding (ESB.AFP.0108.0138); Anthony Hewlett (ESB.AFP.0108.0158) and Doug Mitchell (ESB.AFP.0111.0229).

343. Secondly, some members of the crew were inexperienced, tired and uneasy about staying, for example Blundell stated that a young crew member *"was a little bit uneasy about putting water on the fire – she appeared a bit scared and I assumed she was concerned about getting about in the dark and trees falling."* (ESB.AFP.0108.0115 at paragraph 19)

344. Thirdly, crew member Steven Harding said: *"I do not recall any overt objection to being pulled out because we were all pretty tired and there were trees coming down at the time"* (ESB.AFP.0108.0138 at paragraph 19).

345. Accordingly, it is not accurate to contend, as counsel assisting do at paragraph 324, that Harding expressed *"a willingness to remain at the fire at least for some time"*.

346. Finally, none of the other crew members who made statements had walked around the perimeter of the fire and were therefore not as well placed as the Incident Controller to make an informed decision about the matter.

347. Arman gave evidence at T4048 that a factor she considered in the balance regarding whether to stay or not:

... I felt that the following day with fresh crews they would be able to certainly make an impact on the fire in terms of containment.

348. At paragraph 1145, counsel assisting contend that the effect of the conversation between Lucas-Smith and Graham at 19.42, was that they agreed that there would be no overnight firefighting at Bendora. It is submitted that the most that can be said was that there was discussion about the issue and there was doubt expressed that overnight fire fighting was likely. It overstates the proposition that there was any agreement at all. To the extent that any conclusion need be drawn, your Honour could be satisfied that, as Graham stated, whilst doubtful of the prospect of overnight firefighting, his mind was still open on the question. The same is true of Lucas-Smith who stated at T825 that, in dealing with Graham, he was being kept informed of the situation but not offering an opinion.

349. Lucas-Smith's position in relation to the decision to withdraw is summarised in the following extracts of evidence (T829). He stated that he

... would not have made such a view (that crews should remain overnight) without knowing what the incident controller was saying in the field

and he trusted Graham's judgment on the matter. At T830, Lucas-Smith stated that Arman and Graham were experienced officers and he trusted their judgment, but that he had to take responsibility for the decision and he approved the decision without knowing anything of the detail. Finally, Lucas-Smith said at T834 that he did not express any disagreement with the decision in his statement because it was a hindsight issue -- they made the decision and he had confidence in the officers. The ACT submits that Lucas-Smith's trust in his subordinate officers was not unreasonable and your Honour should so conclude.

350. At paragraph 1146, counsel assisting argue that Lucas-Smith “*had a responsibility to be much more involved in the decision than he was*”. The question about whether they could do anything that night, “*almost inviting a negative response*”, was a key link that led to the decision to withdraw. The ACT submits that Lucas-Smith made a decision at the time that the best course was to meet with RFS personnel at Queanbeyan to deal with what he (as it turned out correctly) considered to be the fire causing most concern for ACT assets at that time. That was a decision of which, at least at the time Lucas-Smith was cross-examined, counsel assisting was not critical. At T835, Mr Lasry QC stated: “*I am certainly not criticising you for being at Queanbeyan ...*”. Indeed, it might have been suggested that for him not to have ensured that that fire was adequately dealt with would have been a failure to discharge his responsibilities. It was also a decision which Roche agreed was appropriate “*given the size of the McIntyre’s Hut fire*”-(T7627). It is submitted that to now criticise Lucas-Smith for making a judgment call of this kind is not warranted.

351. At paragraph 1147 of counsel assisting’s submission, it is submitted that Lucas-Smith’s failure to respond to Graham’s doubt by emphasising the importance of over night firefighting and rapid aggressive attack “*was a serious error of judgment.*”

352. The ACT submits that such a finding should not be made firstly because no such proposition was put to Lucas-Smith to afford him the opportunity to reply. The alleged omission took place in the following circumstances Lucas-Smith was taking a phone call in a motor vehicle en route to a meeting relating to the McIntyre’s Hut fire; the phone call was a general up-date of a fire situation not then well understood; there was no Incident Controller on site; there were no reports of details of the fires or specific matters relating to location, terrain and other relevant matters and the comment in question was short and not determinative of any course of conduct.

353. The ACT submits that, when these circumstances are taken into account, any criticism of Lucas-Smith for failing to respond to Graham’s doubt is unwarranted. Such assessments need to take account of the realities and practicalities of the situation and the criticism can only be justified, in hindsight.

354. Lucas-Smith gave evidence at T824/5 that he was informed of the decision to withdraw from Bendora after he returned to Curtin and after the crews had been stood down. It is clear that he played no part in the decision. It follows that, whatever second thoughts he might have had about the decision to withdraw, there was no practical method whereby he could have reversed it.

355. In the context of Lucas-Smith's concession that more analysis should have been conducted into Arman's reasons for withdrawal and that someone of his experience might have made a different decision, counsel assisting submit at paragraph 1148 that his error of judgment in *"treating so casually even flippantly, what he should have seen as a very important decision and not probing the issue was a key link leading to a decision to withdraw"*. In view of the fact that Lucas-Smith was elsewhere, did not communicate with the incident controller and played no part in the decision, such a finding would be artificial and should not be made.

356. Even if Lucas-Smith had been party to the decision and if it was open to be critical of his part in it, it is neither accurate nor fair to characterise his actions as casual or flippant. This is because neither of these alternative descriptions were put to him; secondly, he went to the meeting at Qucanbeyan because the McIntyre's Hut fire was perceived by him to present the most serious and most immediate problems to the ACT (ESB.AFP.0110.0551 at paragraph 25 and T835). And finally, he had confidence in the skill and experience of his subordinate officers. The ACT submits that the proper analysis is that Lucas-Smith made a decision in regard to his priorities as he saw them and, whilst in hindsight different decisions could have been made, his conduct cannot be characterised as unreasonable in the circumstances.

357. It remains unclear as to what specific evidence of Graham's about the decision-making process should be rejected, as urged by counsel assisting in paragraph 1150. At T2721-2, Graham conceded in effect that there was an opportunity for him to question further the decision; that there was a deficiency in the way he handled the decision and it could have been done better. The evidence is a clear and honest account and involves concessions made against his interest. It is

submitted that, far from rejecting his evidence, your Honour should conclude that he was a honest and credible witness and that his evidence should be accepted.

358. The factors which influenced Arman to withdraw her crews are set out in paragraphs 52 to 55 of her statement (ESB.AFP.0111.0009) and are as follows:

- a. the fire was too big to put out or contain that night;
- b. it was getting dark and there was a concern for the safety of the crews, having regard to the falling timber;
- c. the crews had been working since 7.30am and there was a concern about fatigue;
- d. there was no access to immediate medical care in the event of injury;
- e. she was aware of the fact that in recent remote area fires “*crews had been withdrawn on the first night for safety reasons*”; and
- f. the fire was not moving quickly

The ACT submits that Arman’s decision and her reliance on these matters were reasonable and proper in the circumstances.

359. The ACT submits that the applicable law and protocols underscored the point that the safety of firefighters was an important matter. Furthermore, the ultimate responsibility for such decisions relating to safety rested with the employer or field controller.

360. Section 37 of the *Occupational Health and Safety Act 1989 (ACT)* (OH&S Act) prescribes the duties of employers in relation to employees. Relevantly, s.37 provides:

(1) An employer shall take all reasonably practicable steps to protect the health, safety and welfare at work of the employer's employees.

(2) Without limiting subsection (1), an employer contravenes that subsection if the employer fails to take all reasonably practicable steps—

(a) to provide and maintain a working environment (including plant and systems of work)

(i) that is safe for the employer's employees and without risk to their health; and

- (ii) that provides adequate facilities for their welfare at work; or*
- (b) in relation to any workplace under the employer's control—*
 - (i) to ensure that the workplace is safe for the employees and without risk to their health; and*
 - (ii) to provide and maintain a means of access to and egress from the workplace that is safe for the employees and without risk to their health; or*
- (c) to ensure the safety at work of, and the absence of risks at work to the health of, the employees in connection with the use, handling, storage or transport of plant or substances; or*
- (d) to provide to the employees the information, instruction, training and supervision necessary to enable them to perform their work in a manner that is safe and without risk to their health; or*

361. It is submitted that s.37 had application to the crews at each of the firegrounds on 8 January, and it was the obligation of Arman to ensure that there was compliance with the legislation. That required her to take all reasonably practicable steps to provide and maintain a safe working environment for the crews. It was an obligation that she could not abdicate to any other person and in particular to a person not present at the site and therefore unable to assess the risks involved. It would be no defence to an allegation that Arman breached s.37 that she had received contrary advice from officers at the ESB.

362. The issue of firefighter safety is dealt with in Chapter 6 of the Rural Fire Control Manual for the ACT (ESB.AFP.0028.0112). The general need for safety is emphasised in paragraph 6.1 of the Manual which provides that: “*safety is a prime responsibility of every person at the incident not just the field controller*”. The responsibility of the field controller is stated at paragraph 6.3 as follows: “*the field controller bears the responsibility for the welfare and safety of each person assigned to his/her fire ground work force*”.

363. Roche’s attention was drawn to these protocols in cross-examination and he agreed that general safety factors may be given added emphasis by reason of reduced visibility at night (T7528ff).. At T7533-4, he agreed that the incident controller should take into account the effect of fatigue on the crews in making the decision

whether to stay at a fireground. Although Roche did not think it necessary to examine OHS legislation in ACT, he assumed that the fireground was a workplace and safety rules applied whether it was a workplace or not (T7534).

364. Roche agreed that, on the assumption the fireground was a workplace, the OHS Act imposes a positive obligation to provide fire fighters with a safe system of work (T7536); and he agreed that the safety of firefighters is a pre-eminent consideration in deciding to attack a fire and the means of attack and further that the responsibility for the decision is reposed in the incident controller (T7538).

365. In the light of these matters, the ACT submits that Arman's reliance upon the issue of firefighter safety as a basis for the decision to withdraw, was reasonable, – and this is so even though others might have decided differently.

366. Arman's concern about the fatigue of her crews was not novel. Another illustration of the concern regarding crew fatigue is exhibited in the evidence of McNamara regarding the fire fighting effort at Stockyard Spur on 9 January (ESB.AFP.0103.0052 at paragraph 29 to 46). That of course related to fire fighting in daylight hours – however, it involved a fresh crew which commenced duty at 6 am at Bulls Head, arrived at the fire ground at approximately 10 am (which included a one and a half hour walk into the fire) and involved construction of a rake hoe line. McNamara noted that at around 3.00 pm, *“the alarm bells started to ring with me as I noticed that team members were becoming fatigued”* (paragraph 46) and that *“at least two crew members (were) showing signs of fatigue and exhaustion”*(paragraph 47)

367. Similarly, Hayes stated that one of the major issues for him was that when the fire standby level was anything less than red *“we end up taking quite a long working days work and then going out and fighting for long periods. This is unhealthy for our staff and can lead to problems with fatigue”* (ESB.AFP.0108.0002 at paragraphs 203 to 205).

368. Two further matters had some influence on Arman's thinking about the decision to withdraw crews – the first referred to at T4038 of her evidence was the response from the COMCEN operator at 20.03 to the effect that he understood that the

teams would be removed from the location in the evening and returned tomorrow, but he would confirm with the duty coordinator. Of that response, she stated: *"I guess it did influence me a bit"* and she acknowledged that, in hindsight, she should have clarified the matter with COMCEN.

369. The second matter which was said to have influenced Arman's decision was her confusion as to who bore the responsibility for the decision. In truth, this confusion had no impact on the events of 8 January. It was her understanding that it was the responsibility of the incident controller on the ground to make the decision but sometimes decisions could be overruled by ESB (Q236 TROC DPP.DPP.00040021); at other times, there was discussion with ESB and the decision was made jointly (T4037). In the event, the decision was made by Arman and that decision was not varied by Graham at ESB.

370. As was stated earlier, the ACT accepts that, in hindsight, it would have been of benefit for Arman and Graham to have discussed the matter in greater detail before the decision was made. Even in that event however, it is unlikely that, as things stood on 8 January, a different decision would have been made. This is confirmed by Graham's evidence referred to at T3018, which was that had Arman conveyed to him the matters which influenced her decision, he would still have supported her decision to withdraw. In these circumstances, Arman's position (referred to in paragraph 1152) that she was willing to stay if SMT had said so (TROC Q244 and 247) is academic.

371. It follows that counsel assisting's submissions at paragraphs 1152 to 1153 that Lucas-Smith and Graham failed to give the matter the thorough and urgent consideration it deserved should be rejected. That is because Graham would have made the same decision even if he had further time to consider it and Lucas-Smith was not party to the decision – *"the die was very much cast"* when he came to learn of the decision.

372. The ACT accepts, as did Graham, that there was a deficiency in the way the matter was handled. Furthermore, whilst Graham's lack of experience in the prevailing fire conditions and wildfires of this kind, may have played a part in how he acted (consistent with his concession at T2723 he *"did not have the same level of*

concern” as more experienced fire fighters), it is submitted that no such findings should be made, as it is a matter too remote from the findings the Court is authorised to make.

5.2.2.3 The Attitude of Crews

373. At paragraphs 1154 and 1155, counsel assisting address the issues of crew fatigue, their willingness to work and lack of consultation by Arman with the crew as to the decision to withdraw apparently in the context of a claim made by Nicholson that it would have been reckless for the crews to remain. The attitude of the crew is a relevant consideration for the incident controller to take into account. If the crew were willing to remain, the decision in relation to overnight fire fighting was the responsibility of the incident controller. It is submitted that whether they were affected by fatigue or not was an issue about which their subsequent statements alone were not determinative (as to this, see Harding statement ESB.AFP.0108.0138 at paragraph 19) -- it was a matter to be assessed by the incident controller at the time and in the prevailing circumstances.

374. If the purpose of this submission is to review the way in which an incident controller determines whether a crew under her control should continue on the fire ground when issues of fatigue, overwork and safety are involved, the ACT submits that it is not helpful for this Inquiry to descend to matters of such detail when they invariably fall to be decided in the individual circumstances of the case at hand. It clearly was a matter to be decided by the incident controller in the manner she considered appropriate. The suggestion that she be assisted by those at the SMT, seems to ignore the fact that the SMT was in no position to make any assessment about, inter alia, crew fatigue.

5.2.3 Expert Evidence

375. At paragraph 1156, the submission is made that Roche and Cheney’s evidence that the decision to withdraw was wrong was “*obviously correct*”. The ACT does not

dispute that, in hindsight, a reasonable decision to stay could have been made. However, the ACT does dispute that, judged at the time, the decision was obviously erroneous -- in the circumstances as appeared to Arman and Graham, the decision was a reasonable one.

376. Counsel assisting submit at paragraph 1157 that Roche and Cheney were “*correct*” in their conclusion that Arman did not have sufficient experience to control the fire in this type of environment and to make the appropriate decision. Further, it is suggested that Lucas-Smith and Arman acknowledged that her lack of experience played a part in the decision. If SMT was functioning correctly this situation would have been remedied by Lucas-Smith participating in the decision. Further, it is contended that Cheney is correct in asserting that safety of firefighters has to be looked at against the consequences of not fighting the fire. The consequences of not fighting the fire were given insufficient attention by those involved in the decision.

377. The ACT submits that the question of whether Arman was sufficiently experienced to control the Bendora fire on 8 January, judged at that time, should be answered in the affirmative. It may be that, in hindsight, the opposite view might be taken as both Lucas-Smith and Arman themselves did.

378. The ACT submits that the approach by Cheney to balance the safety of fire fighters against the consequences of not fighting the fire is not sustainable. If the correct assessment by an incident controller having regard to OH&S considerations is that to stay would be unsafe, his or her legal obligation requires that the crews be withdrawn. The relevant requirements are referred to in s. 37 of the OH&S Act. Those requirements cannot be diminished or compromised by reference to events which occurred ten days later or at all.

379. A further concern is that the proposition has implicit in it the prism of hindsight, i.e. that the incident controller should have known that, if the crews did not stay, the fires would have grave consequences for the urban edge of the ACT and that she should have factored that knowledge into the decision-making process. It is submitted that this is not a tenable proposition and should be rejected.

380. At paragraphs 1158 and 1159, counsel assisting contend that Nicholson's opinion – that the decision to withdraw was correct and it would have been reckless to remain – was not credible and his evidence should be rejected for reasons including these:

- a. he fails to analyse the consequences of withdrawal “*for the future of the effort against the Bendora fire*”; and
- b. he leaves out of account Lucas-Smith's concession that he “*would*” have made a different decision in Arman's position.

381. The ACT makes the following submissions, in relation to the first reason, Nicholson's adoption of it indicates that another reasonable commentator assessed the question of whether to withdraw or not in a manner not dissimilar to Arman. That gives support for the contention that the manner in which her decision was made should be accepted as reasonable, even if others would have acted differently.

382. As to the second reason, as formulated it misstates the effect of Lucas-Smith's evidence which was not as categorical. He said at T825:

If I had been on the fire ground, I may have done things differently. But I dare say the people there were working on the best judgment ... [emphasis added]

and at T835 that people with more experience of highland firefighting under those conditions:

... might have made a different judgment. If I had been sitting in Odile Arman's position, I think I would have made a different decision, but I was not. [emphasis added]

383. The evidence is to be properly understood as an expression of what Lucas-Smith might have done, judged in hindsight. So much is made clear by his explanation of the actual context in which the decision was made at T835 where he stated that reports had been received from the helicopters:

... that both ... (Bendora and Stockyard) were relatively small fires, and not posing a significant and immediate threat to ACT resources. The McIntyre Hut fire was and ... that was my priority

5.2.4 Resources for the Following Day

384. In their submissions in paragraphs 1161 – 1167, counsel assisting are critical of both Graham and McRae for failing to recognise the inadequacy of the resources sought for the next day.

385. The ACI submits that it is both inaccurate and unfair to attribute responsibility for the lack of additional resources to Graham alone. In truth, the system was designed to work in a team framework with contributions from all participants – so much is clear from Graham’s evidence at T2756/7, where he stated that it was for the incident controller to request more crews and that did not happen. Furthermore, SOP 7 makes it clear that for Second Response, the responsibility rests with the Incident Controller to advise the Operations officer of additional resources that are required. Each was entitled to rely upon the expertise and contribution of the other in making resourcing decisions. The fact that, for the reasons stated, there were not sufficient resources should more correctly be characterised as a systemic fault contributed to by more than one person.

386. So far as McRae’s part in this matter is concerned, he gave evidence that he was given at short notice the opportunity of making the helicopter flight where he made observations of the fire; he was not a formal air observer and he “*wasn’t considering whether resourcing was sufficient or not*” (T3189). In substance, it was not McRae’s task to consider or give advice on that issue. That is not to say that an opportunity was not lost to provide useful advice to the incident controller – however, in the light of these matters, any criticism of him in this regard is not warranted.

387. Counsel assisting contend that the failure to appreciate the significance of the information as to fire size and Graham’s lack of urgency are matters of concern. However in light of their conclusion that – “*we accept that by early afternoon and factoring in travel times, even a dramatic increase in resources may not have materially affected the outcome, having regard to deterioration in weather and increase in fire activity in mid to late afternoon*” – i.e. the asserted failing may not

have adversely affected the outcome – the ACT submits that your Honour should make no findings in this regard.

5.2.5 Proposed Findings

388. At paragraph 1168, counsel assisting submit that the following findings (reproduced in summary form) should be made:

- i. the decision to leave the crews overnight or not on Bendora was critical to future prospects of controlling the fire;
- ii. Arman took into account safety considerations *“but ultimately reached that decision because she believed ESB wanted her to make that decision and she was insufficiently experienced to weigh the competing considerations”*;
- iii. Graham was *“insufficiently experienced”* and had a view before receiving detailed information from the field;
- iv. Lucas-Smith displayed *“a casual approach”* to the important decision and failed *“to participate in the process”* to an appropriate level;
- v. the conduct of Lucas-Smith and Graham was consistent with each of them *“wanting Ms Arman to withdraw crews”* and led to Arman forming the belief that ESB wanted her to withdraw the crews;
- vi. Graham failed to seek more detail from Arman and discuss the matters with more senior officers and failed to ensure that crews remained overnight;
- vii. the decision was wrong;
- viii. had the crews remained over night and the fire-fighting effort been adequately resourced the next day *“including with the assistance of heavy machinery”*, it was *“likely that the fire would have been contained within 24 to 36 hours”* and *“substantially controlled and suppressed before onset of extreme conditions”* on 17 and 18 January;
- ix. the Bendora fire was *“severely under-resourced”* on 9 January.

389. In relation to the first proposed finding, the ACT accepts that the decision to leave the crews overnight or not on Bendora was an important decision, but whether it would have had an effect on the ultimate control of that fire is doubtful given the circumstances of the adverse conditions experienced the following afternoon on 9

January. To categorise the decision as “critical” to future prospects of controlling the fire, is to make assumptions concerning the success of the efforts to control the fire and as has been submitted earlier, no such assumptions can reliably be made. The ACT submits that the findings in the terms proposed, should not be made.

390. The reasons for Arman’s decision to withdraw have been canvassed above; it was not asserted that her evidence in this regard was not reliable or credible and the ACT submits that the finding should reflect her evidence. Indeed, Arman stated in her IROC at Q292:

I didn’t have the benefit of hindsight. I made decisions ...based on the situation at the time and what was presented in front of me and with the experience that I had ... I made them in good faith ... my main interest was the safety and welfare of the crews ...

391. The ACT submits that there is no basis for elevating as the “ultimate” factors, her belief concerning what ESB wanted or her asserted lack of experience. In fact, a fair reading of Arman’s evidence tends to the conclusion that the primary issues in her thinking were the safety of the crews and the related issue of fatigue and the view that little could be done that night. It is submitted that the Coroner should not make the second proposed finding.

392. In relation to the third, fourth and fifth proposed findings, for the reasons detailed above, the ACT submits that no such findings should be made. In summary, those reasons are that the proposed findings are too remote from the issues of cause and origin of the fire; and secondly, the evidence does not bear out the factual conclusions in the findings.

393. The ACT accepts (as Graham did himself) the facts in the sixth proposed finding, but disputes the necessity to make any formal finding about these matters.

394. In relation to the seventh proposed finding, the ACT submits that there is no basis for the making of an unqualified finding of error when that finding relies upon considerations as to what would have happened based upon hypothetical rather than actual events.

395. The claims in the eighth proposed finding, appear to be predicated on the assertion by Roche in his report (DPP.DPP.0009.0001) that, given specified resources and an assumed construction rate of rake hoe lines “*the Bendora fire could have been contained in 24 hours*”. Based upon this material, Counsel Assisting urge a finding that the fire would have been contained – a proposition of greater certainty than that expressed by Roche.

396. At p.72 of his report, Roche opines that containment of the Bendora fire could have been achieved in 24 hours with “*an initial commitment of 3 RAF teams with tanker and light unit support. ... the RAF teams should have been able to achieve a construction rate of around 100 metres per hour ... containment of the fire perimeter could have been achieved overnight or at least mid-morning of 9 January*”. Roche does not detail the numbers of “*tanker and light unit support*”; furthermore, his estimate of rake hoe line construction of 100 m/hr is stated to be a rate that such teams “*should have been able to achieve*”. He also does not specify whether in his estimate he had in mind fresh crews or crews that had already been working for a day or part thereof.

397. When considering the reliability of Roche’s opinion about the rate that a rake hoe line could have been constructed, it is instructive to have regard to the evidence he gave in cross-examination about that issue. At T7544, Roche agreed that constructing a rake hoe line was extremely arduous work. At T7545, he referred to the rate of construction as “*80-100m per person per hour*” – the rate being dependent on the conditions such as terrain, slope, and debris on the ground. Furthermore, he stated that there was 30% reduction in efficiency towards the end of a 10 hour shift.

398. Roche stated that he would expect that the capacity to maintain the rate would be affected by the previous activity of the particular fire fighter (T7546).

399. As to how he came to select the figure of 100m per hours , Roche stated that “*there are a number of different figures bandied about from time to time*” - “*that’s a reasonable mid-point ... to start from*” (T7591). In addition, he did not speak to anybody who was present at the site, who could say whether the figure was

realistically achievable or not. In a similar vein, Roche said – “... *there are no such things (as standards). If you look at the documentation there is a whole range of different views ... in my experience ... they are appropriate figures from which to start*” (T7887).

400. At p.61 of his report of referring to the rate, Roche stated: “*These rates then need to be adjusted to take into account forecast weather conditions and what is known about the on-ground conditions, including fuel loads, terrain, and the location and quality of existing trails. Estimates for completion then need to be assessed against what is in fact being achieved each shift ...*”. Roche conceded that he himself did not do this exercise (T7888/9).

401. The following observations can be made about this evidence – firstly, it appears that there is a variety of opinion about what rates of construction can reasonably be achieved; secondly the starting point for Roche’s calculations is 100m/hour and this is higher than 80-100m/hour, that he gave in evidence – the lesser figure must reduce what could have been achieved; thirdly Roche conceded that the achievable rate depends on individuals involved and the circumstances of the task. Furthermore, Roche did not check with those crew members on ground whether the rate he proposed, was achievable. Finally, it is not apparent whether the rate selected by him, allowed for the reduction in efficiency due to fatigue as a general matter and whether he allowed for fatigue in the particular circumstances of the Bendora crew having to work in effect, a double shift. His estimate also ignored the steep, rocky and heavily vegetated terrain that existed at the Bendora fire.

402. The ACTI submits that the approach adopted by Roche is similar to his approach regarding the McIntyre’s Hut fire i.e. a broad brush approach which did not take into account people with local knowledge contributing their information about the topography and alternate strategies; in that case, he did not consider comparable arrival times and resource estimates for alternate strategies. Roche conceded that “*perhaps*” the Court was left without any expert assistance as to “*the practical feasibility of any alternative containment strategy*” by reference to the available time and resources to complete it (T7891/2). It is submitted that this evidence constitutes an unreliable basis on which to make findings.

403. At p.73 of his report, Roche further stated that *“the deployment of heavy machinery should have been ordered ready to commence work at first light on 9 January.”*

404. In order to make good the proposition that had the decision to withdraw not been made, it was likely that *“the fire would have been contained within 24 to 36 hours”*, there needs to be evidence which supports the contention that the crews which were at Bendora on 8 January would have achieved that containment. To the contrary, the evidence discloses that the Incident Controller did not have 3 RAF teams available; some members of her crew were relatively inexperienced and many had worked that day; and that not all members of the crew would have been available for work on the rake hoe line – there needing to be tanker drivers, look-outs and the like.

405. The proposed finding fails to have regard to the capacity of the crews that went to Bendora and what those crews with their skill, level of experience and fatigue or otherwise, could have achieved. It is not self evident that they had the capacity to produce rake hoe lines at 100m/hr; nor is it self evident that they would have been able to continue at the assumed rate having regard to fatigue, potential injuries and deployment on other than rake hoe duties. The large ‘fingers’ of fire observed on the fireground by Hayes would have added considerably to the length of the containment lines proposed by Roche, even allowing for the shortest route between fingers. It is therefore wholly speculative whether they would have achieved containment of the fire in the postulated period.

406. Regarding the issue of capacity of the crews, Cheney noted in his private view with the Coroner on 20 August 2003 that:

The fireline construction required chainsaw operators skilled at cross cutting downed log material and construction with hand tools was considered difficult but not impossible.

...
The task of building fireline in tall forest is one that perhaps should not be expected of volunteer fire fighters. (DPP.DPP.0010.0271 at p.6)

These views provide further uncertainties for the acceptance of the proposed finding.

407. Finally, the suggestion of adequate resourcing for 9 January is predicated on the presence of bulldozers. The evidence discloses that no such bulldozers were available until late 9 or early 10 January. It follows that Roche's view is a hypothetical opinion not based on a consideration of the actual resources at Bendora on 8 January, nor what heavy equipment was available in that period. Accordingly, the ACT submits that it would be speculative to make a finding in the terms sought and your Honour should decline to do so.

408. The ACT accepts that the Bendora fire was under-resourced on 9 January but submits that there is little utility in a finding that it was "*severely under-resourced*". Even if that was the case, it is doubtful that extra resources would have made a difference. The fire crossed rake hoe lines that had been constructed and a grew very quickly into a fire too large to contain with rake hoe lines once it crossed Warks Rd on the afternoon of 9 January 2003.

5.3 Stockyard Spur Fire

409. Counsel assisting note at paragraph 1169 that the first problem in relation to initial response was one of access to the fire ground so much is clear from the evidence of Gray.

410. At paragraph 1170, counsel assisting submit that the following findings should be made:

- a. it is reasonable to conclude that if the initial response was in accord with SOP 7 and had included "*properly fit, trained and equipped RAFT crews*", the crews could have walked into the fire and "*done useful suppression work*"
- b. difficulties in locating the fire could have been addressed by having Gray fly over the fire in Firebird 7 to familiarize himself with the route;
- c. overnight crews would have greatly assisted the handover the next day even if they could not complete a containment line around the fire;
- d. the difficulties of access to the fire "*should have alerted those in command to the urgent need to source a bulldozer*" to open up Stockyard Spur track; and

- e. a timely dispatch of a bulldozer would have greatly assisted RAFT crews in construction of control lines around fire perimeter the next day.

411. The first proposed finding commences from the premise that despite the evidence of Gray (ESB.AFP.0108.0230) and McNamara, a hypothetical RAFT crew could have walked to the fire and done useful suppression work overnight. Gray was a fire fighter of some 22 years experience (T3688). His assessment at 19.14 hours was that he did not think the fire could be reached that evening and he conveyed this to COMCIEN (paragraph 13 of his statement and T3696). Gray stated that it was he who initiated the decision to withdraw and he believed it was the correct decision (T3698). That evidence was not challenged.

412. If the finding is an implicit criticism of the incident controller in failing to reach the fire ground and making the decision to withdraw, it should be rejected. In this regard, the ACT submits that your Honour should place greater reliance on the evidence of those who were present at the time, rather than a hypothetical opinion based upon a hypothetical fact that access would have been gained by notional RAFT teams and what they might have achieved.

413. Roche at p.76 of his report said that *“on evening of 8 January, a request should have been made for the deployment of a bulldozer at first light ...”*. The evidence of Beutel (ESB.AFP.0108.1215) indicates that even though he took steps on 8 January to source bulldozers, none would have been available in the relevant time frame.

414. Roche concluded at pp.76/7 that *“had access been more readily gained and resources dispatched in accordance with SOP 7, there was ... an excellent chance that this fire could have been contained overnight.”*

415. Roche does not make clear what he means by access being *“more readily gained”*, neither as to manner of the access nor the putative time of arrival. In his evidence, Roche conceded that he had misstated the evidence of Gray to the effect that the fire could have been accessed by vehicle (T8096/7). Undoubtedly, the size of the fire was increasing with the lapse of time as was the opportunity for rapid

containment. The ACT submits that any finding of containment based upon this conclusion, when significant variables are not specified, is unreliable and should not be made.

416. Roche's conclusion that the fire could have been contained and secured well before the next period of adverse fire weather with 3 RAF teams, a D6, 3 tankers and 3 light units, also fails to take into account the unavailability of a D6 bulldozer and the deployment of ESB's resources to other fires.

417. For similar reasons the proposed findings in paragraph 1172 should also be rejected. The conclusion that had the above steps been taken, it was likely that "*the fire would have been contained within 24 to 36 hours*" and "*controlled and probably suppressed before onset of extreme conditions*" on 17 and 18 January, cannot be made. Especially in light of the observations of Roche at p.83, where he argued that Bendora and Mt Gingera could have been contained in the first 24 hours but continued:

The Stockyard fire was a little more problematic given the difficult access ...

418. The reliability of Roche's opinion in this regard, is questionable having regard to his concession that as early as September 2003 - before any evidence had even been heard- he had "*a view leaning to that regard (that the Stockyard Spur fire could have been held)*" (18097).

419. The ACT submits that there is no basis for the finding that the fact that the steps were not taken consistently with the weight of response (SOP 7) and a rapid aggressive response "*was a failure by the ESB that was a cause of the Stockyard Spur fire that burnt into areas and damaged property in the south of the ACT*" to be made.

5.4 Mt Gingera Fire

420. In response to paragraph 1173, the facts establish that there was no attempt to resource this fire at any time before 12 pm on 9 January. The reasons for Lucas-Smith and Graham taking this position are adverted to above – those being the inaccessible location of the fire and its small size.

421. It ultimately took crews approximately five and a half hours from time of response to gain access to the fire ground in the daylight hours of 9 January – paragraphs 12 and 13 of the statement of Callan, (ESB.AFP.0111.0102). It follows that if crews had been responded at 16.00 the previous day (as they were for the other two fires) crews may not have reached the fire ground until at least midnight. There must be considerable doubt that crews arriving at that hour would have been in a fit state to achieve any significant gains in containing that fire.

422. Roche in his report at p.80 expressed the view that the fire *“could have been attacked overnight on 8 January had resources in accordance with SOP No. 7 and RAF teams been dispatched shortly after it was detected ...”* Once again he provides no indication of the how the fire was to be accessed or his view of the time such crews would have arrived or what effective work they could have done when they got there.

423. Further Roche stated at p.82 that: *“the resources committed to the fire on the 9 January should have comprised at least 2 RAF teams, a medium dozer supported by 2 or 3 tankers and a similar number of light units. Had these resources been in place ... (along with helicopters for water bombing and supporting ground crews, the fire could have been contained within the ... (day shift on 9 January) ...”* No such bulldozer was then available, nor were other resources available in light of competing priorities. For example, otherwise available helicopters were fully engaged on other fires.

424. At p. 83 of his report, Roche proffers the opinion that the Mt Gingera fire could have been contained within 24 hours if the fire had been attacked overnight on 8 January. That opinion is based upon the availability of crews and equipment as has been earlier referred to. So much is clear from Roche’s evidence at 17636 to the effect that even if the response to Gingera had complied with the SOP, *“then it was still insufficient given the conditions”* (which confirmed his opinion at p.51 of his

report). That conclusion applied to all the fires given “*the weather conditions at the time and the observed fire behaviour*”.

425. The ACT submits that any conclusion based on Roche’s opinion so formed, is an unsound basis upon which to make findings about the probability or likelihood of that fire being contained. Accordingly, it is submitted that there is no sound basis upon which to make the findings proposed in paragraph 1176.

Conclusion

426. It is accepted that a more careful examination of the decision to withdraw from the fire at Bendora should have occurred. Counsel Assisting have urged upon your Honour numerous conclusions and findings which relate to the experience and state of mind of specified individuals antecedent to the decisions made. Putting aside the utility of such an exercise, it ignores the reality that decisions are often made in circumstances of competing priorities and at times on incomplete information. It is one thing to conclude that a better decision might have been made or the decision-making process might have been better carried out. It is quite another to blame those who took the decisions at the time they did. Such a course is unwarranted and counter productive. A very real consequence of dissecting the decision or process in the kind of detail that the submissions of counsel assisting do, and urging findings of an adverse nature about the persons involved, might be to discourage persons from taking up positions which require such decisions to be made or to discourage effective and timely decision-making.