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2009 VICTORIAN BUSHFIRES ROYAL COMMISSION

MELBOURNE

TUESDAY 2 FEBRUARY 2010

(98th day of hearing)

BEFORE:

THE HONOURABLE B. TEAGUE AO - Chairman

MR R. MCLEOD AM - Commissioner

MS S. PASCOE AM - Commissioner

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CHAIRMAN: Yes, Mr Rozen.

MR ROZEN: Commissioners, this morning the schedule has us starting with the oral submissions in relation to the Murrindindi fire. Can I indicate at the outset that counsel assisting's written submissions in relation to the Murrindindi fire are to be found at (SUBM.202.009.0001). As is the case with other fires, the written submissions are lengthy and detailed and of course there are responses to those submissions which are also lengthy and detailed.

It is my intention this morning to address the Commission orally in relation to five topics. The first of those is to make some general observations about the Murrindindi fire, primarily in response to matters raised in the submissions of the State. The second concerns the composition of the incident management team. The third topic that I will address concerns the appointment of the incident controller. The fourth topic is concerned with information gathering and sharing by the incident management team, and the final topic that I will address the Commission on concerns the Marysville backburn and issues of fire fighter safety that arise from the backburn.

Ms Richards will then address the Commission in relation to two further topics. Firstly, the topic of evacuation and particularly the issue of the evacuation of Marysville. Secondly, the issue of municipal emergency management planning.

Commissioners, the Murrindindi fire was first reported at 5 to 3 on the afternoon of 7 February 2009 at the Murrindindi mill. The fire ultimately caused the deaths of 40 people, destroyed some 400 houses, and the

entire town of Marysville was devastated by the fire. In all, 168,000 hectares of forest and private land were burned by the Murrindindi fire.

The initial run of the fire saw it burn in a south-easterly direction towards Narbethong and Warburton. Nearly all of the loss of life occurred between approximately 6 and 7 pm on the afternoon of 7 February 2009 when the fire's direction changed as a result of the impact on the fireground of the south-westerly wind change. The fire was managed by an incident control centre at Alexandra. The control agency for the fire was the Department of Sustainability and Environment, DSE.

In the State of Victoria's overview at paragraph 2 of its written submissions, the State submit that the fire was much bigger and faster than expected and in paragraph 4 they say that, "The Alexandra incident control centre made assumptions and predictions based on their collective experience about fire behaviour and so it took some time for the behaviour and enormity of the fire to be appreciated."

We make two general points in response to that. Firstly, as Mr Rush noted yesterday, the fire agencies had spent the week before 7 February 2009 telling the community quite properly what a bad day it would be and that the Premier had warned the state that it would be worse than Ash Wednesday. Counsel assisting submit that it is therefore curious that the State now says that they were surprised that the fire was worse, bigger, faster and fiercer than anything they had previously experienced.

In fact, the Murrindindi fire did not move that much faster than had been predicted. According to

operations officer Bowdern at paragraph 31 of his statement, it is said that a calculation was made that the forward rate of spread of the Murrindindi fire would be 8 kilometres per hour, with a spotting distance of up to 5 kilometres. In fact, the fire travelled about 11 kilometres in the first hour and breached the Black Range 12 kilometres from the point of origin at 4.15 pm. It is conceded that the spotting distances far exceeded the estimate of 5 kilometres.

The second general point that counsel assisting make in response to this submission is that the size, speed and spotting distances of the Murrindindi fire were all quickly apparent from Andy Willans' observations which were communicated to operations officer Bowdern at about 4 pm from Mr Willans' reports of spotfires over the Black Range at 4 pm, from the widespread reports of spotting in Narbethong by 4.30 pm, and definitively from Mr Lawlor's aerial observations at 5 pm.

The second general submission that we would seek to make at this time concerns commendations for particular individuals involved in the response to the Murrindindi fire. In our written submissions at paragraph 13.25 counsel assisting praise the courage and presence of mind of SES volunteers and the police in relation to the Marysville evacuation.

In addition, it is appropriate at this point in time to commend the bravery and self-sacrifice of firefighters. It may perhaps be unfair to single people out, but we do note at this time in particular the actions of Mike Lauder and his team in protecting the campers at the Murrindindi Scenic Reserve, the readiness of

Marysville CFA volunteers to leave their town and travel to the point of origin of the fire to fight it, despite their reservations in doing so. We note Mr Cobb's courage in making ground observations, and I will return to that evidence presently, and we note Mr Williamson's endurance in leading the team that cleared the road from Marysville to Buxton in the early hours of 8 February 2009.

We do submit, however, that firefighters on the ground were badly let down by their incident management team, an incident management team that counsel assisting submit failed to devise any real strategy for responding to the fire and failed to gather and share information that was critical to the success of the firefighters' efforts and their safety.

I turn then to the topic of the incident management team. In counsel assisting's written submissions at paragraphs 13.2 and 13.3 it is submitted that it is open to the Commission to find, firstly, that the Murrindindi fire incident management team demonstrated significant shortcomings in its strategic planning for and management of the Murrindindi fire and, secondly, that the incident management team that was in place at 3 pm when the fire commenced was underskilled and fell a long way short of a level 3 incident management team needed to manage a level 3 incident, particularly one such as the Murrindindi fire.

The State of Victoria in its written submissions takes issue with those submissions. The State says at paragraphs 176 and 178 that there were no significant shortcomings in preparation or management. The State submissions expand on these submissions at paragraphs 12

through to 25 in relation to pre-planning of the Alexandra incident control centre. At paragraph 16 the State submits, and I quote, "It was not planned to have a level 3 incident management team in place prior to a fire starting. Rather, the planned incident management team was pre-positioned and was intended to be capable of responding to initial attack and to managing the fire during the escalation of the incident."

Counsel assisting note that the Alexandra ICC was on the list of pre-determined hot start incident control centres referred to yesterday by Mr Rush.

The approach to pre-planning described by the State of Victoria in its submissions was, it is submitted, clearly inadequate on a day that was predicted to be worse than Ash Wednesday, when first attack was the only hope of controlling a fire, as emphasised by Mr Waller in his briefing to the DSE officers, and when Mr Rees had instructed for incident control centres to be ready for a hot start.

At paragraphs 17 to 21 of its written submissions, the State refers to what personnel were available and unavailable to staff the incident management team. But there is a conspicuous failure to mention any of the qualified CFA staff that are listed in the north-east local mutual aid plan. The plan is at (DSE.HDD.0012.2636_R), if this can be brought up, and if we can go to page 2740_R, please. There is a heading there at the top of the page, "2.3 Joint IMT", incident management team: "When the grass fire danger index is above 35 or the forest fire danger index above 50, the DSE regional duty officer and the CFA coordinator will have

immediately available nominations for key ICS positions, primarily controllers, planning officers, resources officers, communications planning officers, operations officers and logistics officers and others where appropriate by 10 am."

It goes on: "Exchanging of nominations between DSE and CFA will be on an as needs basis. When either organisation has emergency commitments or ongoing fires that may affect their ability to respond or supply sufficient resources, they shall advise the other agency."

The State seeks to explain the omission of the CFA from their considerations in setting up the incident management team at paragraph 25 of its written submissions by saying, and I quote, "It has not been standard practice in the Murrindindi fire district to co-locate with the CFA prior to an incident. The understanding has been that each agency will maintain readiness and first attack capabilities at their respective locations. If and when a fire starts, resources and expertise can then be deployed to the most appropriate location as required."

Counsel assisting say that that may have been the practice and there is certainly evidence to suggest that that is the practice, although we note it is difficult to reconcile with the approach set out in the local mutual aid plan to which reference has just been made, but counsel assisting submit that it is a bad practice. It compares unfavourably with the way, for example, the Epsom incident control centre at the Redesdale fire was set up with a genuine joint IMT in place. In the submission of counsel assisting, the practice should be identified as a bad one and it should change.

Without labouring the point, we note that in the local mutual aid plan there were 13 level 3 accredited operations officers identified and 16 safety advisers listed in the plan. There was not a level 3 operations officer in place on 7 February at the Alexandra ICC and nor was there a safety adviser.

Mr Rice of the CFA is on both of those lists. He is identified as a level 3 accredited operations officer and a safety adviser and, as will be explored presently, Mr Rice was in Alexandra throughout 7 February 2009 but at no point was he called upon to fill a position in the incident control centre.

Counsel assisting have noted in our submissions that at the time of the outbreak of the Murrindindi fire the pre-arranged IMT at the Alexandra ICC was a long way short of a level 3 IMT. We have noted that only two of the five key members of the team were accredited at level 3 and the three that did not have the appropriate accreditation for a fire of this magnitude were those who filled the crucial positions of incident controller, operations officer and deputy operations officer.

In these submissions we seek to refer to the most important member of the incident management team, the incident controller. It is that topic that I turn to now.

Counsel assisting submit at paragraphs 532 to 534 of our written submissions that there should have been a level 3 incident controller in place from the outset at the Alexandra ICC. In fact, there was not a level 3 incident controller in place at the ICC until the morning of 8 February 2009, 16 hours after the fire commenced and 12 hours after it devastated Narbethong and Marysville.

The first incident controller at Alexandra was Mr Miller, who was accredited at the time as a level 1 incident controller. Mr Miller was the duty officer and filled the incident controller role in accordance with local practice and in the absence of the arrangements which counsel assisting submit are anticipated by the local mutual aid plan.

Mr Miller was replaced at approximately 5.10 pm by the level 2 accredited Mr Lovick. Mr Lovick travelled to Alexandra from Merrijig. The evidence indicates that at least one highly experienced level 3 incident controller was available and based in Alexandra, a short walk from the incident control centre.

Peter Rice, who the Commission heard from, is a volunteer and former career officer with the CFA with 40 years firefighting experience. During the course of the hearing, counsel assisting asked witnesses why Mr Rice was not approached to perform the role of incident controller. The evidence indicates that the appointment of Mr Lovick, the second incident controller appointed for the Alexandra ICC, was made by Mr Farrell, a senior DSE officer.

Mr Farrell was asked by counsel assisting why he did not consider Mr Rice, who was one of five level 3 incident controllers listed as available in the readiness and response plan to which references have already been made. Mr Farrell's evidence is that was the plan that he was using to staff positions in the incident control centre. That's at transcript 8506 and I don't need that to be brought up.

Mr Farrell was asked these questions and the evidence is as follows: "Did you make any further

inquiries about the availability of other level 3 incident controllers closer to Alexandra?---No."

"You now understand, do you not, that Mr Rice, Peter Rice, the group officer for the CFA in Alexandra, was in Alexandra, was available and was appropriately qualified as a level 3. Why was he not considered to be appointed incident controller for that fire?---I don't know."

"He could have been at the incident control centre within a matter of minutes after the decision was made, could he not?---Yes."

"Instead of which we wait for an hour to an hour and a half before Mr Lovick can assume his role as incident controller?---That's correct."

"Have you made inquiries as to why Mr Rice was not put forward as an option for you to consider?---No, I haven't."

In its written submissions the State now seeks to advance an argument about why Mr Rice was not appointed that was not canvassed in the evidence with either Mr Farrell or Mr Rice. The State submits at paragraph 57 of its written submissions that Mr Rice was not on the list of available incident controllers that was being used by Mr Farrell.

The list that Mr Farrell referred to in his evidence as being the list that he was using is in evidence before the Commission and it is at (DSE.HDD.0012.2636_R), the document that was up a moment ago, at page 2746_R. Towards the bottom of the screen there, it is apparent that Mr Rice's name is included amongst the five level 3 incident controllers that are listed in the response and readiness plan.

The State's submissions refer to evidence of Mr Creak in support of the submission that Mr Rice was not included on the list and this may explain the apparent confusion in the submissions. The evidence referred to in the State submissions of Mr Creak was evidence that he gave in relation to the staffing of the Kilmore incident control centre. Counsel assisting, Mr Rush, asked Mr Creak why Mr Rice was not used to fill the incident controller position at the Kilmore incident control centre and Mr Creak's evidence was as follows. This is at transcript 10897 and I don't need it to be brought up; it is a brief quote.

Mr Creak said: "The previous discussions I had had with Mr Rice had indicated that he was not willing to travel beyond his home location and would prefer to stay at his home location at Alexandra, so for that reason he wasn't available for a response outside of his own area so he wasn't listed." When Mr Creak was asked why Mr Rice was not appointed as the incident controller for the Alexandra ICC he said, "I can't say exactly why not." And he wasn't questioned by the State about that matter.

Counsel assisting submit that it was never put to either Mr Creak, Mr Farrell or indeed Mr Rice that Mr Rice was unavailable to perform the incident controller function at the Alexandra ICC. In those circumstances the Commission is left to speculate on the real reason or reasons for the failure to consider Mr Rice for the position. It may be that it was because he was a volunteer or because he was not from the control agency or for some other reason.

Counsel assisting submit that the absence of an

experienced and accredited level 3 incident controller in charge of the response to the Murrindindi fire during the afternoon of 7 February 2009 was a significant failure by the fire agencies. We maintain as set out in our written submissions that there was a disturbing lack of strategic direction provided by those at the ICC to the brave men and women on the fireground. Neither Mr Miller nor Mr Lovick were trained to fulfil the incident controller function at a fire of this magnitude.

Commissioners, we adopt in advance the submissions which we anticipate will be delivered later today by Ms Doyle in relation to the Churchill fire, where she examines the differences between a level 2 and level 3 incident controller and identifies the evidence that indicates the importance of a level 3 incident controller at a level 3 incident.

Before leaving this topic we note the evidence of Mr Haynes at paragraph 172 of his second statement that there were 83 CFA endorsed level 3 incident controllers as at 7 February 2009 and the evidence of Mr Slijepcevic at paragraph 111 of his later statement that there were 15 fully available accredited DSE level 3 incident controllers on the 7 February.

Counsel assisting submit it is a matter of great concern that not one of those 98 incident controllers was approached to be the incident controller for the Murrindindi fire on 7 February 2009.

If I can turn to the topic of information gathering and sharing. As already noted, at paragraphs 5.35 to 5.67 of counsel assisting's written submissions we criticise the lack of strategic planning by the Alexandra

ICC between the time of ignition of the Murrindindi fire at 3 pm and 6.45 pm when the fire consumed Marysville. Part of the criticism identified in the submissions is that the incident management team failed to act appropriately on the information that they had about the fire and its predicted path and, secondly, that the team did not use all of the information available to it.

This second criticism, that is that not all of the available information was used by the team, seems to be accepted at least in part by the State of Victoria. For example, at paragraph 63 of its written submissions, the State submits that "Between 1500 and 1600", 3 pm and 4 pm, "there were no reliable observations of the progress of the fire generally available to DSE or CFA."

This is the crucial first hour of a fire that, as is well-known, ultimately caused the deaths of 40 people. What is particularly disturbing about the submission is that during the entire period referred to, that is between 3 pm and 4 pm, a DSE fire spotter, Mr Andy Willans, had a perfect view of the development of the Murrindindi fire. Mr Willans gave evidence in the proceedings that he was located on the Mount Gordon lookout tower which is three kilometres west of Marysville. Mr Bowdern, who was the operations officer at the Alexandra ICC, was asked about the view Mr Willans had of the developing fire and Mr Bowdern said that Mr Willans had "the box seat".

Mr Willans gave evidence in June 2009 about what he saw of this fire between 3 pm and 4.30 pm, at which time he evacuated the tower for reasons of his own safety. His description of the fire during its first half hour is at transcript 3033 starting at line 6. What

Mr Willans said was as follows: "That cloud mass from its infancy in that first half hour, it was huge. In that first half hour, from a tiny little trindle of smoke that I spotted and was able to give a bearing to, it grew in such incredible stature. I'd seen nothing like it. It terrified me. In the next half hour to when it breached the Black Range Road, I guess it would have doubled the amount of smoke, its height, its width. It was enormous. The following half hour until I left it was massive. It's beyond description. This thing was huge, absolutely huge. I can't explain it. And it was alive. This thing was just full of ember, ash, burning materials. This thing was absolutely alive."

Mr Willans also gave evidence about his views about the danger that the fire posed to Marysville and that evidence is at page 3037 of the transcript commencing at line 2. He said this about the concerns he had as early as 3.30 pm on the afternoon of 7 February: "I felt then that this thing was going to impact not only myself, my tower, my home, Marysville itself, bearing in the back of my mind these things travel at enormous speeds and the wind, the temperature of the day, were contributing factors to me making that call. Also there was a wind change called for between 1800 and 2000 hours that day. We were only at 3.30 in the afternoon. I'm facing a massive cloud like I'd never seen before. I felt then that it was going places and it was going to kill people; just my gut instinct. Marysville is a small town, it is in a hollow. They couldn't see this, I could. My call to them then was quite - I was quite - not frantic, I was quite determined to let them know that this was like

nothing else they've ever seen before. They had to be told."

It is counsel assisting's submissions that this crucial information should have been immediately conveyed to the incident management team. It would then have informed the entire response, including the provision of warnings, fire suppression and the question of evacuating Marysville. I make clear that counsel assisting make no criticism of Mr Willans for the communication failure. After being unable to contact the incident control centre, he tried unsuccessfully to contact the Marysville CFA captain. Ultimately, as detailed in our written submissions, he spoke to the Marysville CFA communications officer.

Mr Bowdern, the operations officer who was in charge of firefighting at the incident control centre in Alexandra, said he had no contact with Mr Willans between 3 pm and 4 pm. His first contact was at 4 pm.
Mr Willans told the Commission that he had tried to contact the incident control centre earlier, but the phone was engaged. That was at page 3028.

Between 4 pm and 5 pm, that is the second hour of the Murrindindi fire, the progress of the fire was tracked by Peter Cobb of the DSE. Mr Cobb bravely drove into dangerous locations to observe spotfires. The Commission will recall his evidence which was given with the benefit of a map that identified the location of the various spotfires that Mr Cobb identified. However, his valuable observations were also not conveyed to those in charge of the firefight at Alexandra.

When Mr Miller, the incident controller

throughout this period, was asked about Mr Cobb, his evidence was as follows and this is transcript page 8331 commencing at line 4. Mr Miller was asked by counsel assisting: "Who was Mr Cobb reporting to?" Mr Miller said, "I'm not sure who he fed that information back to but I am not aware of it coming into the ICC at that stage." Counsel assisting asked: "How would it be, Mr Miller, that information, and I say as important as that concerning the fire would not end up at the Alexandra incident control centre?" Answer: "I don't know." Counsel assisting: "Is there no system to ensure it does?" Answer: "The standard arrangement is that crew leaders or sector commanders will report back through operations officers, yes." Counsel assisting: "Why didn't it happen on this day? Answer: "I don't know."

The detailed real-time observations of the progress of the fire by a man of 27 years of forest firefighting experience, Mr Cobb, were not conveyed to the incident control centre.

In response to counsel assisting's submissions about why no consideration was given by the incident control centre to the evacuation of Marysville, a point Ms Richards will return to presently, the State responds that, "The incident management team was not in a position to understand the run of fire until about 1700." That's at paragraph 169.

Counsel assisting submit that this is an astounding submission for the State to make. As we have noted, there was extensive information available that should have made the run of the fire very clear to those in charge. To this day the Commission has not been told

why that information was not conveyed to those in charge.

It is of concern that the State of Victoria does not agree with counsel assisting's submissions that this is a significant shortcoming in the management of the Murrindindi fire. In those circumstances we ask: Can the people of Victoria have any confidence that anything has really changed? Will there be another fire on a catastrophic day in the future where those in charge make crucial decisions such as whether to evacuate a town in an information vacuum?

One report that did make it through to the ICC was the report from Mr Lawlor, who flew over the fire at 5 pm. He told the incident management team at 10 past 5 that Marysville and Buxton would be directly in the path of the new firefront when the predicted south-westerly wind change occurred. However, this vital piece of intelligence was not provided to the man in charge of firefighting resources in Marysville, Mr Williamson. It was Mr Williamson who, and it is accepted with the best of intentions, authorised the lighting of a backburn south of Marysville 15 minutes before the main firefront devastated the town. The backburn failed because it was swallowed up by the fire when the south-westerly wind change occurred at about 6.45 pm. The final topic I wish to address concerns the backburn and questions of firefighter safety.

The Commission heard a good deal of evidence about a failed backburn that was lit under the direction of Mr Williamson of the DSE. Counsel assisting submit at paragraphs 628 to 644 of our written submissions that the backburn should never have been lit. We submit it was futile in the circumstances of 7 February 2009 and,

further, the firefighters involved were needlessly exposed to the risk of injury.

The State of Victoria responds at paragraphs 108 to 137 with a justification of the lighting of the backburn. The State notes in its submissions that the backburn was lit at 6.30 pm in circumstances where Mr Williamson thought the wind change would arrive in approximately 45 minutes. The State says this was a crucial aspect of Mr Williamson's decision; paragraph 117. The State argues that 45 minutes was an adequate time for a backburn which could have reduced the intensity of the main fire when it impacted on Marysville.

Council assisting submit that the obvious difficulty with this submission is that wind changes don't arrive on schedule. The Bureau of Meteorology's wind change charts, which we are told were being relied upon by the incident management team, contain the following warning, and I quote: "Note: Timing of wind charges cannot be forecast with precision."

This very point is made by the State in response to counsel assisting's submissions about the evacuation of Marysville. The State says at paragraph 158 of its submissions that, "Weather predictions including wind change predictions are not always accurate." The Commission has heard evidence along similar lines. For example, Mr Jeremiah, a level 3 accredited incident controller, told the Commission in relation to the Churchill fire that his experience of wind changes is that they are not accurate to the minute.

Further, as counsel assisting have pointed out in our written submissions at paragraphs 3.9 and 6.37, there

was information available to the incident control centre that the wind change on 7 February was moving faster than initially forecast. It is submitted that the incident management team took inadequate steps to monitor those information sources. For example, it is far from clear that the Coldstream automatic weather station was being monitored and it is common ground that the incident management team did not seek a spot fire weather forecast from the bureau at any time on the afternoon of 7 February.

The DSE men on the fireline in Marysville felt they had to act quickly to try and save Marysville. It will usually be the case that firefighters in the position of Mr Williamson and his colleagues will not be in possession of the information about the fire location and behaviour and weather predictions that an incident management team will have. It is for that reason that the DSE fire management manual contains the following advice. This is set out at 6.33 of our written submissions. Section 4.72 of the manual is concerned with backburning and burning out and it includes the following advice to firefighters: "Backburning and burning out must be thoroughly planned and properly executed. A poorly planned or poorly executed backburn will risk firefighter safety, immediately increase fire area and make fire suppression more difficult and expensive."

And the following appears at 4.18 of the manual: "Caution. Only after serious consideration of all alternative tactics, the consequences of any potential escapes and with direct approval of the incident controller is backburning or large scale burning out to be

used under very high to extreme forest danger indexes." And of course 7 February was such a day. The manual goes on: "Backburning under these conditions will most likely fail and should only be considered when conditions are such that any spotting which occurs can be controlled with the available resources."

The evidence indicates that, in accordance with the requirement for the incident controller to approve the backburn, Mr Williamson's subordinate contacted the incident control centre. There is some debate between the parties about precisely what occurred at the incident control centre, but we submit that one thing is clear: No-one at the incident control centre raised a concern about the effect that an earlier than forecast arrival of the wind change might have on the proposal to conduct the backburn.

Counsel assisting submit that in a properly staffed incident management team the incident controller would have been assisted by a trained and experienced safety adviser in responding to the backburn proposal. That safety adviser's sole concern under the fire agency standard operating procedures would have been the safety of firefighters. The Bunyip fire provides an excellent practical example of this process operating as it should. As we have noted in our written submissions on that fire, firefighters were withdrawn from the fireline at one point by the level 3 accredited incident controller on the advice of the safety adviser that he had appointed.

It is common ground that there was no safety adviser to participate in the discussion about the backburn, as one had not been appointed. The State says

in its submissions that the Commission should not be unduly concerned about this failure. It says at paragraph 186 that firefighter safety was a priority for the Alexandra incident management team.

The backburn was lit and within 15 minutes it was overrun. In a witness statement Mr Williamson told the Royal Commission about what happened. This is at counsel assisting's submissions paragraph 6.41. Mr Williamson said this, and I quote: "I now know that if I had not made this call to evacuate and if crews had not left at this time we would have lost 60 to 70 people within 30 seconds to one minute later. Kit bags in the back of vehicles caught on fire due to ember attack and many of the DSE vehicles suffered damage to parts such as mirrors and plastic components which melted due to the intensity of the fire as the crews were driving towards the Marysville football oval."

The State's response to this compelling evidence is set out at paragraph 195 of its submissions. The State says this: "There is no evidence that the backburn caused unnecessary and severe risks to the safety of firefighters. The evidence overwhelmingly supports the proposition that it was the main fire which overran the backburn and threatened the firefighters in Kings Road." Counsel assisting make the simple point that it was the presence of the firefighters in the forest south of Kings Road that exposed them to the risk. It is surely irrelevant whether the flames that burnt the DSE vehicles were part of a backburn or part of the main fire.

The State says there was no other option to protect Marysville. Counsel assisting beg to differ. We

submit that a better use of the 80 or so firefighters with numerous vehicles in Marysville from 6 pm onwards would have been to warn as many residents as possible of the fate that was about to confront them and to urge those residents, with all of the authority that firefighters have, to evacuate to the oval which was recognised widely as a place of relative refuge. We note in our written submissions that there are examples of individual firefighters doing that very thing and we also note that it was with mixed success. That is, some people left on being advised to do so by firefighters, others didn't.

No-one who made it to the oval was harmed. Instead, as we all know from the evidence, 34 people died in Marysville on 7 February, including a number in buildings on the Kings Road, metres from where the crews involved in the backburn were situated. Once again, counsel assisting make no criticism of Mr Williamson and the other men and women on the fireground. We do criticise the lack of strategic direction that was provided to those firefighters by the members of the incident management team. We maintain our submission that inadequate consideration was given to the safety of the firefighters involved in the decision to allow the backburn to proceed.

In conclusion, Commissioners, these submissions commenced with the proposition that there should have been a level 3 incident controller at the ICC during the afternoon of 7 February 2009 directing the firefight. The State response to that submission is to say "it may have been preferable" to have had a level 3 incident controller in charge. That's at paragraph 179. But the State go on

to say that there is no evidence that the failure to have a level 3 incident controller resulted in any significant shortcomings in the incident management team's management of the Murrindindi fire.

In our written submissions counsel assisting point to numerous management shortcomings that can only be described as significant. Some of those have been highlighted in these oral submissions. A number, such as, one, the failure to ensure that all available information about the progress of the fire was passed on to the ICC; two, the failure to assess thoroughly the prospects of success of the backburn weighed against the risk to firefighter safety it posed; and, three, the failure to consider the evacuation of the town of Marysville, can only be described as serious errors in fire management.

In those circumstances it is necessary to ask why such mismanagement occurred and whether all of these shortcomings would have existed under the leadership of an incident controller with the proven skills, training and experience that characterise an accredited level 3 incident controller.

They are the submissions that I seek to make at this time and Ms Richards will now continue with submissions in relation to the Murrindindi fire.

CHAIRMAN: Thank you, Mr Rozen.

MS RICHARDS: Commissioners, I am going to deal this morning in oral submissions with the topic of evacuation, specifically the evacuation of Marysville, and the related topic of emergency management and more particularly municipal emergency management planning.

The subject of the evacuation of those in the

path of the Murrindindi fire, in particular the evacuation of Marysville, is dealt with in considerable detail in the written submissions of counsel assisting commencing at paragraph 9.1. That discussion follows closely from the related topics of emergency management and warnings.

I think it would be useful if I go to the key findings that counsel assisting say should be made based on the evidence about evacuation in the face of the Murrindindi fire and these start at page 79 of the submissions. Perhaps we could get those up on the screen.

The first key finding that's proposed is that many residents of Marysville and Buxton were able to evacuate safely. This was not due to municipal emergency management planning or to any decision taken by the incident controller to recommend evacuation. There was ample information available to the incident management team as to the location, speed and ferocity of the fire and, as Mr Rozen has pointed out, it should have been clear by 4 o'clock in the afternoon that Marysville was under threat after the forecast wind change.

If anyone in the incident management team had turned their mind to it, information could have been sought from Mr Lawlor, the air attack supervisor, as to the safety of possible evacuation routes from Marysville. Had a decision to recommend evacuation been made by 1630 or even 1700, the evacuation of those who wished to leave could have been effected more systematically and more safely than was possible as the fire bore down on the town.

Yet evidence also demonstrated that it was only the Marysville SES unit who had planned for the need to

evacuate Marysville and who implemented their plan to provide assistance to aged and infirm residents on Black Saturday. The police who directed those gathered on the oval to drive in convoy to Alexandra had to make snap judgments on very limited information in the absence of any fire agency presence at Gallipoli Park. The judgments that they made in those pressing circumstances, in the submission of counsel assisting, were sound. The courage and presence of mind of the police and the SES volunteers involved in evacuating Marysville and Buxton should, in our submission, be commended.

Counsel assisting also propose related key findings in relation to emergency management and these appear starting at page 77 of the written submissions. The first key finding in relation to evacuation is that the emergency management planning in place for Murrindindi shire lacked the substance, detail and precision needed to respond adequately to the events of 7 February 2009. Specifically, and I will skip to paragraph (b) as this relates to evacuation, the Murrindindi municipal emergency management plan did not include any plan for the evacuation of Marysville or any other township in the municipality.

Emergency management planning did not include detailed planning for the evacuation of locations identified to be at risk of bushfire that made reference to any of the following matters: The particular location, the surrounding topography, the roads on which evacuation might take place, the size and the make-up of the population, any vulnerable members of the community who need assistance to evacuate, any particularly vulnerable

sites such as schools and hospitals, any places of refuge and possible emergency relief centres.

It follows that local emergency management planning also failed to identify who would take what action to effect an evacuation and triggers for that action. The municipal emergency management plan did no more than repeat the general delineation of responsibilities for evacuation set out in the State emergency response plan. It should have included enough detail to give those responsible for effecting an evacuation a framework for decision and action.

So those are the key findings proposed by counsel assisting, but to return to the basis on which those findings are put forward. Anyone viewing the scenes of devastation in Marysville after Black Saturday, and by now most of us have seen many times the footage produced by Mr Hull of what remained of Marysville the following morning. Anyone viewing those scenes should be in no doubt that Marysville was a town that needed to be evacuated in advance of the fire. It is folly to suggest that all of the residents of Marysville should have stayed put and sheltered in their houses as the fire approached. There was no designated refuge in Marysville, although as we know there was an informal, widely known refuge at Gallipoli Oval.

The Commission has heard from many residents of Marysville who stayed to defend their homes, only to have their homes burned to the ground and their lives put at grave risk. As Mr Rozen has mentioned, 34 people died in Marysville that evening. The Commission has examined the circumstances of the deaths of each of those people and

the Commission is well aware that most of those people died in or near houses. Only the extremely well prepared and the extremely lucky were able to save their homes in the face of the firestorm that swept through that town. To compound matters, Marysville's water supply, which was a very reliable, plentiful, gravity-fed water supply, was unable to meet the demands placed on it on Black Saturday, leaving many residents without water to fight the fire.

In the event, much of Marysville did evacuate safely from their homes and from the town, driving north through Buxton and then to Alexandra. They did this at a time when the fire was already burning and when, according to CFA orthodoxy, it was too dangerous for them to leave and they should have stayed in their houses, regardless at that time of their level of preparation.

Counsel assisting's written submissions go into considerable detail about the way in which this evacuation was effected, precisely because it occurred contrary to the accepted policy that evacuation during a bushfire should not take place and yet, as we know, hundreds of people were evacuated to safety. The evidence shows that many people left the town of their own accord, while others gathered at the Gallipoli Oval.

The local SES, alone of all of the emergency services, had formulated some kind of plan for evacuating vulnerable residents, putting together a list of elderly residents and others who might need assistance to leave town. They implemented that plan starting at 5 o'clock in the afternoon, having heard reports over the CFA radio that the fire had reached Narbethong.

Those who had gathered at the oval were directed

by police to drive north to Alexandra through Buxton, leaving shortly before 7 o'clock just as the fire reached the town. The police involved in this action made a rapid risk assessment based on very limited information that was available to them and judged it safer to evacuate the oval than to remain there. They made their decision at a time when there was not one fire truck at the oval to protect those who had gathered there. As we know, the convoy escorted by police and SES personnel reached Alexandra safely.

The State's submissions on this topic of evacuation are revealing. They just avoid the issue altogether. They concentrate first on the initial warning from Andy Willans on the Mount Gordon fire tower, telling Glen Fiske, captain of the Marysville CFA, that he should evacuate Marysville and, second, on answering submissions that the incident controllers did not consider evacuating Marysville. The response proffered is in essence that both Mr Fiske and the incident controllers acted in accordance with CFA policy and accordingly should not be criticised for their actions. Otherwise, the State makes no response at all to counsel assisting's factual account of the evacuation of Marysville, and yet later on in its written submissions suggests that the key findings proposed in relation to evacuation should not be made.

In relation to the CFA's policy of not recommending evacuation when a fire is burning, the State mostly reiterates the submissions it made on evacuation for the interim report. There is no real attempt to grapple with whether that policy stands up to scrutiny, with whether the policy served the town of Marysville

well. The State says in its written submissions that it is unable to agree with the general proposition advanced earlier by counsel assisting in relation to the interim record that safe evacuation may be possible when a fire is burning. It follows from that submission of the State that its position must be that safe evacuation is never possible when a fire is burning and that position is self-evidently wrong. The position belies a one-size-fits-all, lowest common denominator policy that, because safe evacuation may not be possible in all cases, it will never be recommended.

Counsel assisting's submission in relation to evacuation is, as it was when we made submissions in relation to the interim report, that while late evacuation may be extremely dangerous, safe evacuation may be possible when a fire is already burning. Whether safe evacuation is possible will depend on a wide range of matters: The characteristics of the particular location under threat; the roads that service that location; the speed, intensity and path of the fire; the weather conditions, including of course any predicted wind change. These are all matters that should be within the knowledge of the incident controller and the incident management team, who are in the best place to assess that information and to determine whether evacuation may be recommended in that case.

All of this was accepted by the Commission in the interim report and resulted in recommendation 6.3 that the CFA and DSE amend operational policies to require the incident controller to assess whether relocation should occur and to recommend relocation when warranted.

The Commission made it clear in its interim report that it was not speaking of compulsory evacuation, simply warning and advice to people in the path of the fire that they were in danger and that they should leave unless they were ready and willing to stay and defend their home. The Commission anticipated that advice to evacuate or relocate should in the first instance be delivered with bushfire warnings. Police would continue to be responsible for effecting evacuation or relocation and at times would need to deliver advice to specific locations, possibly even going door-to-door.

In its response to the interim report the State supported this recommendation, noting that guidelines would be developed to assist incident controllers and emergency services personnel and, understandably, that relocation recommendations would only be made where the incident controller determines and is fully satisfied that people can relocate safely.

Its submissions on evacuation in response to the Murrindindi fire appear to contradict this position in its response to the interim report, in particular the statement at paragraph 158.1 of its written submissions that, "Whilst there is scope for including in warnings a recommendation that people leave an area immediately, it is not appropriate for incident controllers and control agencies to make specific recommendations about evacuations." Perhaps counsel for the State can clarify their client's position on this very important issue.

To return to the specific circumstances of the evacuation of Marysville, what stands out is that the evacuation was effected by local planning and action on

the part of the Marysville SES and by snap judgments made by police on the Gallipoli Oval and of course by people who made their own decision that it was time to leave. It was not the result of emergency management planning at either state or municipal level or any decision made by the incident controller to recommend evacuation.

In counsel assisting's submission there was sufficient information available to the incident management team at Alexandra by 5 o'clock at the very latest on which it could have recommended the evacuation of Marysville. It was at that time that the Marysville SES, with much more limited information than was available to the IMT, decided to act and to evacuate vulnerable residents.

It must be pointed out that evacuation recommended at that time would have been able to be effected more systematically and more safely than the random doorknocks and hastily arranged convoy that left the oval as the fire bore down on the town. But, consistent with the then policy of the fire agencies, perhaps still their policy, neither of the incident controllers considered recommending evacuation.

What the Marysville experience does highlight is that local planning, even on a small scale, can work. It also shows up a big hole in local emergency management planning. The Shire of Murrindindi's municipal emergency management plan had very little to say about evacuation. It says this: "Victoria Police are responsible for evacuation. The decision to evacuate rests with the combat agency in conjunction with the police and available expert advice." So far that simply restates what is in

the state emergency response plan. "Consideration must be given to the area which is to be evacuated, the route to be followed, the means of transport and the location to which evacuees will be asked to attend." It then goes on to identify the responsibilities of the Murrindindi shire in relation to providing emergency relief centres.

The CFA and the DSE are identified as the control or combat agency for fire, CFA for urban and rural fires and the DSE for forest fires. Beyond that, there is very little or nothing that goes further than basic principles of responsibility for evacuation that are found in the State emergency response plan. The only local content that we find in Murrindindi's municipal emergency management plan is the location of emergency relief centres and the identification of some locations such as schools, camps, hospitals, nursing homes and industrial sites, which have their own special evacuation plans.

The Municipal Association of Victoria is quick to point out in its submissions that the Murrindindi municipal emergency management plan was compliant with the requirements of the Emergency Management Act and the guidelines for the preparation of municipal emergency management plans found in the Emergency Management Manual Victoria, and that's true. The Murrindindi municipal emergency management plan has been certified by the director of the SES as complying with the guidelines for preparation of municipal emergency management plans. Hence, we find that the MEMP of other councils that are in evidence before the Commission deal with evacuation in a broadly similar way to that of the Murrindindi municipal emergency management plan.

Clearly it would have been immensely useful had the Murrindindi municipal emergency management planning committee engaged in detailed evacuation planning in the manner outlined in counsel assisting's submissions. For example, if they had planned how to use the list of disabled and elderly residents needing special consideration that was maintained by council under the plan, the list might have been used on 7 February to warn and evacuate those residents. As we know, it was not.

It must be said that councils are under a very significant burden placed on them by a wide range of legislation, including, among many, the Emergency Management Act. The Commissioners are by now well aware of the burden that is placed on councils to respond with limited resources. It is perhaps expecting too much for a council to do more in municipal emergency management planning than the minimum required of it and that directs attention to the guidelines themselves.

The guidelines are found in chapter 6 of the Emergency Management Manual of Victoria and they are quite lengthy. I don't propose to go to them this morning, but it must be said that in respect of the response arrangements to be included in a municipal emergency management plan, they are extremely general. The guidelines outline what should be included in relation to response arrangements and say that control and support agencies should be identified and local arrangements for response to identified emergencies should be detailed. There is no further requirement for the municipal emergency management planning to give attention to what those local arrangements should be.

There is clearly scope for including detailed evacuation planning in a municipal emergency management plan in detailing the local arrangements for responding to identified emergencies, but while the guidelines remain as general as they are we cannot expect councils to undertake that work.

The Municipal Association submits that detailed planning of the kind suggested by counsel assisting could be considered by the Commission, but also submits that it is not appropriate for responsibility for that planning to rest with councils. The Municipal Association goes on to submit that the appropriate agency to take on that responsibility would be the Victoria Police.

In the submission of counsel assisting, the municipal emergency management planning committee, an established body that brings together local emergency services personnel and council staff, is the obvious place for this kind of planning to occur. The best place for a detailed evacuation plan is in the municipal emergency management plan. While Victoria Police are responsible for implementing any decision to evacuate, the decision itself rests with the control agency and its successful implementation in a given location will require a multi-agency plan.

In our submission, the experience in Marysville highlights a need for emergency management planning to include detailed planning for the evacuation of locations identified to be at risk of bushfire. This planning should include reference to the particular location, the surrounding topography, the roads on which evacuation might take place, the size and nature of its population,

any vulnerable members of the community who need assistance to evacuate, any particularly vulnerable sites such as schools or hospitals, any place of refuge and possible emergency relief centres. The planning should identify who will take what action and triggers for that action. If possible, the plan should be rehearsed by those responsible for enacting it and the plan should be detailed so that, in responding to an emergency, those responsible have a framework for decision making and action.

This is an issue that has emerged very clearly, in our submission, from the evidence in relation to the Murrindindi fire and the evacuation of Marysville and it is an issue to which counsel assisting will be returning later in the hearings. Attempts are being made at present to arrange for some evidence from Calfire about how evacuation is planned and effected in the State of California.

Commissioners, unless there are any questions that concludes the oral submissions I have in relation to the Murrindindi fire.

CHAIRMAN: Thank you, Ms Richards.

MR MYERS: Commissioners, I should like to say a few things by way of response to the oral submissions that have been made this morning.

First of all, the written submissions on behalf of the State are detailed and grapple in a careful and considered way with the issues that arise out of the Murrindindi fire and in general I don't wish to go to them but simply to commend them to the members of the Commission.

Ms Richards said on quite a few occasions in her submissions a few moments ago "it must be said". Now, in fact most of what was said by Mr Rozen and Ms Richards didn't need to be said and shouldn't have been said. For the most part it was irresponsible and sensationalist, adversarial, pointless and damaging.

The first thing that ought to be recalled about the Murrindindi fire is, as Mr Willans who had a perfect view of it described it, it was unprecedented, terrifying, massive, beyond description, growing enormously and so on.

It is not at all curious, as suggested by Mr Rozen, that in those circumstances decisions were made in the heat of the circumstances that existed that are able to be criticised in a hypothetical way after the event. There are many things that happened which are regrettable, but that doesn't mean that someone has to be found to be at fault. The fact of it is that the fire in Murrindindi was a fire in which one could exhaust the thesaurus of adjectives in describing its almost indescribable ferocity.

The general response of the firefighting services in Victoria on 7 February was good beyond the expectations that one could have in the circumstances of that day. For example, yesterday one heard about Coleraine and Weerite. The circumstances of Murrindindi are not the same as the circumstances of Coleraine and Weerite. They weren't grass fires in relatively unpopulated areas.

We urge the Commission not to be inflamed by the sorts of submissions that were made this morning. They will not help in dealing with these issues in the future and nor will they help ease the minds of those who

suffered loss of family, friends or property on 7 February.

In fact, quite apart from that, it's wrong to say, as was put by Mr Rozen, that the people of Victoria were badly let down by the incident management team, that it was clearly inadequate. The fact of it is that the persons who were required to deal with the Murrindindi fire were required to deal with circumstances that no-one expected. Of course a terrible day was expected, but not of the kind that the people responsible for suppressing the fire at Murrindindi faced.

We maintain our submission that particular individuals should not be mentioned adversely. No good purpose is served by that.

There are two particular matters that I wish to mention. There was some criticism, one gathers, of why it was that Mr Rice was not asked to be the person in charge of the management of the fire. Mr Rice came along and gave evidence. He was never asked any questions by counsel assisting dealing with that topic. Indeed, no-one was.

We wouldn't have to leave the matter to speculation if the witnesses had been properly examined, but speculation of course in these circumstances is a little easier than dealing with the facts. The fact that there were many people within Victoria who might have been qualified to be in charge of the firefighting efforts in relation to the Murrindindi fire is really not to the point. It's only the persons who were there and available who could have been considered

Concerning information gathering and sharing,

which was another topic dealt with by Mr Rozen, there are just a couple of particular things that I wish to point out. For whatever reason, Mr Willans didn't convey the information that he had to the incident management team, and that's the fact. It may have been better if it had been conveyed to the incident management team, but it wasn't.

The rhetorical question asked by Mr Rozen - can the people of Victoria have any confidence that anything has changed in the light of issues concerning information gathering and sharing - is risible. A great deal has changed. The State has acted diligently and responsibly to undertake steps to implement the recommendations made by this Commission in its interim report and to do many other things to protect this state and its citizens and their property against fire.

The answer to the question is, yes, the people of Victoria can have confidence that a great deal has been done and much has changed as a result of 7 February last year. The irresponsible implication of that question is rejected.

As to the matter of the backburn, well, apparently with the benefit of hindsight counsel assisting are able to tell the Commission by reference to footnotes in the Bureau of Meteorology reports and other documents that it shouldn't have been done. We don't accept that. The circumstances were desperate and persons who were acting responsibly, in good faith made decisions in order to attempt to protect Marysville.

The fact that the steps were not successful in one sense only is neither here nor there. It would have

been better if they were successful of course. But the fact that they were not successful doesn't mean that those persons who made that decision are to be criticised or those who were responsible in the incident control centre are to be criticised.

One thing again that's absent in the evidence and enables speculation of the kind that was undertaken this morning by Mr Rozen is this: no level 3 incident controller was asked about what he or she would have done in the circumstances which have been the subject of speculation this morning; a gap in the evidence that permits speculation; mischievous speculation.

As to Ms Richards further submissions concerning evacuation, we have dealt with the question of evacuation directly and fairly in our written submissions. There's nothing to add to those.

We invite the Commission not to criticise those who decided that it was not safe, it was better not to evacuate from Marysville. Decisions have to be made in these circumstances which, with the benefit of hindsight, may or may not be right. The only test is whether the persons acted in good faith and reasonably, and everyone involved in this matter did.

I'm sorry that I have had to speak in this way. It's most regrettable. But the submissions this morning call for a firm response. The suggestion the State has not done anything as a result of which the people of Victoria can have confidence that things have changed in relation to the suppression of bushfires and the protection of the people of Victoria and their property is simply without foundation. If the Commission pleases.

CHAIRMAN: Yes, Dr Lyon.

DR LYON: Thank you, Mr Chairman. I can start by saying that the oral submissions of Ms Richards today certainly recognise that the issues between counsel assisting and the local government and the MAV were comprehensively raised and responded to in the written submissions. So that means I can be very brief.

CHAIRMAN: Yes, thank you.

DR LYON: There are two points to make. The first is this. It is regrettable, it is unfortunate that the issue of emergency management and evacuation so far as it concerns the content of the MEMP was not raised in oral evidence nor was it raised in the issues for consideration in the statements of the local government witness Ian Ellett. So that means the Commission did not have the benefit of evidence on the topic or the views of local government as to whether, how or where evacuation procedures should appear and whether they should appear in the MEMPs or somewhere else.

It is also unfortunate that it wasn't raised as an issue until we read the submissions of counsel assisting. So that means that in response we are somewhat hamstrung.

But the two points raised by Ms Richards require some response today, and that is: should the guidelines to the emergency management manual of Victoria be amended? The guidelines are promulgated by the police minister, and of course in our submissions we point out that the appropriate agency for conducting evacuations, as pointed out in the EMMV, is the Victoria Police and the role played by councils is a limited role. We certainly

appreciate the recognition this morning of the burden councils have in emergency planning and response in the words of Ms Richards.

If the police are the appropriate agency to conduct evacuation and if it is also recognised that the MEMP, the municipal emergency management plan, is not a blueprint for all agencies and all levels of government, then the query is raised: is the MEMP actually the appropriate place in which to put comprehensive evacuation procedures?

We raise the possibility that with township protection plans being promulgated through the State whether or not, given the input of so many agencies and the more public nature of that document, the TTP is not a more appropriate place for such procedures.

Councils do recognise that they have a role in emergency planning and response. That was taken up in our submissions. But in terms of achieving the most effective outcome for the people of Victoria we ask that the submissions of counsel assisting and the proposed key findings not be made in a way that's critical of councils but take up whether there is a more appropriate place by which this outcome can be achieved.

CHAIRMAN: Yes, thank you, Dr Lyon.

MR MYERS: Before my learned friend speaks, I should just like to say one thing, Commissioners. It may be suggested that something I said about Mr Rice is incorrect. On page 8526 of the transcript Mr Rush was examining Mr Rice and he asked whether consideration was "given to you actually becoming the incident controller of the Murrindindi fire?---No, it was not discussed."

"Did you at any stage consider that possibility?---No. Incident controllers within the north-east of Victoria have traditionally always been appointed, and it is not a sort of situation where someone, even though they may have the qualifications or the accreditation - you just don't walk in and say, 'Hello, I'm Peter Rice. I'm here to take over as the incident controller.' It is not the way it has happened over the years. Also the north-east had a preplanned level 3 incident management team roster planned for 7 February. I wasn't on the roster for that particular day. A copy of that had been emailed to me a day or so earlier, and I was aware that I wasn't on it. So it wasn't discussed, and I felt that that decision would be getting made elsewhere."

I wanted to make sure that I draw that to your attention in case it's said that I misled you. Thank you.

MR RUSH: Unfortunately, Commissioners, that's not of course the only point where it might be said that Mr Myers failed to address the evidence concerning Mr Rice, because it was raised with Mr Farrell, Mr Creak and I think Mr Miller.

It is regrettable, as my learned friend said, that he had to use the terminology which he did. Counsel assisting have a difficult enough job without the State of Victoria indicating by submission this morning in the way in which Mr Myers put forward those submissions matters that do concern the evidence and are fairly addressed on the evidence by counsel assisting.

Counsel assisting opened indicating that where matters were good they would be identified as they have been; where matters are bad they would be identified as they have been. It is all very well for Mr Myers to refer

to Coleraine or to the Weerite fires. They were identified by counsel assisting as being fires that were excellently handled, excellently prepared.

What Mr Myers has failed to grapple with in any of his responses is what was raised here; that in north-east Victoria, both at Kilmore and at Alexandra, there was no preparation for an incident control centre based on level 3 which the CFA indicated at the very outset on 6 February the level 3 would be in place at both Alexandra and at Kilmore.

Counsel assisting have done no more than address what is required of this Royal Commission in the terms of reference. It is necessary in response to Mr Myers to point out the terms of reference because it would appear that he has not read them recently.

Terms of reference 1 require the Royal Commission to investigate the causes and circumstances of bushfires which burned in various parts of Victoria in late January and February 2009; 2, and importantly, to inquire into the preparation and planning by governments, emergency services, other entities, the community and households for bushfires in Victoria, including current laws, policies, practices, resources and strategies for prevention, identification, evaluation, management and communication of bushfire threats and risks; and, 3, to inquire into and report on all aspects of the response to the 2009 bushfires, particularly measures taken to control the spread of fires, the measures taken to protect life, private and public property, including but not limited to the immediate management and response and recovery; resourcing, overall coordination and deployment; and

equipment and communication systems.

That is what counsel assisting's submissions address and will continue to address. From counsel assisting's point of view, that is the evidence and they are the matters that we will continue to investigate, report on and make submissions.

For the State of Victoria to make the submission it has is really tantamount to indicating that counsel assisting in some way or another should withdraw from the proper role and function it has in the Royal Commission. We will not do so.

In relation to the very few points that were raised by Mr Myers in answer to the submissions that were put this morning, they will be addressed by my colleagues.

CHAIRMAN: Yes, Mr Rozen.

MR ROZEN: Thank you, Mr Chairman. Just a few brief matters in reply. Firstly, it was said by my learned friend Mr Myers that it was wrong to say that the people of Victoria were badly let down by the incident management team. I didn't say that. What I said was that the firefighters on the fireground were let down by the incident management team. The basis for that submission is as set out in our written submissions and the matters that I have raised today.

The second matter in reply is it appears that it is maintained by the State of Victoria that, as Mr Myers put it, the circumstances on 7 February were circumstances that "no-one expected". There is a great deal of evidence before the Commission about the entirely proper and appropriate pronouncements that were made by the Premier, by fire agencies and the like to draw to the community's attention the nature of the fire danger that the state

faced on 7 February 2009. In our submission, the evidence does not bear out a submission that the circumstances that in fact arose on the day were circumstances that no-one expected.

Thirdly, the matter of whether Mr Rice was asked to be incident controller I think has been largely addressed by Mr Myers and Mr Rush. The position is in fact that all of the relevant people, that is Mr Rice himself, Mr Farrell, Mr Creak and Mr Miller, were asked about the question. The transcript references are included in our submissions. It is surprising, to say the least, that it would be said by counsel on behalf of the State that those witnesses were not asked about the issue.

It was said by Mr Myers that the Commission ought only be interested to know about persons that were there and available. It is our submission that the evidence seen in its totality indicates that Mr Rice was both there and available. It is not suggested for one moment that Mr Rice ought to have marched into the incident control centre and announced that he was the incident controller. That of course would be highly unusual and improper. The submission that counsel assisting make is that he is a person who ought to have been considered for the role in circumstances where there was no other level 3 incident controller apparently available.

Finally, in relation to the observations made by Mr Willans, true it is that the observations were not conveyed. My learned friend Mr Myers says that for whatever reason the observations were not conveyed. The evidence indicates that Mr Willans attempted to communicate those observations but was unable to do so.

That is the only evidence before the Commission on that matter, that he was unable to contact the incident control centre.

They are the matters in reply, thank you.

CHAIRMAN: Yes.

MS RICHARDS: There are just two points in reply in relation to evacuation, Commissioners. Mr Myers said the only test was whether those concerned acted reasonably and in good faith. In relation to the scrutiny of those people's actions that may be the inquiry, but the matters that this Commission has to inquire into go much further than that and it is for this Commission to inquire whether the policy that the fire agencies had in place on 7 February in relation to evacuation was a good policy, whether it served the people of Marysville well, whether it achieved the ultimate goal of protecting life. In our submission, when that inquiry is embarked upon, the answer is clear. It did not. The policy needs re-examination.

Secondly, I simply note that Mr Myers did not take the opportunity to clarify his client's position as to whether evacuation should be recommended by an incident controller in an appropriate case.

Thank you, Commissioners, unless there are any questions.

CHAIRMAN: Thank you, Ms Richards. We will take a break now. As I understand it, we are dealing with Redesdale and Bendigo between now and lunchtime.

MS RICHARDS: Yes, and Churchill this afternoon.

CHAIRMAN: And Churchill from 2 pm. We can perhaps have a little more generous break in those circumstances. We will resume at 11.30.

(Short adjournment.)

CHAIRMAN: Yes, Ms Richards.

MS RICHARDS: Commissioners, I will now address in oral submissions both the Redesdale and Bendigo fires. In relation to the Redesdale fire, I can be very brief indeed.

The Redesdale fire was first reported to the CFA at about 1511 on 7 February. It started on open farmland near the eastern bank of the Coliban River about two kilometres to the west of the township of Redesdale.

The fire burned for about 19 kilometres to the south-east from its point of origin and after the wind changed to the south-west at about 1835 the fire then burned to the north-east and in some areas to the north. The total area burned by the fire was about 10,000 hectares and it was nearly 20 kilometres long and eight kilometres wide at its widest point.

The Redesdale fire was managed by a level 3 incident control centre at Epsom on the northern outskirts of Bendigo. A level 3 incident management team fully staffed by qualified CFA and DSE personnel was in place at the Epsom ICC in advance of the fire starting. The Epsom ICC assumed control of the incident at about 3.30 that afternoon and John Deering of the CFA was appointed the incident controller.

The fire was brought under control by 7 o'clock the following morning and was completely blacked out by 14 February. There were 12 houses damaged or destroyed by the fire, as well as 50 sheds and other outbuildings, the Baynton church and a bridge. There was no loss of life in the Redesdale fire.

The incident management for the Redesdale fire and consequently the response was exemplary. It demonstrates what can be achieved with good planning, pre-positioning qualified staff in a well-equipped ICC, and methodical and intelligent information gathering and sharing. Counsel assisting submit that the following key findings should be made in relation to the Redesdale fire and these appear starting at page 25 of counsel assisting's written submissions.

First, the cause of ignition of the Redesdale fire has been investigated but not determined. Possible sources of ignition that have not been excluded are, first, ignition by a spark or hot exhaust system; second, deliberate ignition; third, ignition by farm operation or, fourth, ignition by a carelessly discarded cigarette butt. While these possible causes could not be excluded by investigators, there is no evidence that any of these sources ignited the fire.

Second, it's proposed the Commission should find that the Redesdale incident management team gathered information about the Redesdale fire thoroughly and efficiently during the afternoon of 7 February 2009. As this information came into the incident control centre it was shared with IMT personnel.

The way in which information was gathered and shared by the IMT at the Epsom ICC enabled it to assess which communities were at risk, to prepare and distribute timely and informative warnings to those communities and to put in place appropriate road closures. When I say put in place, I mean to ask the police to implement road closures.

Fifthly, good information gathering and sharing by the incident management team also enabled it to work out the strategy adopted in fighting fire, which was to make a concentrated effort to secure the north-eastern flank of the fire before the impending wind change, to protect the communities of Redesdale, Mia Mia and Heathcote further to the north-east. This strategy was finalised within an hour of the Epsom ICC assuming control of the incident, so by 4.30 that afternoon. It was implemented in the two hours between then and the wind change and was effective. A red flag warning was issued at 1730 and was transmitted to all stations on the fireground with advice that a strong south-west wind change was forecast to occur between 1830 and 1900. In fact the wind change came through at 1835.

Next, the effective management of the Redesdale fire by the Epsom ICC is testament to the importance of good planning leading up to a day of extreme fire danger, in particular pre-positioning properly qualified and experienced staff in an ICC. It also highlights the value of focusing on gathering and sharing information within the incident management team, within fire agencies and with the public.

The response to the Redesdale fire was hampered by a number of communication difficulties. Radio communications between Redesdale and divisional command and the fireground were poor, probably due to a combination of radio black spots and the heat and smoke of the day. Mobile telephone communications were intermittent and ground observers were unable to transmit information electronically via broadband internet

connection.

Members of the Victoria Police responding to the Redesdale fire also encountered difficulties with radio communications due, it is clear on the evidence, to the high volume of radio traffic directed through Bendigo D24.

The evidence on which these proposed key findings is based is discussed in detail in the written submissions of counsel assisting, and I don't propose to go further than outlining the key findings. The proposed findings are by and large accepted by the parties, although the State raises some additional matters in its written submissions and in particular emphasises aspects of the preparation and planning that enabled the Epsom ICC to operate so well on 7 February.

That's all I need to say about the Redesdale fire.

The Bendigo fire started a little over an hour after the Redesdale fire at around 1620. It started near Bracewell Street, Maiden Gully, on the north-western outskirts of Bendigo. It burned through both public open space and suburban blocks on the western side of Bendigo. When the wind changed to the south-west at about 1830 the fire was 5.5 kilometres long and had almost reached Spotlight on the Calder Highway, a point which was only two kilometres from Bendigo's CBD. After the wind change the fire burned towards the north-east further into suburban Bendigo. The total area burned by the Bendigo fire was 354 hectares, of which about half was public land.

Police believe the cause of the Bendigo fire to be suspicious and, as has been the case with other fires

where cause is believed to be suspicious, no submissions are made in relation to cause of the fire.

The CFA again was the control agency for the Bendigo fire and responsibility for managing the fire was allocated to the Adam Street ICC. Adam Street is a level 2 ICC located at the Bendigo and Fortuna group headquarters in Adam Street, Golden Square, a suburb of Bendigo. The level of readiness at the Adam Street ICC and its ability to manage the Bendigo fire contrasted markedly with the state of affairs at the Epsom ICC.

The fire was declared contained at shortly before 10 o'clock on the evening of 7 February and was declared safe at 3 am the following Monday. One person lost his life in the Bendigo fire. Kevin Mick Kane was overcome by flames outside his home in Daniel Street, Long Gully, after the fire had been burning for a little over an hour on its initial south-east run. The circumstances surrounding his death were described by his sister, Jillian Kane, who gave evidence early in the Commission 's proceedings and have also been examined by the Commissioners during the inquiry into the fire-related deaths.

The property losses suffered during the Bendigo fire were some 61 houses and 125 outbuildings that were either destroyed or damaged by the fire. In contrast to the experience elsewhere, the losses after the wind change were minimal; only two houses were lost after the wind changed to the south-west.

Counsel assisting submit that the following findings should be made in relation to the Bendigo fire, and these are set out commencing at page 54 of counsel

assisting's written submissions.

First, while the planning and pre-positioning of staff at the Epsom ICC was exemplary, the management of CFA region 2 did not plan adequately for the eventuality that more than one significant fire might break out in the region on 7 February. When the second fire did break out on the outskirts of Bendigo, the facilities and the personnel available to manage the incident were inadequate. The Adam Street ICC was largely irrelevant to the response to the fire in the critical hours before and immediately after the wind change.

However, and this key finding should be given equal prominence with the first, it is a credit to the firefighters who responded to the Bendigo fire that they were able to establish a working incident management structure on the fireground and were able to deploy resources reasonably effectively.

With a quick and active initial response, the CFA might have been able to bring the Bendigo fire under control. However, with the delay in members of the public being able to report the fire to 000 and the consequent delay in brigades being paged, it was 20 to 30 minutes before the first firefighters arrived. By that time the fire was out of control.

A particularly interesting key finding to emerge from the evidence about the Bendigo fire is the next one, that fuel reduction on the western outskirts of Bendigo, in particular the burn in the Dai Gum San diggings area in the spring of 2008, was critical in reducing the impact of the Bendigo fire on residential areas.

The next finding put forward by counsel assisting

is that there was a deal of unnecessary confusion about the location of the emergency relief centre in Bendigo on 7 February 2009 and poor advice to the public about where those evacuating could go. This confusion might have been avoided with better communication between the Adam Street ICC and the MECC, the municipal emergency coordination centre, in particular with earlier attendance by a CFA liaison officer at the MECC.

An interagency initiative that did work well during the Bendigo fire was the allocation of a police member to each of the sector commanders for the Bendigo fire later in the evening of 7 February. The Commissioners will recall Eric Smith of the Eaglehawk brigade spoke favourably about that initiative.

Next, the lack of a pre-positioned information officer and the very basic computer facilities at the Adam Street ICC hindered the provision of timely warnings and advice to the public about the Bendigo fire. The information officer, Mr Beaton, did an outstanding job in preparing urgent threat messages after he arrived at the Adam Street ICC, and I interpolate there that that was at 1800 that he arrived, but his efforts were diminished by the email difficulties he encountered. The probable result of these difficulties was that people relying on the CFA website for information about the Bendigo fire between 1717 and 2137 and ABC 774 listeners heard no urgent threat messages for that fire between 1800 and 2252.

In spite of these difficulties, there was very good information flow to the community through local radio, in particular ABC Bendigo. Mr Beaton's strategy of

ensuring that information was provided to local radio was effective and was enhanced by ABC Bendigo's thorough reporting of the Bendigo fire.

The evacuation of residents in areas of fire was done at the initiative of police and not at the request or direction of the CFA's control agency for the fire. During the early hours of the fire Sergeant Gaffee had limited information about the movement and extent of the fire gained by his own direct observations and those of other police relayed through D24. This meant that the commendable efforts of Sergeant Gaffee and the police under his command to evacuate areas of risk were reactive rather than systematic.

With the resources that were available initially police were only able to warn a limited number of residents. Had additional police been rostered to work on the afternoon of 7 February, Sergeant Gaffee would have been able to warn more residents of areas under threat of fire as well as managing traffic more effectively. This experience suggests a need for Victoria Police to roster additional staff when catastrophic fire weather is forecast.

The last key finding proposed by counsel assisting arising from the evidence in relation to the Bendigo fire is that a feature of the fire was an almost total breakdown of radio communications between the fireground and the Adam Street ICC. In the absence of any other explanation, firefighters in Bendigo have developed a theory that it was the smoke plume created by the fire that interfered with radio communications with the ICC. While this theory cannot be accepted in the absence of

technical evidence, it would be a matter of grave concern if it is indeed the case that fire agencies' radio systems do not function reliably in the presence of smoke.

Perhaps not surprisingly, there is less agreement with these proposed key findings than in relation to the Redesdale fire. In these oral submissions I will concentrate on the following two points only: the preparation and performance of the Adam Street ICC and the delays in members of the public being able to report the fire to VicFire through 000.

Firstly, in relation to the Adam Street ICC, I have already outlined the proposed key finding about the adequacy of that incident control centre. In essence the finding that is proposed is that the facilities and personnel available to manage a second fire in Bendigo were inadequate.

The State submits that this finding should not be made because it is not supported by the evidence. It says that the following finding should be made instead, and this appears starting at the bottom of page 1 of the State's written submissions. "The planning and pre-positioning of staff at the Epsom incident control centre was exemplary. The Country Fire Authority north-west area, comprising regions 2, 18 and 20, was well prepared for the eventuality that more than one significant fire might break out in the area on 7 February 2009 in accordance with the chief officer's instructions. Across the area there were three level 3 ICCs staffed with preformed level 3 IMTs at Epsom, Swan Hill and Mildura. In region 2 there were two preplanned ICCs and preformed IMTs at Epsom, level 3, and Adam Street, level 2."

The State then says, "It would have been optimal for a level 3 incident to be run from a level 3 facility. However, the Epsom ICC was already in use at the time the Bendigo fire started, and the preformed level 2 IMT at the Adam Street ICC was rapidly restaffed to a level 3 IMT after the Bendigo fire had commenced."

Then, "Whilst the Adam Street IMT," the State says, "had limited involvement in the initial stages with the firefighting response, which is not uncommon for an ICC in the initial stages of a large fire, it played an important role in the response to the fire in the critical hours before and immediately after the wind change."

In the submission of counsel assisting, the alternative finding proposed by the State flies in the face of the evidence about the incident management of the Bendigo fire and the preparation for it. While the planning and pre-positioning of the staff at the Epsom ICC was indeed exemplary, the Epsom ICC was not given responsibility for managing the Bendigo fire.

John Cutting was the regional duty officer for CFA region 2 and the manager of the Bendigo regional emergency coordination centre on 7 February. He had foreseen the possibility that more than one fire might break out in region 2. During his briefing to the region's group officers on 6 February Mr Cutting had warned that "it may be the second or third fire that catches us out". Yet, while region 2 was superbly well prepared for the first fire, it was hardly prepared at all for the second fire that broke out in Maiden Gully.

Shortly after becoming aware of the Bendigo fire, Mr Cutting telephoned Mr John Deering. Mr Deering, you

will recall, was the operations manager for CFA region 2 and had been appointed the incident controller for the Redesdale fire. Mr Cutting asked Mr Deering if he had the capacity to manage a second fire from the Epsom ICC. Mr Deering's response was to the effect that the Epsom ICC was already operating at capacity and could not manage a complex new fire as well as the Redesdale fire.

Mr Cutting then went to his next option, the level 2 ICC at the headquarters of the CFA's Bendigo and Fortuna groups at Adam Street. He rang Peter Rogasch, the Fortuna group officer, and told him in his words, "Pete, you're it. You're all we've got."

At this point it is necessary to examine the State's claims about the level of readiness in the CFA north-west area and specifically in region 2. The State says, first, that the north-west area of the CFA was well prepared for the eventuality that more than one fire would break out in the area, with level 3 ICCs pre-positioned at Epsom, at Mildura and at Swan Hill.

It doesn't really answer a submission about the level of preparedness in region 2 to say that regions 18 and 20 were also ready. Notably it is not suggested that the Mildura or Swan Hill ICCs were able to manage an incident in region 2.

The evidence cited in support of this level of preparedness is the state duty officer's list of ICC preparedness, which was annexed to Gregg Paterson's statement. If you look at that list, which I won't go to now, you will see that it shows that for region 2 Mr Cutting had advised that there was a level 3 ICC located at Epsom and a level 2 ICC located at Bendigo.

Quite separately on the list, Bill Johnstone had advised that for regions 18 and 20 there was a level 3 ICC located at Mildura, a level 2 ICC at Swan Hill and also a joint DSE/CFA oddly level 2 ICC at Bendigo. So there was no level 3 ICC in place at Swan Hill, only at Mildura and Epsom. But, whatever the level of the ICC at Mildura and at Swan Hill, it is not seriously suggested that they were in a position to manage the Bendigo fire. It certainly wasn't an option that Mr Cutting spoke of in his evidence.

As we have seen in relation to the Kilmore and the Alexandra ICCs, inclusion in Mr Paterson's list isn't proof that any particular ICC was ready for a hot or even a warm start; i.e. that the ICC would be able to operate virtually immediately; that there are people there, all the facilities, the equipment is set up and running and tested, to quote Mr Rees.

So what was the level of preparedness at the Adam Street ICC? The evidence shows quite clearly that there was not a level 2 IMT in place at the Adam Street ICC on 7 February when the Bendigo fire broke out. Mr Rogasch was appointed the incident controller with perhaps an underwhelming vote of confidence by the regional duty officer. While Mr Rogasch is undoubtedly a very experienced firefighter, he had no qualifications or experience as an incident controller. None. He had been mentored as a level 3 planning officer and had acted as a deputy planning officer and a deputy operations officer at level 3 fires. It's a huge jump from that level of experience and those qualifications to be placed in charge of managing a level 3 incident on the fringe of one of Victoria's regional cities.

The State says that there is no evidence to support a finding that the fire would have been managed differently if a level 3 incident controller had been appointed. It is our submission that the State can't have it both ways in relation to its system of accrediting incident controllers. There is a well-defined set of skills, experience and qualities necessary to be accredited as a level 3 incident controller, and those are directly related to the demands on an incident controller for a level 3 fire.

If this system has any value at all, and counsel assisting submit that it does, we can assume that it makes a difference to have a person with the right skills, experience and qualities in charge during a major incident. Certainly the system should not simply be ignored by appointing underqualified or in this case unqualified incident controllers to manage level 3 fires. This is an issue that Ms Doyle will address in some more detail in relation to the Churchill fire this afternoon.

It's not as though there were no other level 3 incident controllers in Bendigo on Black Saturday. Mr Deering, as we know, was fully occupied with the Redesdale fire. But the evidence shows that at least former CFA chief officer Trevor Roach, Mike Wassing and Mark Gilmore, all of whom are qualified level 3 incident controllers, were in Bendigo and were available to assist, and indeed they did assist as events unfolded. However, none of them was pre-positioned at the Adam Street ICC or brought in as an incident controller in the early stages of the fire.

After Mr Rogasch was appointed incident

controller, he allocated people to the roles of operations, planning and logistics officers. The qualifications and experience of those people are not known. These matters were a noticeable omission from the statements prepared for the Commission in relation to the Bendigo fire. In our submission, the Commission can assume that it would have been told had they been properly qualified.

Finally in relation to pre-positioned personnel there was no-one present at the Adam Street ICC to staff an information unit when the Bendigo fire commenced.

The next point to be made in relation to the Adam Street ICC is that the facilities at the ICC themselves were inadequate. Drawing on Mr Rogasch's description of the facilities available, it's clear that they were very basic indeed. The building was small. He spoke of being limited by its physical size. There were only two computers with very limited access to the CFA network, a slow and rather temperamental email system and only black-and-white A4 printers. The ICC did not even have the full range of maps required to manage the incident.

Critically, the Bendigo IMT had no access to the CFA's incident management system from either of the two computers at the Adam Street ICC, and hence had no access to information on the IMS and could not enter information into it. Adam Street was also dogged by poor radio and telephone communications with the fireground which were perhaps related more to the conditions and the volume of traffic on the day rather than the adequacy of the facilities.

So, in our submission, the evidence supports a

conclusion that the Adam Street ICC was not prepared for a warm or hot start as a level 2 ICC either in terms of the people who were gathered at Adam Street or the facilities available to them.

Next, the State claims that Adam Street was rapidly restaffed to a level 3 IMT. Again the evidence just does not bear out this claim. The Bendigo fire started at 1620 and Adam Street was put in charge at 1645. A much needed information officer first arrived at about 1800 when Peter Beaton arrived from the Epsom ICC. Mark Gilmore arrived on the fireground at 1830 and assumed the role of divisional commander without reference to the Adam Street ICC and indeed unaware of its existence until 7.45 that evening. So I don't think that we can count him as part of the Adam Street ICC staff.

Russell Manning and a team of DSE staff was sent from the Epsom ICC to the Adam Street ICC and arrived at 1900, by which time the fire had been burning for nearly three hours. Mr Manning, who is a level 2 qualified incident controller and a level 3 operations officer, became deputy incident controller. The qualifications of the staff who arrived with him are not known.

A qualified incident controller first took charge of the incident management team at 9.30 that evening when Mike Wassing took over from Mr Rogasch. Mr Wassing had arrived at the Adam Street ICC at 6.30, and he and Mr Rogasch had agreed at 7.30 that Mr Wassing should take over as incident controller.

What the evidence reveals is that there were some level 3 qualified staff appointed to roles within the Bendigo IMT from 7 o'clock onwards and that a level 3

incident controller was first appointed at 9.30. That is hardly a rapid restaffing to level 3. Less than half an hour after a level 3 incident controller was appointed the fire was declared contained.

Notwithstanding this, the State submits that the Adam Street ICC played an important role in the response to the fire in the critical hours before and immediately after the wind change. Once more, the evidence does not support that proposed finding by the State.

Looking at the evidence, the Adam Street ICC did none of the things that you would expect a level 3 ICC to do at any time during the early stages of the fire in advance of the forecast wind change. It didn't formulate or direct a strategy for responding to the fire. Key personnel on the fireground were simply unaware of the existence of the ICC. These personnel include Eric Smith of the Eaglehawk CFA, who was the initial incident controller, who was unaware of the ICC's existence until at least 6.30; Mark Gilmore of the CFA, who became divisional commander who learnt of it first at 7.45; and Jeff Wilkie of the DSE, who didn't learn of it until after 8 o'clock.

The Adam Street ICC didn't do any of the following things before the wind change. It didn't seek a spot fire weather forecast from the bureau. It didn't prepare a fire prediction map. It did issue a red flag warning. It didn't communicate with police about where roadblocks were required. It didn't liaise with the MECC about, for example, the location of emergency relief centres, which led to the relief centre having to be hurriedly relocated when it was realised that it was in

the path of the fire after the wind change.

Mr Beaton attempted to issue the first warning from the Adam Street ICC at 6.30 but was stymied by the rudimentary email system. Consequently, the warning was in fact not received by many, perhaps most, of the intended recipients.

What the evidence establishes is that in fact the ICC was largely irrelevant to the response to the fire.

I should reiterate at this point that, while counsel assisting's submissions are critical of the level of preparedness in CFA region 2 for the second fire and of the Adam Street ICC in particular, it would be wrong to think that we're critical of all aspects of the response to the Bendigo fire.

As detailed under the heading "Response", CFA and DSE personnel responded quickly and effectively in difficult circumstances. The account of the response to the fire in the written submissions leads to the proposed key finding that it is a credit to the firefighters who responded to the Bendigo fire that they were able to establish a working incident management structure on the fireground and deploy resources reasonably effectively.

That brings me to the second rather briefer point that I wish to make in oral submissions, and that relates to delays at 000. Proposed key finding 23.4 is that with a quick and active initial response the CFA might have been able to bring the Bendigo fire under control. However, with the delay in members of the public being able to report the fire to 000 and the consequent delay in brigades being paged, it was 20 to 30 minutes before the first firefighters arrived. By that time the fire was out

of control.

The State does not agree with this proposed key finding to the extent that it criticises the CFA's initial response to the fire. The proposed key finding is not critical of the CFA's response to the fire once it learned of its existence. The point to be made is that delays in answering emergency calls to report the Bendigo fire meant that the CFA had no opportunity to bring the fire under control with a quick first response, bearing in mind that it was Mr Cutting's assessment that with a quick and active initial response the fire might have been able to be brought under control.

Unlike many of the fires that broke out on 7 February, the Bendigo fire did not start in a remote or inaccessible place. It started near a sealed road on the outskirts of Bendigo about 10-minutes drive from the Eaglehawk fire station. The fire was seen by a nearby resident at 4.20 out of her dining room window, I think. At this time the fire was, as she described it, only a few feet in length and can only have been burning for a very short time. She tried to ring 000. She couldn't get through. There are in evidence police statements from half a dozen other members of the public who saw the fire in its early stages and tried unsuccessfully to ring 000.

Eventually the fire was reported by two members of the public who drove to the Eaglehawk fire station and reported it to the firefighters there. Eric Smith times their arrival at about 4.30 and the arrival of the Eaglehawk pumper at the fire at about 4.40, so 10 minutes later. By the time the Eaglehawk pumper had arrived, however, the fire had taken off and was out of control.

On a day like 7 February the only opportunities that fire agencies have to bring a fire under control is in the critical first 10 or 15 minutes. That opportunity was present for the Bendigo fire because of its proximity to a fire station. However, delays in answering calls to 000 meant that the CFA did not learn of the fire until it was reported directly to the Eaglehawk fire station.

Of course we will never know if the fire could have been controlled if the Eaglehawk pumper had arrived 10 minutes earlier and perhaps if other brigades had been paged at an earlier time. The conditions on that day were, as we know well, extreme. However, it must be said that it is the case that the only opportunity that the CFA had to bring the fire under control slipped away while callers to 000 waited for their calls to be answered.

Commissioners, unless there are any questions, those conclude oral submissions in relation to both the Redesdale and Bendigo fires.

CHAIRMAN: Yes. Thank you, Ms Richards.

MR CLELLAND: I can be very brief, Mr Chairman. The State does not propose to add to its written submissions.

CHAIRMAN: Yes, thank you.

DR LYON: Nor does local government, sir.

CHAIRMAN: Yes, thank you, Dr Lyon.

MR GARNER: If the Commissioners please, Ms Richards referred to some communications difficulties in relation to both the Redesdale and the Bendigo fires which I will just seek to briefly address.

The first was that there was evidence that mobile communications were intermittent. That evidence was given by Mr Brittain in relation to the Redesdale fire and

Mr Rogasch in relation to the Bendigo fire. Their evidence did not include any specific details of the calls referred to and does not specify whether the difficulties were encountered on a 2G or a 3G network, or which was the entity which provided the relevant network that was being used.

Moreover, the evidence does not specify why calls were not successful, whether it was because the other phone was engaged or didn't answer or the call dropped out or there was some other reason for the unsuccessful nature of the call.

In those circumstances, it is very difficult to draw any specific conclusions as to the causes of these mobile phone difficulties or to frame any possible remedies based upon the available evidence.

Secondly, reference was made by Ms Richards to CFA radio communications difficulties from both the Redesdale and Bendigo firegrounds. Telstra notes that the Telstra CFA network does not cover either the Bendigo or Redesdale regions, which are CFA region 2, and that the CFA radio networks in those regions use CFA radio infrastructure which is owned and controlled by the CFA, not Telstra.

Ms Richards referred to proposed finding 11.8 in relation to Redesdale, which was that the fire agencies were hampered by a number of communication difficulties and that mobile communications were intermittent. Telstra does not support that proposed finding. In our submission it is too broad to be helpful in any way and will not assist the Commission in framing any recommendations in relation to communications.

Ms Richards also referred to the problems or the delays in answering emergency calls on 000 in relation to the Bendigo fire. The Commission has already heard evidence and submissions in relation to the causes for the delays in the 000 service and has indeed made findings and recommendations in the Commission's interim report. I don't wish to revisit that, save to note that the thrust of those findings was that the delays in getting through to 000 were caused by a bottleneck at the ESTA answering point and not at the Telstra answering point. As I say, I don't wish to revisit all of that evidence at this time.

Finally, can I say, Commissioners, that the issues dealing with communications are dealt with fully in Telstra's written submissions in detail in relation not just to the Bendigo and Redesdale fires but all other fires, and of course Telstra relies on those written submissions additionally. If the Commission pleases.

CHAIRMAN: Yes. Thank you, Mr Garner.

MS RICHARDS: There is nothing in reply.

CHAIRMAN: Nothing more you want to add? Thank you, Ms Richards. We will adjourn now until 2 o'clock, when we will deal with the Churchill fire.

LUNCHEON ADJOURNMENT

UPON RESUMING AT 2.00 PM

MS DOYLE: If the Commission pleases, we turn now to an examination of the Churchill fire. I won't recite the facts and circumstances about the ignition of the fire and its early phase at length, but you will no doubt recall that at about 1.30 pm on 7 February a caller to 000 reported a fire at Churchill near the intersection of Glendonald Road and Jelleff's Outlet. The fire behaviour from the outset was extreme. The fire crowned in the plantation near those intersecting roads and spread quickly uphill to the south-east. The first crew who attended this fire were unable to engage in successful direct attack. The focus of the fire from that time onwards was essentially one of suppression where possible but principally protection of lives and assets.

By 4.50 on the afternoon of 7 February the fire had progressed a great distance and there were multiple spotfires, including one, a significant one, in the grassland on the western verge of the township of Yarram which itself developed into a significant fire placing significant strain on resources.

When the wind change impacted the Churchill fire at about 6 pm there was by that time an uncontrolled flank of fire running from the point of origin through to the east side of Mount Tassie, approximately 13 kilometres away. As has now become notorious in the hearings in relation to each of the fires, that uncontrolled flank of fire then effectively became the firefront and swept through townships located on the eastern flank of the fire, including Carrajung, Callignee, Koornalla and by the evening Gormandale.

This fire was listed as under control at 6 o'clock on 19 February, having burnt over 24,000 hectares and resulting in the deaths of 11 people, two in Hazelwood South, one at Jeeralang, four in Koornalla and four in Callignee. Some 247 homes were also destroyed.

Now, in terms of the management of the fires you will recall, Commissioners, that the Churchill fire was managed by an incident management team based at an ICC in the Traralgon DSE offices. However, the control agency for this fire was in fact the CFA. As it turns out and as you will hear further tomorrow, the Delburn fires had been burning for some days, and a CFA-led incident control team responsible for those fires was already located in those Traralgon offices working on the ground level.

As part of the DSE response to what it even in those days referred to as a code red day, it had ensured that there was situated at the Traralgon offices a preformed IMT with a designated incident controller named Lawrence Jeremiah, who is a highly-experienced DSE employee with level 3 incident controller qualifications.

When the Churchill fire broke out, and I'll go to the detail about the way in which the incident controller was selected further in a moment, the CFA was almost immediately designated the control agency because it was identified quickly that the fire would principally burn on private land.

A decision was made at the regional level that, as the existing CFA-led team was already managing the Delburn fires with Mr Lockwood at its peak as the incident controller, what ought to happen was that that team should

expand in effect to now manage the Delburn and the Churchill fires. Mr Lockwood was appointed incident controller then of the entire complex and Mr Jeremiah was assigned the role of deputy incident controller.

A number of DSE employees then filled important slots in the team, including Mr Gillham, who was planning officer, Mr Kennedy, who filled the role of operations officer, and Mr Mitchell, who filled the role of deputy operations officer. There were a number of other employees from both DSE and CFA who filled the relevant slots in a strategic planning unit, in the information unit, as situation officer and in various liaison roles.

I make those remarks by way of introduction and I pause to note that the career staff, both from DSE and CFA, and volunteer firefighters who fought the Churchill fire in the field did an outstanding job. The Churchill hearings, which were conducted in Traralgon, were replete with stories of great fortitude and bravery. The sector and divisional commanders in particular deserve recognition for the way they managed their ground crew and maintained order and calm during a fast-moving, frightening fire.

The details of the particular suppression efforts and steps taken to protect particular assets, including homes but also the critical infrastructure of this state, such as Loy Yang Power, are detailed in counsel assisting's written submissions. No criticisms are made of the decisions made and steps taken in the field in relation to suppression tactics and efforts to protect life and assets.

But the written submissions do in some respects

make the point that the IMT responsible for the Churchill fire failed to perform to an optimal level. There were shortcomings in the IMT's work. In particular those shortcomings were exposed in relation to the team's use and dissemination of information. This is where the team fell down and this impacted on the quality of its predictive work, on the timeliness of warnings to one locality and importantly it impacted on firefighter safety.

The submissions of counsel assisting describe the Churchill IMT as in some respects dysfunctional, and we submit today this is the case. There are multiple instances of information and knowledge not passing between individuals in a team or between units in the overall team structure. This has happened in a way one would not expect if a team were working well and if it were functioning and operating in a manner one would expect with experienced leadership at the helm.

The key findings that counsel assisting submit ought to be made in relation to this fire are set out in detail in our written submissions, and some of them the State rejects in whole, others are accepted in part and some are accepted in full. I won't read each of them, but if I can just take you to the page which is now on the screen. It's at paragraph 13.3, where 17 proposed key findings are set out in counsel assisting's submissions.

You'll notice that a number of themes emerge from those findings, and I'm going to focus on five of those themes this afternoon. The first proposed finding listed there is that the CFA incident controller appointed to the Churchill IMT was less qualified and less experienced than

the DSE deputy incident controller. The evidence revealed that the CFA incident controller, Mr Lockwood, was endorsed only to occupy the position of incident controller at a level 3 incident under the supervision of a mentor. He subsequently, that is after the fires, obtained level 3 endorsement but did not hold it as at February 2009. Not only was he not provided with a mentor on the day this fire burned; his evidence was he had never been assigned a mentor.

The submission made by counsel assisting is that this set of circumstances is inexplicable in circumstances where there was a pre-positioned level 3 team headed by Mr Jeremiah ready and waiting and it is also inexplicable in circumstances when it was well known and widely known that the state was facing a day of extreme fire danger and that if any fire in addition to the Delburn fires broke out in that area they would do exactly as they did on that day; namely threaten communities, principally those around Traralgon South, and also the critical infrastructure of our state. We heard evidence in the hearings about the role that Loy Yang Power and other assets in the valley play in ensuring the uninterrupted supply of energy to all the citizens of Victoria.

In those circumstances, we submit it is inexplicable that there was not available within the CFA, for example, an experienced level 3 incident controller or that steps weren't taken to support Mr Lockwood in a better way given his relative inexperience.

Now, the five main areas that will be explored in my submissions this afternoon include that point I have just touched on, namely the appointment of the incident

controller. Was the best person for the job appointed on the day?

Secondly, the use by the IMT of information, principally valuable information in relation to weather, we say it was not used in an optimal fashion or in the way one would expect either internally, in terms of predictive work that might have been done, or externally, in particular the way it might have been used to ensure firefighter safety. We say the work of the strategic planning unit was of less value because of that unit's failure to have any regard to the spot fire weather forecast.

We also make a strong submission that the absence of an incident action plan, which is required to be prepared by an incident controller and key members of his team, is important in relation to the Churchill IMT because it demonstrates that there was an absence of a clearly articulated strategic plan for achieving any of the goals that the team might have sought to implement on that day.

I'll also deal with the absence of an organisational chart and a resource list, but that is quite intimately tied to the lack of an incident action plan.

Mr Rozen will deal with the question of warnings. There are two important failures pointed to in the key findings we propose in relation to the timeliness of the warning to the Callignee communities and the absence of any warning at all to Koornalla. Mr Rozen will also deal with firefighter safety. Now, as I have hinted at, this really intersects with what I call the use of information,

but in this particular instance there was a failure to get timely wind change information out to ground crew which crystallised in three very dangerous burnover events which have been the subject of an internal investigation by the CFA. Mr Rozen will speak to that matter and the related matter, which is the failure of this IMT to appoint a safety adviser; another mandatory requirement under the AIIMS manual and relevant standard operating procedures which just was not adhered to in this fire.

So I turn to the first matter, the appointment of the incident controller. I emphasise that the decision as to who would be incident controller wasn't made by Mr Lockwood. So he can't be criticised for having had essentially foisted upon him on that afternoon a significant job. The decision was made at regional level. Mr Lockwood dutifully took on the role assigned to him, and he can't be criticised for finding himself in that position. But it is a fact that Mr Lockwood had only been endorsed as a level 2 incident controller and, as I have already mentioned, authorised only to act at level 3 incidents with a mentor in place. He was not supplied with a mentor during this fire.

The State now refers in its written submissions to a number of matters it says that justify the appointment of Mr Lockwood, for example, in preference to Mr Jeremiah. This is a matter they identify at paragraph 15 in their written submissions, if we can just turn to the matters that are outlined there. This is in the State's submissions, (RESP.3000.005.0080).

In the second sentence there it is suggested that the combination of Mr Lockwood's capabilities, the exact

circumstances of the day, and there they point to the fact that Mr Lockwood was already the incident controller for Delburn, the proximity of critical infrastructure and the nature of the standard operating procedures and practice in place mean it's not inexplicable that Mr Lockwood was appointed incident controller.

Counsel assisting take issue with each of those propositions. The first matter I want to underscore is that there is no evidence that any of those matters, other than the standard operating procedure, featured in any of the decision making made at the regional level. The evidence is clear. Mr Lockwood was made the incident controller because the CFA was the control agency. That's really at the heart of it.

There is ample evidence in this Commission that not only did the standard operating procedure, which incidentally is standard operating procedure 3.01 -- that standard operating procedure which applied on 7 February governed the appointment of the control agency and the incident controller, and simply said the control agency shall appoint an incident controller from either agency, but giving no guidance as to suitability or the criteria which might be weighed if one were considering whether one should appoint Mr Lockwood or Mr Jeremiah.

True it is the procedure acknowledges the theoretical possibility that in circumstances where the CFA is the control agency they might appoint a DSE incident controller. The only thing is, Commissioners, in relation to every single fire that burned on 7 February the control agency in every instance fielded the incident controller.

You will recall the evidence of Mr Haynes, who gave evidence subsequent to the Churchill run of hearings. He acknowledged in his statement and in his oral evidence that the overwhelming tendency of the agencies is and was to always appoint an incident controller from the agency that is the control agency.

Importantly, when the relevant players gave evidence in Traralgon none of them pointed to these matters that are now collected in the written submissions for the state government. Rather they emphasise the fact that Mr Lockwood was appointed incident controller because the CFA was the lead agency. Indeed, the way Mr Lockwood described it at transcript page 9288 was that the "decision was made above us" at regional level.

Mr Jeremiah, it should be noted, did say that he was aware that Mr Lockwood would have more experience with matters such as open cut mines, and that may well be the case. But significantly Mr Jeremiah was not saying those matters were thrashed out or even discussed at the time of Mr Lockwood's appointment.

Those may now be recognised as features which assisted Mr Lockwood in the task that faced him on the day, but it can't be pretended that there was any assessment of those matters in the decision to appoint him. Nor has it been explained why there was no other CFA level 3 incident controller in the region who could have taken on the role instead. There is scant evidence about preparedness levels and resources in that region at the time. It was explained in evidence that there were two known level 3 incident controllers theoretically available but clearly occupied on other tasks on that day. So no

criticism is made about not moving those gentlemen.

But the other evidence that Mr Lockwood gave is that there are 40 career staff and 2,500 volunteers in region 10. It is extraordinary that among that body of staff there was such a deficit in training and resources that it fell to Mr Lockwood to run this difficult, complex fire in the circumstances.

We now know from the evidence of Mr Haynes and Mr Slijepcevic that shortfalls in the numbers of trained and experienced level 3 incident controllers in both agencies have been known for some time but were in fact the subject of a detailed study or succession planning, as one of them called it, in 2006. There is clear evidence that in February this year there were 93 level 3 incident controllers around the state, and that the CFA expects and hopes to have 100 by now. That shows some commitment to increasing the numbers, but it also underscores the fact that even with those numbers the CFA has faced and may continue to face difficulties fielding level 3 incident controllers. Indeed, that was the evidence of Mr Haynes. "We'll try to get level 3 incident controllers in place on a code red day," he said, "but we have never said we could guarantee it. We may have to field a level 2 incident controller and try to get a level 3 one there during the morning or as a fire develops." That is Mr Haynes's evidence.

It is in those circumstances then that the system and related to that the level of resourcing and over time the level of training gave rise to a situation where Mr Lockwood was tapped on the shoulder that day and, we say, put in a situation where his relative inexperience

must be taken to be at least one of the reasons and probably the significant reason why his team's management of this fire failed in a number of significant respects.

It's not that he did no good. It's not that the team did nothing of value. They acted as quickly as they could. They deployed resources in a timely fashion as best they could and indeed a significant number of resources, particularly during initial attack. But there are matters and there is a need to take the bad with the good that are identified in counsel assisting's submissions which we say do demonstrate a shortfall that needs to be acknowledged.

In relation to that question of Mr Lockwood's relative inexperience, I should in fairness note that when Mr Lockwood was invited in cross-examination by the State to indicate whether he felt his training and experience had equipped him for the role he confirmed, he thought, that his training and experience were adequate and he didn't feel he had been put in a position he ought not to have been. That's a matter that was explored at transcript page 9253.8. But unfortunately there were a number of things that did not go as well as they should. I will identify some of those in brief form and then turn to the detail.

IMT members were relying on outdated weather information. The evidence shows, and I'll go to this in detail, that only a couple of members of the IMT, and in particular Mr Brett Mitchell, the deputy operations officer, even looked at a spot fire weather forecast which was issued by the bureau at 4 pm that day. It was a spot weather forecast which indicated that a wind change was

predicted to hit the Churchill fireground between 5.30 and 7.

Now, from 4 o'clock onwards that was the best and the latest information available about the wind change. The State says numerous times in its submissions, "You can't take that on its own. There are wind charts. There is real-time information." That's accepted. But when IMT members persist in using old information which is wrong that's not a matter to celebrate. That shows a failure in dissemination of information. That shows a shortcoming in people having regard to the latest and best information. That is capable of having serious consequences, whether it be because of the way and the time at which warnings are issued, as is the case in relation to other fires, or in this case because it may deprive firefighters on the field of critical information that has a direct impact on their safety. So the first point is that IMT members were relying on outdated weather information.

The second matter is that one member in particular of the team provided some wind change information to members of the team but in a manner which was misleading and which the State accepts was certainly not helpful. I'm talking about the evidence that was given at length by Mr Gillham of the planning unit to the effect that when he advised IMT members in an IMT meeting that a wind change was going to arrive at 7 pm, he did so because he was relying on matters including a wind change chart, which is a matter different from the spot weather forecast, a wind change chart issued by the Bureau of Meteorology just before 2 o'clock which said that the wind change would arrive between 6 and 8.

Commissioners, you will no doubt recall the idiosyncratic rationale Mr Gillham gave for the way in which he conveyed the information. He said he fixes on the median point or the mid-point; namely, if he sees a range of 6 to 8, he says a wind change will arrive at 7. The State accepts that that is not the best way in which to relay information, and that giving the window is always more helpful.

But there are two problems with what Mr Gillham did because not only did he provide the mid-point; he provided the mid-point on an outdated range. The latest information from 4 o'clock onwards was that the wind change would arrive between 5.30 and 7. In those circumstances we say and in circumstances where in fact the wind change arrived at 6, which is within the range predicted by the bureau, that was the right information, that was the best information, and other members of the team and firefighters on the ground and the community deserve the best information.

Commissioners, you will recall a spot weather forecast is a one or one-and-a-half page document. It is an easy thing to look at. It was in the building. It was being used by Mr Mitchell. We say: why was it not ever seen by the incident controller or his deputy or anyone in the strategic planning unit? It beggars belief.

Most significantly, Mr Lockwood's evidence was, as I noted, he didn't see the spot weather forecast and it was a complete surprise to him when the wind change arrived at the fireground at 6 rather than 7, which is the information he had been given.

One of the points made by the State in the

broader context about Mr Lockwood's experience is that, even though he only be level 2, at least he was surrounded by good experienced people, including Mr Jeremiah, whose experience can't be doubted. I then ask this question: why didn't any of them bring it to his attention? Mr Jeremiah didn't see the spot weather forecast either. There is no good pointing to the availability or the back-up of an experienced guy in your deputy chair or a great team around you if none of them can give you the piece of paper either.

The other difficulty in relation to this fire and in relation to Mr Lockwood's experience is that he never prepared an incident action plan. I'm going to go to this in some detail because it is our submission that that is not a mere piece of paper or a ticking of boxes. In the absence of a plan it becomes clear in relation to this fire that there was no overarching plan or objective. Now, that didn't dissuade people on the ground from doing their best; from following the local command structure, as they should; from taking initiative; and from engaging in great acts of bravery, and they are to be commended for it.

But there was no strategic direction emanating from the team sitting in the office at Traralgon. There was no overarching plan. There was no statement of a strategy. There were no trigger points for deploying resources to any particular place at any particular time. Indeed, a real flavour of the evidence was local sector and divisional commanders working hard, working together, returning to certain staging posts to speak to each other and doing their best to inform the IMT what they were

doing rather than the IMT issuing any direction, guidance or advice from above.

Now, a red flag warning was issued from this IMT, and Mr Mitchell is responsible for that and he is to be commended for taking that initiative. It would appear he did that while other members of the team were occupied in a meeting. But in the event the process by which the red flag warning was issued and its lateness, it was issued quite close to the time at which the wind change arrived, meant that three tankers somehow -- I will go to the evidence in a moment -- received the wrong message. Having received the wrong message, they were surprised by the wind change event when it arrived, it came upon them suddenly, and they were involved in burnover events which Mr Rozen will go to in more detail.

The other matter we say that speaks of inexperience on Mr Lockwood's part includes his failure to appoint a safety adviser, which is mandatory.

Now, those matters I have just tracked through there, I'm going to go back to some of them in detail, the failure to have regard to the spot weather forecast, the fact that a member of the team was providing outdated and misquoted wind change information, the fact that the incident controller himself was surprised by the time at which the wind change arrived, the two significant failures in relation to warnings that Mr Rozen will go to, the absence of strategic direction and advice from the team, the shortfalls in the red flag warning process and the absence of a safety adviser, we say all of those key matters, though no causal link is drawn by us between them and any particular death or any particular loss of

any asset, nevertheless we say those significant matters mean the management of this fire cannot be described as an unqualified success. There are lessons to learn, and we say a number of them are likely to be the result of Mr Lockwood's relative inexperience and the fact that, whatever deficits existed in his experience or approach to the task, the team around him unfortunately didn't fill the breach.

Part of this gives rise to the question the State asks, "Well, what difference would it have made if a more experienced incident controller had been appointed?" In part our answer to that is this: there is in place a system under the AIIMS manual where incidents are categorised by levels of complexity, level 1, 2 and 3, reserving 3 for the most complex and difficult fires, and this was one such fire.

There is also a training and in the CFA case an endorsement regime which acknowledges that level 3 is an appellation reserved for the most experienced and the best. Now, either these things mean something or they don't and we can throw the whole manual out and just appoint whoever we like whenever we like. But presumably level 3 in terms of complexity warrants level 3 in terms of experience. If it doesn't, then a lot of the evidence and the exploration of the numbers of level 3 incident controllers and the types of skills they ought to possess would be irrelevant. But presumably the State sees value, as we do, in maintaining a system that rewards and recognises those who are the best at what they do, and those are the people who are experienced level 3 incident controllers.

Indeed, there has been evidence in these proceedings of essentially what's known as the A list, the list of level 3 incident controllers from either agency which have been put into a composite document as at late December identifying the cream of the crop, the very best level 3 incident controllers. We happily accept there obviously are such people and their skills can be objectively analysed and they can be listed in a single page document.

Now, in the circumstances in which the state went into 7 February knowing that we could face our most trying day and then having that eventuality arrive, it is our submission that greater effort could and should have been made to make sure some members of that A team were available to assist others who are not so experienced.

Part of this also drives us back to an analysis of what is a level 3 incident controller and what sort of skills and attributes should they possess. There must be some rationale to the adoption of this system of grading skills and grading incidents. I can remind the Commission that the AIIMS manual sets out the classification scheme, and there is no need to go to the detail of the way in which those incidents are assigned different levels.

But we have also heard evidence in the proceedings about the type of person who makes a good level 3 incident controller, and I do want to turn to that briefly. This is a matter that is set out helpfully in exhibit 551 in the proceedings. This is a document Mr Slijepcevic and Mr Haynes spoke to when they gave evidence. It appears at page (DSE.HDD.0074.0284).

While that's coming up, I remind the Commission

this is a 2006 document. It was a joint project by the CFA and DSE. It was undertaken for one of the reasons that I have already highlighted. If we can just look at page 0286 of the document. You will see in the third paragraph there, "Recent succession planning in both CFA and DSE highlighted a shortage in the number of accredited IC 3s." That means level 3 incident controllers. They then go on to note an increase in the median age of the current group.

They also note that, "Under the current fire training pathways, progression through levels 1, 2 and 3 generally takes more than 10 years." I want to pause to emphasise that too. If that be the case, and it may well be, it just shows the level of experience in addition to simply gaining the endorsement that is required before one is a good level 3 incident controller. Again we say that must mean something, and Mr Lockwood didn't have that background.

The rest of this page goes on to identify that in a joint venture it was decided to focus on articulating the role standard for a level 3 incident controller. At the bottom of this page it is explained the way this was done was by gathering a reference group together of highly-experienced incident controllers from all the NEO and CFA agencies, this is right at the bottom of the page, to discuss the role standard.

Now, this manual is called the "Skills, knowledge and personal attributes required to be a level 3 incident controller". Even the title is telling. It is something about personal attributes that matters. Leadership, organisation, the capacity to be calm in stressful

situations, the capacity to lead, to inspire, to advise, to organise; all of these sorts of personal features are the hallmarks of a good leader and they are the sort of matters that are identified here as the kinds of skills you would expect from a level 3 incident controller.

Can I take you to page 291 of this document just to highlight the sorts of attributes that this joint reference group thought were important. At the bottom of page 291 there's a heading "Proposed personal attributes required", and it's identified that they have pooled the answers of the reference group in order to compile this list. I won't read every single one, but if you go to the next pages, 292 onwards, Commissioners, the headings really give you the list or the checklist of the personal attributes you look for.

The first cab off the rank is "Stress tolerance". The next is "Self-awareness". Over the page at 293, "Communication and interpersonal skills". At 4.4 there is reference to "Problem solving". That's on the next page. At 295, the following page, "Effective decision making". The list goes on. You can have recourse to that document at your leisure.

The point I'm trying to make, Commissioners, is that sometimes these attributes are difficult to measure precisely, but they are capable of being measured. When someone is designated a level 3 incident controller or, even better, placed on the list that identifies them as one of the best in the state, it is because they have shown skill and flair in relation to these attributes. It is because they have run big fires. It is because they have been exposed to stress and conquered it. It is

because they are known to be good leaders. That experience is valuable.

When I make submissions tomorrow about the Bunyip fire, I'll draw a comparison, but just pause here briefly to note that you will remember the evidence of Mr Nugent, a very experienced DSE incident controller. You will recall his mastery of the suppression tactics that were necessary in order to deal with the Bunyip fire when it was in the park. You will remember the CFA incident controller, Mr Smith, who took over the next day, who showed passion and wisdom and experience drawing on his years, including the Ash Wednesday fire.

These things are sometimes a little subjective, but these things I submit are important and are capable of being measured and are capable of being recognised. For some people, it has already been recognised and they have been endorsed. Others have not. Their time is yet to come. We say these things underscore the importance of these features and underscore the importance of experience.

I'm going to turn now, having made those general remarks, to a couple of particular incidents that I identified. I'm first going to return to this issue of the use of information in relation to weather.

This is a matter that the State deals with in its submissions at paragraph 19 onwards. Can I just take you to the State's submissions to isolate the point they make about what I might call Mr Gillham and the wind change. This is what they say at paragraph 19: "The State accepts that it would have been preferable had the planning officer referred to the change of" effectively between 6

and 8 o'clock "in the Delburn spot weather forecast rather than using 1900 as the mid-point".

I want to pause there to make two points. It is good that that's conceded; namely, that someone presented with a range of time during which a wind change might arrive ought to refer to the range rather than picking a mid-point. Good. That's point 1.

Point 2: why was he referring to that outdated information at any time after 4 o'clock? He shouldn't have been. There was a spot fire weather forecast available. It was certainly in the IMT by 4.30. We know that by working backwards, because we know Mr Mitchell had it in his hand at 4.30. There is no excuse for continuing, including at a 5 o'clock IMT meeting, to lead other members of the team to believe that the wind change would arrive at 7 when it was known or capable of being known within that building it would arrive between 5.30 and 7. It's exactly what happened. For three tankers, that caught them by surprise when it arrived at 6.

This isn't an example where the State can say, "But it was all happening so quickly and we didn't know." You knew. Mr Mitchell had it, and there is no reason why members of the team were deprived of the most up-to-date and the best information.

So it's not just fixing on the mid-point that's the problem, and we hope that that's been fixed and there has been training or explanation about the best way in which to provide this information to your team mates. But there is that other matter, and in my submission the more important matter, and that is use the best information that's available and that the bureau provides.

Now, I just want to highlight the evidence about team members who didn't see the spot weather forecast, because that doesn't seem to be acknowledged in the State's submissions. Can I remind you that Mr Lockwood said at transcript page 9240 at line 24, "I didn't see it", and he agreed he would have expected it to be given to him.

Mr Jeremiah, the more experienced deputy, also didn't see it. So he was incapable of informing Mr Lockwood about it, if that were the problem. This is a point that's confirmed by Mr Jeremiah at 10201, line 15, and 10199.29. He did say he was less perturbed when it came earlier than he thought because he always factors in the possibility that things will arrive earlier. But, nevertheless, he never saw the document.

Now, Mr Pridgeon, who headed up the strategic planning unit, also didn't see it. He confirms that at transcript 9353 through to 9357, as the matter was debated at some length with him. I'll go to his evidence in a moment, but stunningly he said it probably wouldn't have changed much, was his initial evidence, for him. It was put to him that, given that part of his job was predicting where the fire might go, it's quite useful to have some relevant up-to-date information about when the wind change might arrive. He then conceded in part that it would have helped him at least identify the length of the flank of the fire before it became the front.

It is submitted this must be the case. If a strategic planning unit doesn't have access to good up-to-date wind change information, it must impact on the quality of its output and the way in which it assesses key

matters like how long will the firefront be before it becomes the flank and therefore at what time do firefighters need to know, do the community need to know and at what time is critical infrastructure at risk, which is after all one of the key jobs Mr Pridgeon said they were identifying.

For completeness, I should note the page of transcript where Mr Lockwood confirms that he continued to work on the basis of Mr Gillham's information the wind change would come at 7 and that he was completely surprised when it arrived at 6 is a matter that is identified at transcript page 9235 to 9236.

Now, I'm going to say something briefly about red flag warnings. I'm not going to deal in detail with firefighter safety, namely the outcome of the deficit in that warning. Mr Rozen will do that. But I do need to make a point about the facts that are available in terms of the red flag warning.

In a document that was provided by counsel for the State yesterday, the document that identifies the areas which are described as outline of allegations made by counsel assisting against individuals, I do need to take issue with a paragraph of this. It is paragraph 24, and it relates to Mr Mitchell.

By way of background can I say, Commissioners, the written submissions of counsel assisting deal with the evidence about the red flag warning in detail, probably some might say excruciating detail, because some of the evidence remained unclear, even at conclusion of hearings, and a great deal of effort was gone to in the written submissions to identify what was known and what wasn't

known. At the end of the day, and I'm putting this in summary terms, it became clear that Mr Mitchell had issued a red flag warning at about 5.30 for 6 o'clock. Somehow a group of firefighters - I'll try to use a neutral term - heard or received a different message, a message that the wind change would arrive at 7.

On balance, it appears that all one can say is it's more likely than not that Mr Mitchell did exactly as he thinks he did, doing his best to remember; namely, he issued a wind change warning that it would come at about 6.

It looks to be more likely that Mr Barling, a divisional commander, misheard that information and in error, and it is submitted -- and it is submitted in the written submissions -- an understandable error in the difficult circumstances, misheard or miscommunicated that information; the end result being three tankers received a message that misled them as to the timing of the arrival of the wind change.

This document here at paragraph 24 suggests that it has been alleged by counsel assisting that Mr Mitchell provided an inaccurate red flag warning. In the last sentence there at 24.1 this appears to be a summary or even purports to be a quotation from our submissions, "However, on balance the evidence appears to establish that Mr Mitchell passed down the message to the effect that the wind change was expected at 1900", and the footnote sends you off to our submissions at paragraph 7.39.

First of all, 7.39 can't be read in isolation. It comes after some 10 pages of close analysis of days of

evidence about who said what when. You will remember the terminology I used in those hearings and in questioning Mr Barling was, "Is this sort of like reverse Chinese whispers? The message is wrong at the end and we are trying to trace back what was the initial message?"

You will see in paragraph 7.38 of our submissions, this is at page (SUBM.202.008.0057), Mr Barling, this is the divisional commander I mentioned, accepted that the recollections and logs of others tended to suggest the message he gave them was for a wind change at 1900. I won't go over the evidence. I think you will recall, Commissioners, we had a number of crew members and/or police statements from crew members which tended to suggest that whatever Mr Barling, doing his best, thought he had told them, it seems he told them a number at 1900.

But let's look at paragraph 7.39 and compare it with the way the State says that counsel assisting have put this submission and put this matter. "On balance, the evidence appears to establish that whatever Mr Barling was told or heard when Mr Mitchell issued the red flag warning to him, the message he passed down" -- namely Mr Barling - "must have been to the effect that the wind change was expected at 1900."

At length throughout these pages the evidence is analysed and the conclusion is reached that Mr Mitchell must also be right. He issued the correct red flag warning at 6. So there has never been any suggestion that Mr Mitchell erred. It has been asked why it was left to the end, so late to warn people about a wind change they had known about since 4.30. But, in any event, he did warn people when he saw the spot weather forecast and he

did so in the correct terms. Something went wrong somewhere else in the chain.

You will recall also that Mr Barling was then asked where he was when it came time for him to pass the message on. He said, and the passage is there at 7.40, "I was outside, inside, all over the place." The submission is made in Mr Barling's favour. It is undoubtedly difficult for a division commander focused on the fire suppression effort and managing events on the fireground to be in a position where he is required to receive and transmit important safety messages, without the benefit of a quiet place and a minute taker or logger to record what is received and transmitted.

I think the State take issue with this in another context, this reference to minute takers and loggers. The evidence is this IMT, unlike some, had a minute taker who sat at their meetings and wrote minutes for them and typed them during the day and distributed them. They did have at times a quiet place. They had documents in front of them, including the spot weather forecast, or at least Mr Mitchell did.

It's Mr Barling, who is directing ground crew, using a portable radio, near the fire out on the fireground, who made an error, and it is submitted here an understandable one and one for which he has received no criticism. By the same token, it was never attributed to Mr Mitchell. So I haven't had time to go through every paragraph in this document, but I note that glaring error.

I want to turn briefly to the work of the strategic planning unit. We do make the submission that its work was of little value, particularly given that they

were trying to work in the absence of the spot fire weather forecast. The strategic planning unit is not a unit that's identified in the AIIMS manual, as far as I can see. It seems to have been created for this fire, although Mr Pridgeon did say at transcript 9358 that he was familiar with it and DSE sometimes use such a unit during campaign fires.

He also then went on to say that in a quicker fire like this its overlap with the situation unit meant that its role was a bit more blurred. Whether or not there was overlap with the situation unit, can I also remind the Commission that Mr Pridgeon's evidence was he never spoke to the situation officer for the whole day. So, whatever value he may have obtained or information he might have gleaned from that unit, he didn't avail himself of it.

Our submissions make the point, and this is at 6.5 to 6.9 of our document, that Mr Pridgeon personally produced only two maps during the entire fire which we say quite frankly were of limited predictive value. The first one consists of a line drawn across the map with the fire running to Yarram, and constitutes an estimate of the forward rate of spread. So effectively Mr Pridgeon took some information he did have, the distance the fire had travelled as at a particular time, I think it was at 3 pm, worked out the fire was travelling at about 7 kilometres an hour. He was right. That's useful information. He conveyed it to members of the team. That's good work.

But he did nothing else until about 10 o'clock that night when he drew some other lines on another map which he called a predictive map. Under cross-examination

he accepted that it wasn't so much a predictive map; it was instead trying to identify the perimeter of the fire as at 10 or 11 o'clock at night. Our submission is that's not of predictive value; that's descriptive. That's showing people where the fire has already burnt through. It had already annihilated Callignee and Koornalla. In a sense, so what? It wasn't going to help them plan anything to do with the suppression effort that evening.

The State says in response to that that's unfair because it focuses on what Mr Pridgeon did or didn't do and doesn't give weight to the other work done by other members of his team. But I will remind the Commission at pages 9352 to 9353 Mr Pridgeon was given an opportunity to explain what else members of his unit did, and he confirmed he could recall Mr Marshall had a map with assets marked on it. I asked him didn't they have such a map going into the fire. I think the location of the State's critical infrastructure in the Latrobe Valley is fairly notorious, if not marked on a map, but apparently Mr Marshall spent the day identifying it. Mr Costigan had a map for what Mr Pridgeon called the predictive stuff.

Now, to say we haven't given due weight to that work by other team members is a little rich in circumstances where both maps are missing. Mr Pridgeon had said efforts had been undertaken to try to find them and they couldn't be produced. In relation to that, see page 9357.

In any event, there was no evidence given by Mr Lockwood of using any of those maps to devise a plan because he didn't write one down. There is no evidence of the operations unit relying on those maps to deploy

resources or make any of their plans. In any event no member of that team, as I said, saw the spot weather forecast.

If you are going to be predicting the spread of a fire -- we say it is a very simple point we need make here only in one line -- then you need to know the latest and the best information about when the wind change is arriving.

I should also note that there were statements tendered, these individuals weren't called, by the manager of the information unit, Ms Hunter, and Mr Oldroyd from the information unit. They describe in very clear terms the good work they did warning communities. We say in most respects, other than two failings Mr Rozen will identify, the warnings they issued were timely and accurate.

But it is telling that neither of them referred to having had any interaction with the strategic planning unit and they didn't use any maps produced by that unit. In fact they say Andy Gillham gave them all the information they needed about the fire. Ms Hunter says in particular at paragraphs 28 to 30, "During this time there were no line scans or official predictive maps and I did not see any on the day." So we repeat our submission that the product of that unit was of little value in the circumstances.

I want to turn to incident action plans, Commissioners. We deal with this in detail in our submissions at paragraph 6.19 onwards. This much is clear: there was never an incident action plan prepared for this fire.

Let's get back to some basics about incident action plans, because the State says, "How could they? They were so busy. It was a fast fire." Let's check what the rules are about incident action plans. The AIIMS manual, which for completeness I will remind you is annexure 9 to the statement of Mr Haynes and I think it is also exhibited elsewhere, but it is certainly exhibit 547, provides that incident action plans must be prepared.

I will actually just take you to one aspect of the AIIMS manual in an appendix. This is exhibit 547. It starts at (WIT.3004.024.0124), the precise page being (WIT.3004.024.0163). So this is the AIIMS manual, but I'm going to a particular passage in it. In this section here the AIIMS manual is identifying the work that should be done by the incident management team. In fact it falls under the particular heading "Responsibilities of the incident controller".

If you can move down that page a little, there is a heading "Develop incident action plan". "The incident controller is responsible for determining the appropriate strategies for achieving the objectives of the incident. Action planning is continuous and plans are constantly under review taking into account the current situation reflected in regular situation reports." It then refers to the fact there should be meetings and it must be complete and approved by the incident controller.

The next heading says, "You should implement and monitor it." That seems to be obvious. Once you have devised a plan you ought to check that it is implemented.

Can I take you to an appendix to the document which says what a good plan should include. This is

starting at page 0207. Appendix 2 is headed "Planning" and it starts at 0207. This sets out in detail what is required, and the second sentence under that heading notes, "After consideration of all factors affecting an incident, an incident action plan is developed to manage the incident and as a tool to communicate the incident objectives."

May I pause there to highlight this point. It is no good for someone to have a fantastic plan in their mind. It needs to be communicated to the other core members of the team, and in a fire of any duration it obviously needs to be available in written form to be passed on to the next shift. It is not always distributed in the field. That's accepted. But there are some fires where it is. It was in Bunyip, for example, because they had time to do so.

But that's not really the crux of the matter. The issue is if there is a plan which has been documented then anyone who needs to can consult it. The incident controller can review it. Those down the chain know what to implement.

At times in its submissions it seems the State confuses objectives with plans, because they latch on to evidence like that given by Mr Mitchell. He said, "I knew what we were supposed to do. We were supposed to protect assets and save lives."

We make the point in those submissions and I repeat here those are objectives. They are good things. Of course that's the aim of a firefight on a day like 7 February. But what you need to do is move from a general statement of general objectives to a plan. The

elements of a plan are objectives coupled with strategies for achieving the objectives.

As this appendix then goes on to say after those dot points, "A plan will contain incident objectives and strategies with specific timeframes." Obviously timeframes will guide people as to by what time something should be achieved.

If I can go to the next page, 0209. It is accepted there that it will not always be possible to write everything down instantly, and of course the State - no, this is page 0209. Sorry, can you just go back to page 0208. "The incident action plan provides information", it says there, "describing the incident and how it will be managed." It then goes on to say, "At a small incident the incident controller may develop a mental incident action plan. This will be based on an initial assessment upon arrival and knowledge of pre-existing plans and standard operating procedures. Should an incident develop beyond that catered for in a pre-incident plan and standard operating procedures, so should the incident action plan. For incidents that have a potential for extended involvement, the incident action plan should be documented."

It notes this matter which the State really makes a great deal out of in its submissions, the acknowledgment that, "During rapidly escalating incidents it can be extremely difficult for a written plan to be prepared in the initial stages." That is also accepted. While you are dealing with initial attack and responding to the first report of a fire, of course you shouldn't move out of the room and pick up a pen and start writing an

elaborate plan. But what it goes on here to say is, "Nevertheless, an assessment of the situation should still occur and an objective be determined. As soon as practicable, a written plan should be prepared in case the incident increases in complexity and to record the information for subsequent incident analysis and debriefs."

Then, "A well designed plan," it is said, "will include" and there is an identification there of all kinds of things, including incident objectives, strategies to be adopted, providing information on fallback strategies - and in a sense during a difficult firefight like February 7th that might be just as important as plan A - a structural chart, and if I move down a couple of dot points, an identification of the resources to be allocated to each division or sector. That was never done for the Churchill fire. In fact, the first time that all of the resources deployed to the fire were documented in an organised way was by counsel assisting during opening when a document prepared by us was provided.

One of the other dot points is a communications plan, including information on all agencies involved and appropriate contact details. All of these matters we say are useful. All of them are important. Significantly, the Coroner in the Linton inquest had already found in 2002 that an incident action plan is critical and that it is important and valuable to the way in which a firefight develops and can be very important in particular in ensuring that available information about a wind change is discussed and understood by everyone and that it is communicated properly in the context of firefighter

safety.

I want to direct your attention to a couple of recommendations made by the Coroner, without reading them in full. It is in exhibit 546 and I'm just going to show you where they are. It starts at (TEN.132.001.0001). It is chapter 15 of the Coroner's report into the Linton deaths of 1998 that is relevant to this question. Chapter 15 starts at (TEN.132.001.0383).

Commissioners, you may want to make a note of these paragraphs as I'm not going to read them all, but the core findings are 15.5.11, 15.9.1, 15.9.5, 6 and 7. Just to give you a flavour of what has been found here, at paragraph 15.5.11 at page 0408, following a detailed analysis of what evidence was available about the failure to prepare an incident action plan and to keep it updated, at 15.5.11, which is the bottom of page 048, the Coroner says this: "Had the discipline of a proper and timely incident action plan preparation occurred with the participation of all relevant IMT personnel, a common understanding would have occurred as to the likely time of arrival of the wind change and detailed strategies including relevant safety considerations would have been determined, documented and disseminated through the chain of command to the fireground."

This is what I identified earlier as what, in my submission, is one of the key values of documenting a plan. It helps people to realise what they have missed. It enables somebody who knows more than others to point it out. Perhaps somebody could have said, "That doesn't fit with the spot weather forecast", or "That's a good point. Have we made sure everyone knows about the spot weather

forecast, including people on the fireground." Here we have, about an incident in 1998 all those years ago, the Coroner making the same remarks about the importance of what he calls "the discipline of a proper and timely incident action plan".

I will take you over to page 0410, at paragraphs 15.9.5 onwards. These are the other paragraphs I have identified as being important. Look at what the Coroner says in 15.9.5 in about the third sentence: "It is difficult to imagine a more important function for those in the IMT than the production of incident communications and incident action plans in accordance with the aims-ICS guidelines and dissemination of those plans to appropriate personnel in the command structure. The priority to be accorded to these tasks is clearly reflected in the manual."

He goes on to say: "The explanation that it is difficult to create such plans at an early stage of a running fire and that in effect they cannot be created until the second shift is not accepted." And he goes on to explain why he makes those findings in the particular circumstances.

In that context, I finally just want to remind you that Mr Jeremiah himself identified forming this plan as one of the key basics of running a good IMT. There is no need to go to it; I will just remind you of what he said.

At transcript page 10189 Mr Rozen asked Mr Jeremiah about the work that would be done in the early phases of an incident management team and what he had discussed with Mr Lockwood. Mr Jeremiah said this at

10189.6: "We have I guess three basics in our incident management processes. One is the structure chart, making sure everybody knows who they are reporting to and what the chain of command is. The second one is a communications plan, in particular for fire appliances and crews on the ground, so they can get messages if they need. The third is the strategic plan, which basically assesses the potential and provides some strategies for control." And yet none of those were done, and in particular Mr Jeremiah wasn't able to shed light on why an incident action plan wasn't done.

It has also come to my attention since those hearings that there is a standard operating procedure which requires an incident action plan to be done. I understand that the overall document in which it is contained has been available for some time but through oversight hasn't been tendered. For completeness, we have copies of that available. There is no magic in it. It is (DSE.0034.0291.0316). It simply confirms that it is a requirement to prepare an incident action plan and this applies to both CFA and DSE members. All incidents need to have an IAP, it says, once the incident appears to be progressing beyond an extended first attack. Interestingly enough, this standard operating procedure doesn't admit of any exceptions. It doesn't say unless it is too hard, unless it will take too long, unless the fire is a really fast one. It says you've got to do it and this is the standard operating procedure which applied at the time.

I won't go to the detail of our submissions on the organisational chart and the resources list. They are

dealt with in detail in our written submissions. But I will just note this: that when the State says it really is a trivial matter because in the end people were wearing tabards and everyone knew who was occupying what role and there is no evidence of any problems, I need to remind the Commission of the evidence of Mr Mitchell.

He said not having a resource list was difficult for him, and we set out in our submissions at 6.32, 35 and 36 the concerns Mr Mitchell had, because being from DSE he was even less familiar with what CFA had out on the fireground at Delburn and Churchill. He said he found it difficult to know what CFA tankers had been dispatched. He never got a list. And if he'd had a list, he would have attached it to the communications plan so he could be sure of reaching everyone on the fireground.

I make that point to underscore the fact that these aren't just matters of paperwork, boxes that need to be ticked. These are documents that help people do their job and it is in fact during a fast-moving, difficult fire where that structure would enable some who are struggling or whose memories are failing to have regard to the documents which might help them check what needs to be done, what has been done, which might prompt their memory or which might fill the gaps that their relative inexperience might be exposing on the day.

As I indicated, Mr Rozen is going to deal with the two discrete matters of aspects of warnings and aspects of firefighter safety.

MR ROZEN: If the Commission pleases. In relation to the topic of warnings, the submissions of counsel assisting are at paragraphs 3.1 to 3.28 of our written submissions. In

general terms, to summarise what we submit there, counsel assisting accept that communities in the path of the Churchill fire were warned in a timely manner by the Traralgon IMT. In particular, there were numerous warnings released to communities in the path of the initial run of the fire, that is communities south and south-east of the point of origin. Fire information releases were supplemented by radio interviews engaged in by the incident controller.

However, counsel assisting's written submissions refer to two deficiencies in the warnings issued on 7 February 2009. In each case the problems arose after the wind changed.

Counsel assisting propose the following finding to be made in this regard, and this is at 13.3(v): The Churchill IMT failed to warn adequately the communities of Koornalla, Callignee, Callignee South and Callignee North about the risk they faced once the wind change affected the fire. There was no acceptable reason advanced for the failure to issue any alert or urgent threat message to Koornalla or for the failure to issue an urgent threat message to Callignee, Callignee South and Callignee North prior to 2000 hours, 8 pm, or in any event as soon as was reasonably practicable once updated information concerning the wind change became available at 1600 hours in the form of spot fire weather forecast.

The State's response to this proposed finding is set out at paragraphs 104 to 106 of its submissions. The State accepts that "it would have been desirable" for the communities of Callignee, Callignee South and Callignee North to have been the subject of an urgent threat message

earlier than 8 pm. However, it rejects a finding that there is no acceptable reason for the late warning.

In relation to Koornalla, the State maintains the position expressed in the evidence of Mr Gillham, the planning officer, which the Commissioners will recall, that the failure to warn Koornalla is justifiable because it is "a locality rather than a township". The State submits that the references in warnings that were released to other "key settlements bounding the area known as Koornalla" constituted sufficient warnings of the residents of Koornalla.

I intend to refer briefly to these two issues, starting with the question of warnings to the Callignee communities. Callignee, Callignee South and Callignee North are located about seven kilometres east of Churchill. As any map of the area shows, they were directly in the path of the fire once the eastern flank of the fire was impacted by the south-westerly wind change.

They were devastated by the Churchill fire in the early evening of 7 February 2009 when the fire direction changed as a result of the arrival on the fireground of the wind change at about 6 pm. The devastation occurred some time prior to 7 pm and, as has been indicated by Ms Doyle, four residents of Callignee lost their lives in the fires. Those deaths have been examined by the Commission and it will be recalled that three of them can be described as late evacuation deaths.

An alert message was issued to these towns at 3.30 pm. However, an urgent threat message was not issued until 8 pm. That message when released warned residents that they "may be directly impacted by this fire". It is

common ground that by that time the fire had well and truly impacted on the towns.

Mr Gillham, the evidence indicates, was the planning officer and was ultimately responsible for the issuing of warnings. It will be recalled that he remained steadfastly of the view that it would not have been appropriate to warn the residents of Callignee earlier than 8 pm. See for example his evidence at transcript 9413 line 10 and 9414 line 11.

His explanation for that position was as follows, and this is at 9414, lines 15 to 21. Mr Gillham said this: "The risk of issuing an urgent threat message too early is that it will likely expire unless we renew it on the airwaves and people would perhaps implement, if for example they had a sprinkler system, they would implement that too early if they were relying on that message and perhaps use all their resources prior to the fire hitting."

It is perhaps not surprising that the State makes no reference to this justification for the issue of the urgent threat message to Callignee as late as 8 o'clock. Rather, the State submits that account should be taken of what is referred to as the limited information available to the IMT on the path of the fire around the time of the wind change. That's a reference to paragraph 33 of the State's submissions.

Counsel assisting submit that it is not entirely clear what this refers to. Incident controller Lockwood knew as early as 4.25 in the afternoon that all locations to the east of the fireline would be at risk on the arrival of the wind change. He communicated that

information in a radio interview at that time. The townships of Callignee, Callignee South and Callignee North clearly meet the description of towns to the east of the fireline. In fact, along with Koornalla, they are the closest towns to the east of the fireline.

The State's attempts to justify the late warning of these three towns should be rejected, in our submission. The correct position is as described by incident controller Lockwood in his evidence at transcript 9232, lines 21 to 25. Mr Lockwood candidly conceded that the three towns should have been warned no later than 6 o'clock, when towns further to the east, such as Gormandale, were warned of the anticipated wind change.

If I can turn briefly to Koornalla. Koornalla is even closer to the fire edge than Callignee. It was clearly marked on the map used by the information unit to determine which towns to warn. It was also on the predictive map that Mr Pridgeon's unit prepared that Ms Doyle referred to earlier . Despite this, it was not issued with a warning at all on 7 February 2009. It, too, was devastated by the fire after the arrival of the wind change.

Mr Gillham's explanation for the failure to warn Koornalla was that Koornalla and towns like it are "just merely settlements or bush blocks just spread through the bush"; transcript 9405 lines 26 to 27. Mr Gillham told the Commission that Koornalla was located in the Traralgon Creek Valley and that warnings to Traralgon south of the north of the valley and Le Roy at the south were adequate warnings for Koornalla. The State adopts this evidence as its submission; see paragraph 35 of the State's

submissions.

Counsel assisting maintains the position that Koornalla should have been warned and the failure to warn it was an oversight by the IMT. We ask why should it matter if a location is a town or a settlement, whatever that distinction might be? Surely the important question is do people live and/or work there? If so, they are entitled to be warned and one of the primary responsibilities of our fire agencies is to issue timely and accurate warnings to people who may be affected by the fire.

Once again, the evidence of the incident controller, Mr Lockwood, was straightforward on this issue. He was unable to explain why Koornalla was not warned and he agreed with the suggestion by counsel assisting that it should have been.

If I can turn briefly to the topic of firefighter safety. This is dealt with in our written submissions at paragraphs 8.1 to 8.25 and there are three findings which we submit ought be made in relation to firefighter safety. The first of those is at paragraph 13(viii), which is at page 0086 of our written submissions.

The proposed finding is in the following terms: "No safety adviser was appointed to the Churchill IMT. The failure to appoint a safety adviser to the Churchill IMT was a breach by the incident controller of joint CFA/DSE standard operating procedure J3.04. As one of such an adviser's roles is to assist with the provision of safety advice, the failure to appoint a safety adviser is likely to have contributed to the transmission of a late and inaccurate red flag warning to some ground crew."

The second relevant finding is at (ix): "The Churchill IMT failed to ensure the transmission of accurate and timely wind change information to crew on the fireground in the form of a red flag warning or otherwise. No acceptable reason was advanced for the failure to transmit accurate wind change information to the crew on the ground as soon as was reasonably practicable after receipt of the spot fire weather forecast at approximately 1600."

Finally, at (xii) on page 0087 of our written submissions we submit the following finding is open to be made by the Commission: "As a result of the failure to transmit accurate and timely information in relation to the wind change, firefighters on the ground were exposed to risks to safety and life during three burnover events detailed in official internal investigation reports."

In our written submissions at paragraphs 8.1 to 8.25 we refer in some detail to the experience of the crews of the three tankers which were involved in burnover events, circumstances in which they were engulfed in flames. Each of the burnover events was the subject of an internal investigation report by the CFA. A similar incident at the Linton bushfire in 1998 claimed the lives of five CFA volunteer firefighters. It is counsel assisting's submission that it is fortunate that none of the firefighters in the Churchill fire were seriously injured.

In our written submissions we have examined in detail a red flag warning that was issued by the IMT at 5.30 on 7 February 2009. As Ms Doyle has indicated, that's at paragraphs 7.1 to 7.52. We have submitted that,

on the balance of the evidence, the Commission should find that the warning that was ultimately conveyed to crews inaccurately advised firefighters to expect a south-westerly wind change at 7 pm. As we have noted, this was despite a recently received Bureau of Meteorology spot fire weather forecast that accurately predicted that the change would arrive between 5.30 and 7 pm.

The CFA investigation reports which are in evidence identify the misleading red flag warning as a contributing factor in the burnover events. We summarise the contents of those reports at paragraphs 8.6 to 8.12 of our submissions. An example is the findings in relation to the burnover involving the Glengarry West tanker number 1, which is at paragraph 8.8 of our findings, and I will just quote briefly from the internal investigation finding.

The authors of the investigation report concluded as follows: "The red flag warning that was received at about 1730 hours warned of a south-westerly wind change for 1900 hours. The change in fact impacted the fire area at 1805 hours. While the red flag is given as a guidance and a heads up for field crews and commanders of a significant event coming, in this instance the warning may have provided a false sense of time security by leading the crew to believe they had plenty of time to establish themselves at their new assignment." Similar conclusions were reached in relation to the other two burnover events.

As Ms Doyle has noted, despite it being a mandatory requirement under the fire agencies' own standard operating procedures, there was no safety adviser appointed by the incident controller on 7 February 2009.

That's common ground, but the State complains that Mr Lockwood was not asked in the course of his evidence if he considered appointing a safety adviser. The Commissioners will well recall the evidence of Mr Lockwood at the Traralgon hearings and one can only speculate on what his answer may have been had he been asked whether or not he appointed a safety adviser. It is submitted that the chances are the answer would have been that he didn't recall or didn't know.

More importantly, counsel assisting submit that the presence of a safety adviser would have increased the likelihood of a red flag warning accurately advising of the timing of the wind change. As noted this morning and as will be expanded upon in our submissions in relation to the Bunyip fire tomorrow, we have evidence before us of the practical operation of the role that a safety adviser can play in assisting an incident controller to make decisions about the deployment of firefighters, taking into account their safety.

As we note at paragraph 8.22 of our written submissions, the coronial inquiry report into the Linton tragedy strongly recommended that the CFA train and deploy safety advisers for the very reason that their focus on the safety of crews will increase the accuracy of important information being disseminated by incident management teams.

In its written submissions the State of Victoria indicates an intention to lead further evidence about firefighter safety at future hearings of the Commission and counsel assisting welcome that indication and look forward to participating in any further hearings in

relation to that important subject.

They are the oral submissions that I seek to make in relation to those two topics, if the Commission pleases.

CHAIRMAN: Yes. Thank you, Mr Rozen.

MR MYERS: I can be brief, Commissioners. There are detailed written submissions, both of counsel assisting and of the State, and the State joins issue on every matter upon which it wishes to join issue in its detailed response. It will be seen, without going to particular parts of those written submissions, that in many cases we accept that there were failures to follow exactly the guidelines that were published by the State and by its authorities for the use of fire officers in these circumstances.

What we say, however, is that the particular fire officers who may have departed in some way or another from those guidelines are not to be condemned in the way they have been today by the relentless criticism of Ms Doyle. In fact, they were acting under difficult circumstances and it was accepted, properly by her, that there was no causal link to any death or loss of property as a result of any of these blemishes in the following of the guidelines. But the State doesn't sanction the failure to follow its guidelines; indeed, it is difficult to see what was the burden of the criticism of the State. There were lengthy quotations from the very guidelines which we say should be followed.

We differ really in two things. One thing in which we differ is that we do not see and we urge the Commission not to undertake any criticism of individuals where they may have not strictly followed guidelines, as

has been pointed out here today. There is no point to be served by it. Indeed, it can only be damaging to those individuals. There was sufficient loss of life and of property, and hurt, and the criticism of individuals whose actions did not constitute an event which is a causal link to any death or loss of property should not be undertaken.

The first thing that Ms Doyle dealt with was the appointment of Mr Lockwood as the incident controller. Now, in paragraph 7 of the State's submissions concerning the Churchill fire, this is dealt with and I should just like to read it. "As set out above, the Churchill fire was initially to be managed as a division of the Delburn complex of fires. Decisions as to the management of the Churchill fire were not made by CFA alone. DSE's state duty officer and the regional duty officer were consulted and agreed that the existing CFA-led IMT would manage the new fire." Very sensible; in consultation. "The standby preformed IMT joined the existing IMT at around 1415. In accordance with that decision to place the new fire under the control of the existing IMT, Mr Peter Lockwood, incident controller, Delburn, was appointed IC for the new fire at Churchill. Mr Lockwood's evidence was that he discussed the management of the new fire with Mr Greg Flynn, CFA operations manager, and 'we agreed that the Churchill fire would be a division of the Delburn complex fire. As I was already the IC of the Delburn complex fire it was never suggested that I would not continue in that role after the Churchill fire had started.'" A sensible decision which we defend.

There were numerous criticisms of Mr Lockwood. Although my learned friend said at the outset she was not

going to criticise him, she did so on a couple of dozen occasions, I think as the transcript will show, but those criticisms don't lead anywhere. It isn't shown that any harm came from any of the criticisms that are made. In fact, we repudiate the suggestion that Mr Lockwood did not do a very good job indeed. He did. We also repudiate the suggestion that he shouldn't have been appointed incident controller. He was well up to the job, he thought he was up to the job, and a sensible decision was made that the incident controller of the nearby fire who had a good knowledge of the Churchill area, including the electrical and coal mining assets, should be appointed the incident controller.

In fact, if any other decision had been made, the officers responsible in these circumstances would have been subject no doubt to considerable criticism from those on my right. Moreover, Mr Jeremiah was the deputy controller and he had a great deal of experience.

Can I emphasise again - and I don't want to add anything in relation to the two topics that Mr Rozen adverted to, they are dealt with in our written submissions - can I add again we urge the Commission not to go into these questions of criticisms of individuals. Nothing is to be achieved by it and only harm can come from it. We are looking forward. We are trying to establish a new and better regime for the suppression of fires in Victoria.

The extraordinary thing, perhaps, above all else in the submissions that you have heard at great length this afternoon, repetitious of the written submissions, was the quotation from the various books and guide books

and manuals that are published by the State for the use of fire officers. The only suggestion is that some individuals departed from these. We don't seek to defend the departure in any absolute way, but we do say that it was understandable in the circumstances of a very difficult fire day and no deaths or loss of property arose from it. Thank you.

MS DOYLE: A brief reply, Commissioners.

CHAIRMAN: Dr Lyon, I take it you do not wish to say anything?

DR LYON: I have nothing to add.

CHAIRMAN: Yes, Ms Doyle.

MS DOYLE: It would seem on balance that the State's overarching submission in response to the points made by counsel assisting in relation to the Churchill fire is that we have relentlessly criticised a failure to comply with some paperwork. It's all just about red tape, no actual harm was done, no need to concern yourselves with it.

The answer I give to that is the criticisms that have been made by counsel assisting are more substantive than some paperwork or ticking some boxes. Sometimes the matters that we have addressed find their expression in guidelines, paperwork and plans, as most things do in modern life. They find their expression or their content in a document or ultimately a manual. But our complaint is not that an isolated occurrence came about where somebody departed from a particular standard operating procedure or that somebody forgot to tick a particular box on a form in triplicate.

Our criticism is that there were substantive failures, which I won't repeat, which identify the fact

that there is perhaps a broader failure and lessons to be learned. Mr Lockwood didn't choose to be appointed. I made that point at the outset. But a system and a level of resourcing existed such that he was in a position where he needed to take control, as it turns out, of two fires, and in relation to Mr Myers' emphasis of paragraph 7 I don't disagree with a single word in it. It just underscores the fact that a guy who was only level 2 found himself in charge of two significant fires on the day. I don't see how that helps the State's position.

Equally it seems there were some deficits in people's understanding and probably training in terms of the way they understand and use important documents like spot fire weather forecasts. Now, Commissioners, you may ultimately accede to the State's suggestion that you not name individuals. It is hard to see how one would analyse the events of the day without understanding that there were individuals who did or did not do things, so naturally they have been named in the submissions in that context. But when you go to the proposed key findings, you will find that the responsibilities are always sheeted home to the team and to the overarching system, and that is the way in which we have put our submissions and the way in which systemic issues will also be addressed later on in the hearings.

Further in relation to this matter about these being mere complaints about paperwork and that no actual harm came from the events, I make this submission. Surely actual harm is not the test. It certainly isn't under the terms of reference which guide the work of this Commission.

There is no suggestion in those broad terms of reference that you are restricted to analysing, passing comment on or making recommendations in relation to events where actual harm was caused. The terms of reference are far broader than that and they invite exploration of all places where improvements could be made, including those instances that the State accepts, as they do on a number of occasions in their written submission, and those that they don't accept, and those that they argue in this forum. In neither case is it essential for you to find that there was actual harm.

In fact, on a number of occasions in these submissions counsel assisting make the point, "Thank goodness no firefighters were killed." But that shouldn't mean that we desist from analysing the circumstances in which they were given the wrong message and the circumstances in which the IMT effectively sat on better information that could have been provided to them.

If there is a lesson to be learned, it is open to you to consider it, and if there is a lesson to be learned, it is open to you to recommend it. Those are our submissions in reply.

CHAIRMAN: Thank you, Ms Doyle. I take it it is now contemplated we will adjourn until 9.30 tomorrow.

MS DOYLE: And we will comfortably finish the other fires tomorrow.

CHAIRMAN: Yes. Thank you.

ADJOURNED UNTIL WEDNESDAY, 3 FEBRUARY 2010 AT 9.30 AM