Part One

About the inquiry

1 Preliminary matters and jurisdiction

Saturday 18 January 2003 will remain in the consciousness of the ACT community as a day of tragedy, a day of bravery, and a day of loss for many people.

The ACT is an island in the sea of New South Wales. Once the McIntyres Hut fire in NSW gathered momentum, crossed the border and joined the fires burning in the ACT, it became inevitable that the resultant firestorm would deliver its fury to both rural and urban areas of the ACT, turning some areas into an inferno that firefighters had no way of controlling.

The firestorm was a tragedy of momentous proportion:

- Four people died.
- Four hundred and thirty-five people were injured, some suffering injuries that necessitated removal interstate for long-term treatment of burns.
- Four hundred and eighty-seven homes were destroyed.
- Twenty-three commercial and government premises were destroyed.
- Two hundred and fifteen homes, commercial premises, government premises and outbuildings were damaged.
- Mount Stromlo Observatory, an institution of international renown, was destroyed.
- An inestimable number of animals were killed or injured.
- Almost 70 per cent of the ACT—157 170 hectares—was burnt.
- The financial losses have been estimated to amount to at least $610 million.[1] When (unquantified) losses arising from damage done to catchment areas and the flow-on effect in terms of costs to Canberra's water supply are added, it has been suggested that this figure could be closer to $1 billion.[2]

Could the catastrophe have been prevented? It is, perhaps, impossible to say. It can, however, be said that the firestorm's severity and impact could have been mitigated.

During the inquiry it was submitted that the severity of the firestorm could not have been foreseen. I do not accept this. Australia has a recorded history of extreme fire events dating back to at least 1851.[3] As is discussed in Chapter 7, CSIRO fire expert Mr Phil Cheney predicted several years ago a conflagration of the type experienced in January 2003. He made his prediction on the basis of information in the report of one of the seven inquiries that have been held since 1986 to examine various aspects of the ACT's emergency services.

The point to make here is that experiences in life, be they good or bad, serve no useful purpose if we fail to learn from them. It is to be hoped, therefore, that the many lessons that can be learnt from this catastrophe in the ACT are in fact learnt and result in positive action, not just supportive words and shallow promises.

For the sake of our community today and in the future, I hope my findings and recommendations are not relegated to the archives to gather dust—as has occurred with the reports of several of the previous inquiries.

History is the best predictor of the future.

The evidence before the inquiry revealed that those in authority could, and should, have done many things to reduce the extent of disaster and loss. The evidence also revealed highly commendable efforts—and, indeed, bravery—on the part of volunteer, rural and urban firefighters, parks and forestry staff, the rural landholders, the police, ambulance personnel, the many people who came from interstate to help and, not least, the large number of people in the ACT community who came together to help one another in the face of a terrible event.

1.1 The subject matters of the report

The proceedings I conducted were twofold:

- inquests into the deaths of four people—Dorothy McGrath, Alison Mary Tener, Douglas John Fraser and Peter Brabazon Brooke—on 18 January 2003, when fires invaded a forestry settlement and Canberra suburbs

- an inquiry into three ACT fires that joined a fire that began in NSW and then crossed the border into the ACT. All four fires were caused by lightning on 8 January 2003. The ACT fires were called the Bendora fire, the Stockyard Spur fire and the Mount Gingera fire; the fire that began in NSW was called the McIntyres Hut fire.

The proceedings became known as the 'Bushfire Inquiry'. Although they involved two distinct components, I generally use the term 'the inquiry' in this report for ease of reference to both the inquests and the Bushfire Inquiry.

1.2 Structure of the report

The report is divided into four parts and 10 chapters:

- In Part One, this first chapter describes the legislative basis for the inquests into the deaths and the inquiry into the fires, the obligations and restrictions imposed on me by the law, and a number of other preliminary matters. Chapter 2 lists the names of the people who gave evidence before the inquiry and the names of counsel who represented interested persons, organisations and authorities. Chapter 3 details the course of the inquests and the inquiry, from the first directions hearing on 16 June 2003 until 28 July 2006, the last day on which oral submissions were made.

- In Part Two, Chapter 4 provides information about the situation in the ACT before the fires started on 8 January 2003 and Chapter 5 is a chronology of events, tracing the progress of the fires from their ignition until 18 January 2003, when they burned into the suburbs of Canberra.

- In Part Three, Chapter 6 examines the initial response to the fires, from 8 January 2003, and Chapter 7 discusses the question of warnings to the community.

- In Part Four, Chapter 8 deals with the circumstances of the deaths of Dorothy McGrath, Alison Tener, Douglas Fraser and Peter Brooke and Chapter 9 deals with a number of other matters that arose during the inquiry and are associated with the administration of justice. In Chapter 10 I present my findings and recommendations.

The report is based on a very large quantity of exhibits, evidence and submissions by counsel. It is possible that there will be instances where I quote verbatim from submissions and other documents but make no attribution. This should be treated as a combination of me agreeing with the statement at the time I read and reproduced it and the fact that this final report is the result of several iterations and edits. Some attributions might have been overlooked. This was not intentional: it is inevitable with an inquiry that generated documents running to more than 10 000 pages.

Despite this, at the outset I make it plain that I considered *all* the evidence and took it into account when compiling my report. Given the extensive public interest in the inquiry, it is important that the relevant information be made public. I have therefore authorised the publication of the complete transcript of proceedings and the submissions made at the end of the inquiry. This material already appears on the ACT Magistrates Court website; for the sake of completeness, attached to this report is a compact disc that contains an electronic version of this report, the transcript and submissions.

1.3 The jurisdiction of a coroner

At the outset I record my appreciation of the submissions on jurisdiction made by counsel, especially those from counsel assisting, counsel for the ACT, and counsel for the NSW interested persons. These were very useful, especially in the light of the jurisdictional restrictions referred to by the Full Bench of the ACT Supreme Court in the litigation initiated by the ACT Government and some of its employees.[4]

1.3.1 The Coroners Act

The ACT *Coroners Act 1997* makes provision for the holding of inquests into deaths and inquiries into fires and disasters and contains provisions for related purposes. Interpretation of the Act is in accordance with the provisions of the Act itself, the provisions of the ACT *Legislation Act 2001* and relevant case law.

1.3.2 General functions of a coroner

The general functions of a coroner are dealt with in s. 12 of the Coroners Act, which provides that a coroner has the functions and jurisdiction given by the Act or any other ACT law. It also provides that—except as otherwise provided by the Act—a coroner has all the functions and jurisdiction that were vested in a coroner immediately before the commencement of the *Coroners Act 1956*. (Before self-government in the ACT, the legislation was known as the *Coroners Ordinance 1956*.) The legislation in force before the *Coroners Act 1956* came into force was the *Coroners Ordinance 1932*, as amended by the *Seat of Government (Designation) Ordinance 1938*. It became the *Coroners Ordinance 1932–1938*, which provided, among other things, that the NSW *Coroners Act 1912* applied to the ACT. Examination of that legislation reveals there are neither coronial functions nor jurisdiction not otherwise covered by the *Coroners Act 1997*. I therefore make no further reference to coronial legislation previously in force in the ACT.

1.3.3 Procedure and discretion

Section 47 of the *Coroners Act 1997* provides that a coroner is not bound to observe the rules of procedure and evidence applicable to court proceedings. It also makes provision for a coroner to give directions in the course of an inquest or inquiry. The Act—read in conjunction with and interpreted by the ACT *Legislation Act 2001*—gives the coroner very extensive discretion in the conduct of inquests and inquiries. For example:

- discretion to allow representation—s. 42
- discretion to appoint investigators—s. 59
- discretion about undertaking a view—s. 61
- discretion to seek police assistance—s. 63
- as noted, discretion in relation to procedure and evidence—s. 47.

1.3.4 Learning, not blaming

I adopted this subheading from the submissions of counsel for the ACT because it encapsulates the nature of the coronial jurisdiction. In this regard, counsel for the ACT submitted:

> It is not the role of the coroner to make findings of contribution, blame or guilt. Indeed, the removal of the power to make findings of contribution, which occurred with the enactment of the 1997 Act, emphasises the limits upon the coronial jurisdiction in this respect. It is for the coroner to make findings, comments and recommendations as permitted by the Act.[5]

Counsel's reference to 'contribution' is a reference to the fact that in the legislation that preceded the *Coroners Act 1997* provision was made for a coroner to find that a person contributed to the cause of a fire or the cause of a death.[6] In the absence of such a provision in the current Act, it is arguable that I am prevented from making a finding that a person or people contributed to the deaths of the four deceased persons who are the subject of this report and that I am also prevented from finding that one or more people contributed to the fires that are the subject of this report. I say more about this in Chapter 9.

Counsel for the ACT referred me to Lord Lane CJ in *Reg v South London Coroner; ex parte Thompson*, in which Lord Lane said:

> Once again it should not be forgotten that an inquest is a fact finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts.[7]

Counsel for the ACT also submitted that this passage had been relied on by the High Court in Toohey J's judgment in *Annetts v McCann*. This submission is debatable in that *Annetts v McCann* involved a provision of the Western Australian *Coroners Act 1920*, and Toohey J's reference to Lord Lane's statement was in the context of explaining the rationale behind a particular provision in the Western Australian legislation that was based on the English coronial system.[8] Nevertheless, I take the point that the aim of the inquiry is to seek out the truth of what happened in order to learn from the established facts and endeavour to ensure that, where mistakes have been made or things could have been done in a better way, lessons are absorbed and the prospect of similar mistakes occurring in the future is eliminated or, if this is not possible, reduced.

Once the truth is established, however, it is often impossible to learn from mistakes made without finding fault on the part of individuals—as will be clear from a number of the chapters that follow. The Act anticipates this in s. 55, which is a natural justice and procedural fairness provision aimed at ensuring that any adverse comment made by a coroner in his or her findings or report is brought to the notice of the person who is the subject of the adverse comment and that the person concerned has the opportunity to make a submission or give a written statement to the coroner in relation to the comment. The person may ask that the coroner include in his or her report such a statement or submission or a fair summary of it. Once a coroner receives such a statement or submission, the coroner may modify his or her intended comment or remove it altogether. This is an important provision; it is worth setting it out in full:

> 55(1) A coroner shall not include in a finding or report under this Act (including an annual report) a comment adverse to a person identifiable from the finding or report unless he or she has, prior to the making of the finding or report, taken all reasonable steps to give to the person a copy of the proposed comment and a written notice advising the person that, within a specified period (being not more than 28 days and not less than 14 days after the date of the notice), the person may—
>
> (a) make a submission to the coroner in relation to the proposed comment; or
>
> (b) give to the coroner a written statement in relation to it.
>
> (2) The coroner may extend, by not more than 28 days, the period of time specified in a notice under subsection (1).
>
> (3) Where the person so requests, the coroner shall include in the report the statement given under subsection (1)(b) or a fair summary of it.

It was submitted—directly or indirectly—by counsel for the ACT and for Messrs Mike Castle, Peter Lucas-Smith and Rick McRae that the rule in *Browne v Dunn*[9] precludes me from making any adverse comment, finding or inference from the evidence without giving the person who

might be the subject of that comment, finding or inference the opportunity to reply by having the matter put to him or her in examination or cross-examination. The High Court of Australia recently explained the rule in *Browne v Dunn*: 'The rule is essentially that a party is obliged to give appropriate notice to the other party, and any of that person's witnesses, of any imputation that the former intends to make against either of the latter about his or her conduct relevant to the case, or a party's or a witness's credit'.[10] Their Honours, Gummow, Kirby and Callinan JJ, went on to observe, 'Reliance on the rule in *Browne v Dunn* can be both misplaced and overstated'.[11]

I reject the submission by these four counsel for three reasons. First, this inquiry is neither civil litigation involving parties nor a criminal prosecution. Second, it would be impossible in a matter such as this inquiry—which has been very long and where the evidence has evolved over time—to anticipate every possible matter that could become the subject of an adverse comment, finding or inference and put that to the person giving evidence. (In this regard it should be remembered that neither a coronial inquest nor an inquiry is an adversarial proceeding, and the rules of evidence do not apply.) Third, to accept the proposition would be to ignore the existence of s. 55 of the Act.

As their Honours observed in *R v Doogan*, it is a matter for me as coroner to determine whether any adverse comments should be made in the light of evidence adduced during the course of the inquiry.

1.3.5 Deaths

The *Coroners Act 1997* makes provision, in relation to a range of situations in which a person is killed or dies, for a coroner to hold an inquest into the manner and cause of death of the person (s. 13(1)). The Act also requires a coroner holding an inquest to find, if possible, the identity of the deceased person, when and where the death occurred, and the manner and cause of death (s. 52(1)). Additionally, the Act permits a coroner to comment on any matter connected with the death, including public health or safety or the administration of justice (s. 52(4)). Further, the Act provides discretion to a coroner to make recommendations to the Attorney-General on any matter connected with an inquest, including matters relating to public health or safety or the administration of justice (s. 57(3)). There is also provision in the Act for a coroner to make an interim finding (s. 53).

When considering the scope of these provisions, there is a great deal of case law on which to draw in an effort to determine the boundaries that applied when conducting the four inquests and the inquiry.

The notion of 'causation' is of particular importance and has been considered by the High Court of Australia on a number of occasions. In *March v Stramare* (*E&MH Pty Ltd & Another*), a case involving negligence and personal injury, Mason CJ had this to say:

> Commentators subdivide the issue of causation in a given case into two questions: the question of causation in fact—to be determined by the application of the 'but for' test—and the further question whether a defendant is in law responsible for damage which his or her negligence has played some part in producing … However, this approach to the issue of causation (a) places rather too much weight on the 'but for' test to the exclusion of the 'common sense' approach which the common law has always favoured; and (b) implies, or seems to imply, that a value judgment has, or should have, no part to play in resolving causation as an issue of fact. As Dixon CJ, Fullagar and Kitto JJ remarked in Fitzgerald v Penn (49) 'it is all ultimately a matter of common sense' and 'in truth the

> conception in question [that is, causation] is not susceptible of reduction to a satisfactory formula' (50).'[12]

This common-sense approach has been followed in various Australian jurisdictions, and legislative provisions similar to those that bind me have been considered. In *Harmsworth v State Coroner* Nathan J considered a similar provision in Victoria relating to the coronial power to comment. He explained, 'The power to comment, arises as a consequence of the obligation to make findings … It is not free ranging … It arises as a consequence of an exercise of a coroner's prime function, that is to make "findings"'.[13]

Cause of death was considered by Lee J in *Queensland Fire and Rescue Authority v Hall*. His Honour described cause of death in the following terms: 'The death is the actual event and the cause of it is the process of happening which brought the death about and is the cause of it …'[14] This case was later considered in South Australia in *WRB Transport Pty Ltd & Ors v Chivell*, both in the first instance and on appeal, with the Full Bench applying the *March* decision as follows:

> The cause of a person's death in respect of the coroner's jurisdiction is a question of fact which, like causation in the common law, must be determined by applying common sense to the facts of each particular case: Mason CJ, *March v E&MH Stramare Pty Ltd* (1991) 171 CLR 506 at 515. The coroner, therefore, has to carry out an inquiry into the facts surrounding the death of the deceased to determine what, as a matter of common sense, has been the cause of that person's death. The inquiry will not be limited to those facts which are immediately approximate in time to the deceased's death … That is a factual inquiry which only has, as its boundaries, common sense … The circumstances surrounding the death of the deceased may be important, for the purpose of the coroner adding to his or her findings, recommendations which might prevent or reduce the likelihood of a recurrence of a death.[15]

In the litigation initiated by the ACT Government and a number of its employees during the course of this inquiry, the Full Bench of the Supreme Court of the ACT referred with approval to the earlier quotation from *Harmsworth v State Coroner*.[16] Similarly, they adopted the common-sense approach from *March*, saying:

> A coroner conducting an inquest into the death of a person may be obliged to consider whether the death was attributable to accident or homicide … If that situation does not arise, the coroner will be obliged to make findings as to the nature of the acts and/or omissions that cause the death, even if they reflect adversely on the reputation of one or more people involved in the relevant incident … The application of the common sense test of causation will normally exclude a quest to apportion blame or a wide-ranging investigation into antecedent policies and practices.[17]

A few months after the Supreme Court of the ACT delivered its judgment in *R v Doogan*, the High Court of Australia delivered its judgment in *Travel Compensation Fund v Tambree (t/as R Tambree and Associates) & Ors*.[18] Statements made in each of the four judgments are instructive. When considering the question of causation under the Fair Trading Act, Gleeson CJ stated, '… the statutory purpose is the primary source of the relevant legal norms'.[19]

Gummow and Hayne JJ observed, 'It is now clear that there are cases in which the answer to a question of causation will differ according to the purpose for which the question is asked … it is doubtful whether there is any "common sense" notion of causation which can provide a useful, still less universal, legal norm …'[20] Kirby J agreed with Callinan J: '… Tribunals of fact cannot

resort to "an invariable scientific formula". They must draw on common sense, experience, understanding, a multiplicity of community values and their own judgment …'[21] Callinan J expanded on the subject:

> It would be a delusion to think that a disputed question of causation can be resolved according to an invariable scientific formula, and without acknowledgement that common sense, that is, the sum of the Tribunal's experience as a tribunal, its constituents' knowledge and understanding of human affairs, its knowledge of other cases and its assessment of the ways in which notional fair-minded people might view the relevant facts, is likely to influence the result … tribunals of fact have to do the best they can. And that which has to be done is better done with candour, and candour demands the acknowledgement by any tribunal or any judge called upon to resolve a matter, of the use of his or her common sense in determining causation …[22]

Finally, on the subject of inquests and in the context of adverse findings, counsel assisting submitted that if I am satisfied that the actions or inactions of an agency or person were a cause of any of the deaths I am obliged by the Act to so find.[23] Counsel for the ACT conceded that, although there might be some debate over whether s. 52(1) of the Act imposes an obligation to make such findings in an inquest, power to make such findings does exist.[24]

1.3.6 Fire

The *Coroners Act 1997* makes provision for a coroner to hold an inquiry into the cause and origin of a fire that has destroyed or damaged property (s. 18(1) and 52(2)(a)). It also requires a coroner, if possible, to find the circumstances in which the fire or disaster occurred (s. 52(2)(b)). As in the case of a death, a coroner may comment on any matter connected with a fire, including public health or safety or the administration of justice (s. 52(4)). Again as in the case of a death, a coroner may make recommendations to the Attorney-General on any matter connected with that inquiry, including matters relating to public health or safety or the administration of justice (s. 57(3)). Further, as with an inquest, a coroner may make an interim finding on any matter connected with the inquiry (s. 53).

The scope of the fire inquiry was dealt with at some length in *R v Doogan*.[25] Higgins CJ, Crispin P and Bennett J referred to s. 18(1) of the Act in the following terms:

> … Unlike a death, a fire is not a one-off event but a process that develops over time. The process may have been initiated by a single event such as ignition due to a lightning strike or, as in the present case, by ignition due to lightning strikes at four separate places. However, when the concept of causation is applied to a process that has developed over a period of several days, it must extend beyond such origins to embrace those factors that had a causal effect on the development or continuance of the process. It would be quite unrealistic to regard a fire that had travelled long distances and/or burnt out vast areas of bushland as co-extensive with a fire that had been smouldering on the end of a cigarette when negligently thrown from a car window and then dismiss from any consideration any intervening or contributing events. In any event, the meaning of a statutory provision of uncertain scope is not to be found by relentless adherence to semantics or philosophical argument, but by attempting to deduce the intention of the legislature … We are satisfied that the term, 'the fire', in s18 of the Act should be construed to mean the fire that caused the damage to property rather than merely the initial ignition from which that fire ultimately developed. In the present case, it was open to the coroner to inquire into 'the cause and origin' of the fire that swept through parts of Canberra causing the deaths of four people and immense damage

> to property on 18 January 2003, and to consider all of the factors that might reasonably be regarded as having been causative of the entire process of that fire. The phrase 'cause and origin' is not a hendiadys. A coroner is required to inquire into two separate concepts. The word 'origin' means, of course, the source or beginning, and in the context of a fire it clearly refers to the starting point. Hence, the origin or origins of the fire can usually be identified with some confidence. In the present case, the origins of the fire would have been the locations of the lightning strikes that ignited each of the four fires that later converged into the overall conflagration.[26]

Their Honours went on to deal with the concept of causation, which I discuss in Section 1.3.5 in relation to death. After noting that many factors can contribute to the development of a fire or fires over a period, such that a coroner might need to inquire into a range of causal facts and circumstances, their Honours noted the limitations that apply:

> … even in relation to statutory provisions such as that contained in s18(1), questions inevitably arise as to whether particular factors are too remote to be regarded as having been causative of the fire, as it developed, in any real sense. To take but one example, it may be thought that the thickness of the vegetation at the site where the fire commenced had some causal relevance and, if [the coroner] came to that view, then she would clearly be entitled to make a finding to that effect … Section 18(1) does not authorise the coroner to conduct a wide-ranging inquiry akin to that of a Royal Commission … A line must be drawn at some point beyond which, even if relevant, factors which came to light will be considered too remote from the event to be regarded as causative. The point where such a line is to be drawn must be determined not by the application of some concrete rule, but by what is described as the 'common sense' test of causation affirmed by the High Court of Australia in *March v E&MH Stramare Pty Ltd* (1991) 171 CLR 506.[27]

The ACT has a history of coronial inquiries that have been wide-ranging. Their Honours gave consideration to this and made the following observation:

> We should, perhaps, mention that it was suggested in argument that other coroners had, from time to time, conducted inquests or inquiries that ranged far beyond issues relating to the manner and cause of a death or the cause and origin of a fire. However, the present applications do not raise any issue as to the legality of the approach adopted in such proceedings and it would be inappropriate for us to make any comment about them other than to observe that, even if the relevant provisions of the Act have previously been overlooked, they nonetheless impose legal constraints on the jurisdiction that may be exercised by coroners in this Territory. The position may be different in other jurisdictions where the comparable provisions confer broader powers.[28]

Chapter 9 discusses this further.

Their Honours then went on to deal with what they described as the duty to make findings. In relation to s. 52(2)(b) of the Act, they said:

> … the 'circumstances' to which the provision is directed are circumstances that are related to the cause and origin of the fire … The word 'circumstances' has a wide meaning and the concept referred to in s52(2)(b) of the Act is broader than that referred to in s52(2)(a) of the Act [the cause and origin of the fire] … A coroner is not authorised to make findings in relation to any circumstances arising from the fire, but only in relation to the circumstances in which the fire occurred … In essence, it is for the [coroner] to determine whether any particular factor should be regarded as a

> relevant circumstance and whether the evidence is sufficient to enable her to make any finding about it.[29]

Finally, their Honours dealt with a coroner's right to make comments in accordance with s. 52(4):

> Comments may obviously extend beyond the scope of 'findings'. The latter term refers to judicial satisfaction that facts have been proven to the requisite standard or the legal principles have been established. The former refers to observations about the relevant issues, and may extend to recommendations intended to reduce the risk of similar fires, deaths or disasters occurring in the future.[30]

1.3.7 The ACT as an island

Because the ACT is a self-governing territory surrounded by the state of NSW, the jurisdiction covered by the *Coroners Act 1997* is necessarily limited by the extent to which the ACT Legislative Assembly is empowered to legislate.

Counsel for the NSW represented persons provided to the inquiry extensive submissions on the limits imposed on me in relation to the largest of the four fires, the McIntyres Hut fire, which began in NSW and ultimately joined the ACT fires to become the firestorm. The essence of the submissions is as follows:

- Section 22 of the *Australian Capital Territory (Self-Government) Act 1988* (Cth) gives power to the ACT Legislative Assembly to make laws for the peace, order and good government of the ACT.
- Section 4 of the *Legislation Act 2001* (ACT) applies to all ACT Acts, and s. 3(2)(c)(iii) of that Act provides rules about the interpretation of ACT legislation.
- Section 120 of the *Legislation Act 2001* (ACT) limits the coronial jurisdiction to matters about which the Legislative Assembly has power to confer that jurisdiction.
- Section 122 of the *Legislation Act 2001* (ACT) provides that a reference to a place, jurisdiction or anything else must be taken to be a reference to a place, jurisdiction or thing in the ACT.
- The effect of s. 122 of the *Legislation Act 2001* (ACT) is that the relevant provisions of the *Coroners Act 1997* (ACT) are deemed to include the words 'in the ACT' such that, for example, s. 18(1) is deemed to read 'A coroner shall hold an inquiry into the cause and origin of a fire in the ACT …'
- The first point at which jurisdiction to inquire into the McIntyres Hut fire is acquired is when that fire crossed the NSW border into the ACT on 18 January 2003, and this was the first time it became a fire in the ACT.
- The cause and origin of the McIntyres Hut fire are a question solely for the NSW coroner.
- '… the question of the cause of a fire that comes across the border must be confined to a cause that is directly connected with a relevant matter for the good government of the ACT.

That may extend, for example, to matters of liaison by ACT authorities with firefighting agencies in a State. Or perhaps precautions may have to be taken in the ACT at particular locations on the border because some feature of the terrain or vegetation may increase the risk of a fire crossing the border into the ACT at those points'.[31]

- The ACT Legislative Assembly does not have power to make a law that would authorise an ACT coroner to make any findings, comment or criticism in relation to NSW government agencies.

- In this inquiry there is a lawful power to inquire into the McIntyres Hut fire as long as there is a rational connection with the ACT coronial jurisdiction.

By and large, I accept these submissions that I have no legal power to formally find the cause and origin of a fire or fires occurring in NSW. I am limited to events that occurred in the ACT. In order to make sense, however, of the events that occurred on 18 January 2003 in the ACT once the McIntyres Hut fire had crossed the border and entered the ACT, it was necessary for me to examine as a matter of fact what took place in NSW in the days leading up to 18 January. To do otherwise would be nonsensical and would be to fail to put into any context the fires that ultimately reached Canberra. Indeed, this was recognised by counsel representing the NSW interested persons:

> First, your Honour needs to know the story of the fire in order to put other evidence in context. This is similar to the well-known principle in evidence law of the *res gestae* … Second, some matters of chronology and narrative clearly have relevance to the cause and origin of the fire within the ACT … [Third] your Honour's jurisdiction is that of a coroner [and you] must inquire independently into the facts. In the investigation phase that will involve, of necessity, following evidence to see where it might lead. Thus it was appropriate for your Honour to hear from those NSW witnesses who gave evidence, and to have regard to the NSW documents forming part of the coroner's brief in order to see where that evidence led in terms of cause and origin of the ACT fire …[32]

1.3.8 Hindsight versus foresight

Counsel for the ACT made extensive written submissions under the heading 'The benefit of hindsight'. The general thrust of those submissions was that it is easy to be wise in hindsight, and they referred to several cases relating to the risk of judging actions after the event and with the benefit of hindsight. They also said, 'It would be unfair, unrealistic and inappropriate to measure the performance of persons and individuals in the ACT by reference to a benchmark or measuring stick formulated upon the basis of experience of other jurisdictions or by reference to the extraordinary and catastrophic forces that struck Canberra on 18 January 2003'.[33]

Counsel representing Mr Lucas-Smith and Mr Castle also made extensive submissions on the subject of hindsight. They, too, drew my attention to many cases dealing with hindsight and to a number of statements on the subject by coroners in other Australian jurisdictions. For example, they referred to the words of Northern Territory Coroner Cavanagh in his findings on the death of Sarah Rose Higgins: 'It is always necessary to make allowance for the fact that the coronial process is conducted with the benefit of hindsight. It is not appropriate to judge those individuals whose actions are the subject of scrutiny during the course of that process in accordance with the counsel of perfection'.[34]

Similar submissions were made by counsel representing other interested persons. Counsel assisting took the contrary position, however, when making the following oral submission in reply: 'If the evidence demonstrates, as we submit that it does, that particular people knew particular things at a relevant time and failed to act on their own knowledge then there is no role for complaining about the wisdom of hindsight, but rather the complaint is that there was a failure to have appropriate foresight'.[35]

All the submissions were helpful in my analysis of the evidence and had an effect on the conclusions I reached and the findings and recommendations I make as a result. Ultimately, though, it must be said that wisdom acquired through hindsight is of great assistance when one seeks to avoid making the same mistakes again if a similar situation arises. It also helps ensure that foresight informs future decision making.

1.4 Views

It is a long-established coronial practice—in the ACT specifically and throughout Australia generally—to inspect the scene of an event that is the subject of an inquest or inquiry. Such visits are generally known as 'views'. The undertaking of such views is dealt with in s. 61 of the *Coroners Act 1997* and is discretionary.

The benefit of viewing the scene of a death or a fire is that it helps with understanding the evidence that is later led in the inquest or inquiry. I viewed the devastation of the firestorm on three occasions, all of which were before evidence taking began on 7 October 2003. The three occasions were:

- by car in company with the police in the urban areas on Sunday 19 January 2003
- by helicopter with Mr Peter Lucas-Smith on 28 January 2003
- by four-wheel drive in company with counsel assisting, two officers from the Office of the ACT Director of Public Prosecutions (Ms Sara Cronan and Ms Helen Drew), and Messrs Phil Cheney, Trevor Roche, Sean Cheney and Peter Hutchings.

In the High Court of Australia Dixon CJ and Webb, Kitto and Taylor JJ made plain the rule about views: '… the rule is that a view is for the purpose of enabling the tribunal to understand the questions that are being raised, to follow the evidence and to apply it, but not to put the result of the view in place of evidence: *London General Omnibus Co Ltd v Lavell* …'[36]

Notes

[1] See the statement by Constable Goldsmith: AFP.AFP.0102.001.
[2] Submissions of counsel assisting, p. 488, para. 1327.
[3] See the report of the Royal Commission to Inquire into the Causes of and Measures Taken to Prevent the Bush Fires of January 1939 and to Protect Life and Property and the Measures to be Taken to Prevent Bush Fires in Victoria and to Protect Life and Property in the Event of Future Bush Fires, Parliament of Victoria, Melbourne, 1939, introduction, part 1, p. 6.
[4] *R v Doogan* [2005] ACTSC 74.
[5] Written submission on behalf of the ACT, para. 43.
[6] *Coroners Act 1956* (ACT), s. 56, paras 1(d) (death) and 2(c) (fire).
[7] Written submissions on behalf of the ACT, para. 37.
[8] *Annetts v McCann* (1990) 170 CLR 596 at 616.
[9] *Browne v Dunn* (1893) 6R67.
[10] *MWJ v R* (2005) ALR 222 at 448, para. 38.
[11] ibid., para. 40.
[12] [1990–1991] 171 CLR 506 at 515.
[13] [1989] VR 989 at 996.
[14] (1998) 2 QdR 162 at 170.
[15] (1998) SASC 7002 at paras 20, 21 and 26.
[16] *R v Doogan* [2005] ACTSC 74 at para. 41.
[17] ibid., para. 31.
[18] [2006] 222 ALR 263.
[19] ibid., para. 28.
[20] ibid., para. 45.
[21] ibid., para. 63.
[22] ibid., para. 80.
[23] Written submissions of counsel assisting, para. 1095.
[24] Written submissions of counsel for the ACT, para. 33.
[25] *R v Doogan* [2005] ACTSC 74.
[26] ibid., paras 20–22.
[27] ibid., paras 24, 25, 28 and 29.
[28] ibid., para. 32.
[29] ibid., paras 38–40.
[30] ibid., para. 41.
[31] Written submissions of counsel for the NSW represented persons, para. 74.
[32] ibid., paras 131 to 134.
[33] Written submissions on behalf of the ACT, para. 71.
[34] Written submissions on behalf of Mr Castle and Mr Lucas-Smith, para. 40.
[35] T 380 18 July 2006.
[36] *Scott v Numurkah Corporation* (1954) 91 CLR 300 at 313.