

LAW REFORM COMMITTEE

Inquiry into Coroners Act 1985

Melbourne — 5 December 2005

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Mr N. Bibby, chief executive officer, Country Fire Authority.

The CHAIR — We welcome to this afternoon's inquiry Mr Neil Bibby, who is the CEO of the Country Fire Authority. Mr Bibby, this is a public inquiry and the evidence you give is subject to parliamentary privilege. In the ordinary course of events it is taken as public evidence unless you request that a part of it be given in camera. You will be given an opportunity to correct the transcript for factual errors, but after that it will become a public submission on our web site. Perhaps if you could present your submission but leave us with some time to engage with some of the issues you have raised, we would appreciate that.

Mr BIBBY — Thanks for allowing us to present. Can I start with some personal background. I have been involved in the coronial system since 1990, starting with helping to run the Mistral fan inquiry back then through to Coode Island, Jika Jika, Kew Cottages, Linton and many small inquiries. In my different jobs in emergency management I have had a fair dealing with the previous coroner, Hal Hallenstein, and the other deputy coroner, so I have an understanding and practical experience in that area. I am not just a CEO coming to espouse what my staff members have told me to say. That is why I have decided personally to come; I think it is a very important process.

If I just refer to the letter I sent through about the inquiry, I will touch on each of those headings to explain the background behind it and why we are thinking along those lines, and then I daresay it will be open to questions after that.

Firstly, I refer to the issue of fires where no deaths occur. There is a lot of debate about whether a coroner should have the role to investigate fires where there are no deaths. In our experience there have been a number of examples where the coronial inquiries have led to legislative changes particularly in building regulations after inquiries into fires such as nursing home fires where there have been no deaths but the outcome of the fire had a high probability of death.

I now refer to changes in regulations in relation to sprinklers in nursing homes — a lot of the work that was done in the early 1990s on smoke alarms was done on house fires where there were no deaths but there was a high probability of death. The status of the coronial recommendations was very important in changing not just the Victorian regulations but the national regulations through the building code board.

There are also issues of public policy that need changing. There is a current one before the coroner at the moment in relation to the fires along the Bendigo rail lines. The fires caused no deaths; however, the public policy issue around the appropriate prevention along rail lines — the appropriate protection from sparks from trains and things like that — become an issue, where as an authority we can take it to the other parts of the bureaucracy or to regulation where we can bring those things together.

There have been a number of examples where there has been a significant benefit to the CFA and to the fire services in relation to fires where there has been a probability of death as opposed to there having been no deaths. In the chemical industry as well we had the fires in the 1990s — United Transport, Coode Island and a number of those — where although there were no deaths, there were public policy decisions made and regulation and Australian standards changes which were a direct response to the coronial inquiries in that area. That is why we are of the view that this has a benefit to the CFA. I have heard the other arguments about there being other appropriate bodies and groups and why is it only fire and not other areas the WorkCover authority should be getting into. I speak purely from a selfish perspective; in the fire area there have been a number of wins in that area.

Case management is the next heading we had on the list. We have large inquiries, particularly in the CFA, dealing with volunteers. I daresay the association would have talked about this at length this morning, but dealing with volunteers is not an easy issue when you have them coming into the courts of Melbourne. Some of them have not been inside Melbourne let alone inside a court. That happens in every court, we understand that, but we have a larger number of people. What we are saying is that a clear understanding of the statement as to the purpose and scope of the inquiry is something that we think can be tightened up on.

Even after a mention hearing there is usually a fair amount of latitude to look into other areas, which coroners like to do. We have no problem with that. If they move in another area, they can formally say, 'We are moving into that area', allow the appropriate time to do the research, go into that particular area and then come back to the coroner. That is one area where we think there should be a tightening of the scope of an inquiry so we know exactly where it is coming from. That is also the case with putting together a brief for that. With a broad inquiry brief account should be taken of the amount of time and effort spent in putting the brief together. It was in the millions with the

Linton inquiry because it was a very broad, expansive inquiry. I am not saying that was incorrect but I am saying that if it was more of a focused brief, we would have a better idea.

I will take Linton again as an example in referring to draft preliminary reports and draft recommendations. Linton meant that the inquiry took place some years down the track. The CFA was doing a lot of things. We did not wait for the coronial inquiry to make the decisions to improve our procedures. It would have helped if there were some draft recommendations and some draft findings through the running of the inquiry, or as the coroner read the briefs into those inquiries, and for us to have some imprimatur of the coroner and some additional pressure from the coronial system behind us.

There is also early access to briefs. We found in a number of inquiries that we were only getting briefs a month before. If it is a small inquiry with a brief that has a week to be put together, that is fine. If it is a large inquiry — Jika Jika, Coode Island, all the other ones I have been through — then getting the briefs a month before it makes it very hard for an organisation to prepare itself for it. It also makes it very hard for us to respond appropriately. I will take for example the Kew Cottages inquiries. There were some very technical experiments to be done on the burn patterns, the sorts of sprinklers, the sorts of smoke alarms and things like that that went off. We were not aware of some of those things until after the brief had been brought to us, although we were part of putting that brief in. If there is a need for that sort of experimentation, then bringing the two together — the formal statement of requirement and then an idea of what is in the brief — and then assessing the time of the inquiry would be an improvement in the system. It may not be a requirement of the Coroners Act but a requirement for the practice notes or the custom and practice within the coronial system itself.

Complexity of hearings is our next one. We have had a range of coroners assistants. This is not a derogatory statement but they have ranged from senior sergeants through to silks. We sometimes have trouble seeing the correlation between the two and the importance of those particular people in bringing together the brief. Where there is an administrative function for the coroners assistants and there is a need for more or less a public prosecuting position on the bench on behalf of the coroner, then I think a separation should be thought about.

Natural justice was also an issue. Natural justice is written into almost everything in our legal system. We have had experiences where during the course of an event we have a separation between the powers of the coroner, which are to inquire into the inquiry, and his role in public safety. He may be doing an inquiry or pre-inquiry or post-inquiry, but doing things using his public safety hat and talking to other associations or to other government departments, and bringing together the information that has occurred there is sometimes not in the best interests of natural justice — or could be perceived to be. Bringing together the public safety issue and the judicial issue is, I think, a very hard balancing act for the coroner, but I think it needs to happen in a more open sense.

The last two items we touched on were the items in relation to the coroner where we need clarity on contempt within the coroners system. The coroner has to bear in mind natural justice and the right of a court where there is contempt. There is clarity needed, and again I think a practice note is more important than changes to legislation, where things have been suppressed within the Coroners Court. As an agency we respect that suppression. However, some of them have been brought out in the press under other guises and our response to that could be seen to be in contempt of the recommendations of the coroner. Also, there is an argument that if we disagree with those recommendations, no matter what they are, that could be held to be a contempt of the coronial system. Whether that is true or not, that is an argument that could be had. Clarity in that contempt area is important for proper debate. During an inquiry I think the rights and judicial powers of the coroner obviously have to be respected.

There was discussion about taking legal privilege out of the coronial inquiry system but I understand it has not gone any further, so I do not think that last statement is now appropriate, unless that is being looked at.

The CHAIR — Abrogating the privilege against self-incrimination or the legal professional privilege for lawyers?

Mr BIBBY — The legal professional privilege. I was asked to be succinct, short and brief and I think I have touched on all the items I wanted to touch on.

The CHAIR — Thank you very much for that. Clearly you are very supportive of maintaining the jurisdiction of the coroner in relation to non-fatal fires. Prior to lunch we heard from the Volunteer Fire Brigade, which obviously has a link to your volunteer members, and it indicated that it would like to see that jurisdiction

placed with a more specialist body of independent fire investigation for non-fatal fires. Do you have any comments on that submission?

Mr BIBBY — I am aware of their issues in relation to the burden on volunteerism because with 60 000 volunteers in the organisation, to have volunteers called in for fire-related deaths, let alone those that are not fire-related deaths, adds an extra burden to volunteers who are not being paid. It also adds a burden if there are chances that there could be litigation against them. There are also decisions they make during the fire and if they are questioned at length about their professionalism. All of those things are right and appropriate to ask. They would be coming from a direction about the burden on volunteers who are effectively there to service the community on a volunteer basis and who see that as, 'I joined this job to fight a fire; I did not join this job for the consequences afterwards', keeping in mind they are held internally responsible for their actions.

The CHAIR — But would that not happen whoever is investigating a non-fatal fire? Whether it is a specially empowered investigation body or the coroner, there would inevitably still be that exposure in the public interest if something has happened and people think things might have gone wrong and they need to be investigated.

Mr BIBBY — I agree with you entirely. I understand why they put the submission in but the consequences become WorkCover, the Office of the Emergency Services Commissioner — somebody else doing the same thing. What they have a nervousness in is the judicial process. If the Office of the Emergency Services Commissioner undertakes an investigation, it is not a judicial process. I think that is where they have the nervousness.

The CHAIR — In relation to the whole question of the resources of the coroners office, one of the other issues raised was whether they would be better deployed doing things other than investigating non-fatal fires.

Mr BIBBY — I will give an example of outcomes from resources used. In the scheme of things one little \$10 smoke alarm is not big, but smoke alarms in 80 cent of houses around Victoria and around Australia are significant. Most of that was a direct result of coronial inquiries, fatal and non-fatal — there were two types. In Victoria most of it was a direct result of that under Hallenstein, so I have seen the outcome. The retrospective requirement for nursing homes to have sprinklers was a direct result of fatal and non-fatal investigations. Luckily for us in Victoria we do not have that many fatal fires, so if you left it to only the fatal fires in Victoria, the annual body of knowledge would be reduced.

I will talk about the nursing homes. Every two or three years we may have a nursing home fire where a person dies. We may have also five, six, seven or eight nursing home fires where no-one dies but where the consequences could be serious. Your body of knowledge diminishes if you wait for a person to die before you investigate.

Mr MAUGHAN — Just to extend that, why are fires but not other natural disasters — floods, earthquakes when we occasionally have them, and those sorts of issues — picked on for the Coroners Court to have a look at?

Mr BIBBY — You are relying on my sense of history here. I think it goes back to the Great Fire of London where the coroner had a responsibility then, and it followed from the British system into the Australian system. I think Victoria is the only state with that vestige of background on fire. Your argument is very logical. Currently we do not have anyone to look at those issues which are in the emergency management sphere, which are non-death related but have a high probability or a high consequence factor if something goes in another act. I suppose the workload of the coroner and what you get out of those things is the assessment that has to be made. Talking from a fire point of view, laying down the practical applications of that was where I was coming from.

Mr MAUGHAN — Your reason for supporting the coroner still looking into fires is because the coroner has got greater authority in terms of having those recommendations implemented as opposed to another body that is coordinating the resources of the various firefighting organisations?

Mr BIBBY — That is right. We have a fire investigation agreement — a MOU between agencies. That is really not the actual writing of the investigation. That is to stop the confusion on the scene at a fire where you have police, WorkCover, state electricity — all of those — coming in, so everyone knows what their roles and responsibilities are. That was a fundamental reason for putting that together.

The CHAIR — On the question of the expeditious — or otherwise — way in which the coroner investigates non-fatal fires, we have had adverse comment about some of the investigations and the time it has taken to conduct investigations in relation to the Macedon Ranges fires. Do you have any comment to make about the speed and the timeliness with which inquiries have been conducted into non-fatal fires?

Mr BIBBY — Fatal and non-fatal — I think it is both. Particularly in a volunteer organisation, the time that it takes for a person to give a statement so that the inquiry can start in some cases can be up to two or three years. In our organisation, in some cases this means welfare protection for that person building up to a crescendo in their eyes that is totally inappropriate to them as a volunteer coming into the organisation. I do not see, as happens in other courts, an ability to prioritise those issues which need to occur quickly. The coronial investigation process cannot happen overnight; many briefs have to be put together, but I think two to three years is too long, and I think that is a resourcing issue more than anything else.

The CHAIR — The voluntary fire brigade made comments about the bevy of lawyers, Queen's Counsel and other counsel who represent various interests at hearings and the intimidating nature of that. Have you got any views on the extent to which it becomes adversarial and there is judicial procedure brought to bear on it as if it were some other court, when in fact the role of the Coroners Court is to get at the truth, find out what happened and establish the facts so as to make recommendations to prevent it happening in the future?

Mr BIBBY — As you would be well and truly aware, one of the consequences of a coronial inquiry could be further litigation outside of that, so people are there to protect themselves. Yes, I have been there when the table has been so full of silks that you could not fit in edgewise. I think it is well and truly over the top. I have no idea how to stop that. If you have a solution, I think the government would be very pleased with the money we would not have to spend on that level. I do think, though, that narrowing the scope so everyone understands what the scope of the inquiry is, and with the briefs being written around that, would assist that process. At the moment it could be seen as a fishing trip. We have a brief which is this narrow but could be this narrow, and if there was a specific, black and white understanding of where you were going with the inquiry, the decision by people to take higher legal action may be diminished coming up to the inquiry.

The CHAIR — Would you support the abrogation of the privilege against self-incrimination for the purposes of coronial proceedings if it meant that a certificate was issued so that that evidence could not be used in subsequent proceedings? That is something that has been put to us on a fairly consistent basis.

Mr BIBBY — I would have to think at length about that, but I will give a personal view, because I have no corporate view on this. I would be nervous about changing a practice which is quite staid and has been in place for a fair time. There are other courts to deal with those sorts of legal things. I think having that sort of process could make it even more adversarial.

The CHAIR — Thank you very much, Neil. We appreciate your taking the time to come and speak to us today.

Witness withdrew.