

LAW REFORM COMMITTEE

Inquiry into Coroners Act 1985

Melbourne — 5 December 2005

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Commander Ian Hunter, fire investigation and analysis unit, Metropolitan Fire Brigade.

The CHAIR — We welcome to this inquiry Commander Ian Hunter, the manager of the fire investigation and analysis unit with the Metropolitan Fire Brigade. If you would like to present to us initially, and then we would like the opportunity to ask some questions at the end.

Overheads shown.

Cmdr HUNTER — Thank you. Essentially the MFB is interested in four sections: the coroners powers of investigation, assistance with coroners investigations, investigations and inquests into fires, and the role of the coroner in death and injury prevention. It is appropriate for me to give you a bit of a background as to what our fire investigation unit is. It was formed in 1983. It was the first unit of its type in this nation. The purpose of it was to determine the cause of structure fires that had previously been written off as undetermined. Undetermined fires were running at the time at something like 53 per cent — totally unacceptable to the state, totally unacceptable to insurers and unacceptable to the brigade.

Since the formation of this unit every fire service within Australia has established a fire investigation unit. We have been recognised internationally by fire investigation bodies, and our research work is sent around the world as well as interstate. We have been called on to assist with investigations interstate and to provide expertise and knowledge from our databases to assist interstate fire services and fire investigation units. As recently as this time last year one of my staff investigated a fire in Samoa, a \$9 million fire that had a massive impact on the economy of such a small nation. We have also trained investigators from interstate and overseas. As recently as two months ago the head of the criminal investigation unit in the South Island of New Zealand completed his training. It is a well-established unit. As part of my role as manager I am the chair of the Australasian Fire Investigation and Research Group, which is a working group of the Australasian Fire Authorities Council, the peak body of Australasian fire services. I am the chair of that group.

I must say at this point in time — and the reason for saying this will become apparent — that my fire service background goes back to 1964, when I joined the CFA as a volunteer in a busy rural brigade, and I subsequently transferred to a busy urban fire brigade. The two previous speakers referred to those two types. Then I joined the Metropolitan Fire Brigade. I have been in the fortunate position of being on all sides of the fence and certainly appreciate both services and their roles and their work ethics.

In terms of the coroners powers of investigation, we totally support the coroners powers of entry, search and seizure in relation to investigation and determination of the cause of fires. His powers, combined with section 71 of the Metropolitan Fire Brigades Act, provides a very strong nexus between the two pieces of legislation that solidify and consolidate what we can and cannot do as far as a fire investigation unit. I already have the power to take evidence, but there are times, if one gets into a head-butting situation, where sometimes the coroners powers provide a very strong backup and support.

In terms of assistance with coroners investigations, the MFB has provided specialist investigators to assist the coroner. As well as doing our investigation, we have provided specialists. Relative to Kew Cottages — possibly one of the greatest fire tragedies in Australia's history; it certainly rates with the likes of Childers — the MFB was able to provide fire engineers, building surveyors and structural engineers from our respective departments to assist the coroner in the deliberations relative to Kew Cottages. One of my staff is a specialised LPG investigator and highly qualified in the gas industry. He was called in to assist the coroner with the Longford explosion and fire. Following a series of riots and fires in prisons, we provided the expertise and the testing facility to investigate an issue of bedding fires within prisons. Prison mattresses, prison pillows — mainly the mattresses — were a prime source for prisoners to set a fire to cause a problem. We provided the expertise there. The Cranbourne LPG incident involved a car that had a major gas leak in it. It exploded and sadly a young lad died, and just as sadly other members of the family were horrifically burned and will never recover back to live a normal life. We provide the expertise.

Another role of my staff is post-incident analysis. While investigators determine the cause and origin of the fire, my post-incident analysis staff investigate a fire with a view to how the building behaved during that fire and how our active and passive detection and suppression systems worked. They look at it from the fire engineering perspective. We automatically provide the coroner with a post-incident analysis report and it is an extremely detailed document whenever a fire occurs in hospitals and public venues. The one I quote was the MCG scoreboard fire and the impact of that, because it was prior to the Sydney Olympics and they saw what happened — everybody saw what happened and the problems with that fire. The coroner was considering holding an inquest into that fire. It was not

fatal, but he was examining it pending our report. He was able to say, ‘I am not going to gather any further evidence by holding an inquiry’.

The CHAIR — I have just realised, it was a hotly contested cricket match!

Cmdr HUNTER — Yes, but there was the flow-on effect. The Sydney organising committee for the Olympics learned from this. It was public safety; it was public interest. The post-incident analysis report for any fires in any form of institution is passed on to the coroner. The coroner maintains a watching brief relative to fires and public safety, so we more than gladly assist him because he is such a valuable person to us.

Where we do have instances of a prolonged investigation, or where personnel may be assisting the coroner in a long duration investigation, it would be our preference that those persons be formally seconded to the coroners office for the duration. This would maintain their independence as individuals and it keeps it within the coroners office, particularly where the investigation involves other emergency service organisations or where it may be perceived that the MFB is operating in an area that might concern other organisations. It is a formal secondment, if you like, a ‘deputising’ of them, to the coroners office for that period. Also, from the brigade’s point of view, the benefit of providing specialist expertise far outweighs the disadvantages to the MFB when we are talking community safety, and it is the community we serve. It comes first and foremost.

Relative to investigations and inquests into fires, we totally support the coroners power to investigate non-fatal fires. We currently investigate non-fatal fires. What I think is inevitably missed or easily missed is that the coroner might investigate one non-fatal fire a year, and the previous speaker has referenced the Macedon Ranges fire. I talked to the coroners staff and they are all hard pressed — they have to track back in time — to find out when he last investigated a non-fatal fire because they are currently investigated by the fire services and by the police, and that is kept in the information circle where it is needed. The perception that the coroner will investigate all non-fatal fires is not correct. What we want to see is the power for him to investigate a non-fatal fire left in the Act. We do not want to lose it. It is a tool that is sitting there. It is a tool for the government as far as public safety goes. It is there. It would be a tragedy if we lost it.

The Coroners Act provides a high level means of publicising public safety issues. The fire services — the CFA and MFB — have spoken about childproof cigarette lighters for years. Something comes up in the Coroners Court and is reported in the media, which we can then support, and we have a good chance of success. A good chance of not achieving that is when it is left with the fire services, because the best you can do is virtually a media release, and all of us know that you can put media releases out, but the media does not necessarily publish them, or if it is not a newsworthy item compared to the other day’s events, it is not going to go anywhere. The coroner gives us the higher level of support.

Sprinkler systems in supported residential accommodation means total safety now. The prison mattress fire testing, as I said, we can go back to Jika Jika years ago; that fire was started using the prison mattresses supplied in the cells. A Jika Jika should never happen again from that perspective, so we are strong advocates for the coroner retaining the power, where necessary, to initiate an investigation or for a fire service to ask him to initiate an investigation.

Another issue is that coronial findings will influence change within a fire service that may not occur otherwise if the event was investigated in house. If I could use Linton, the MFB learned so much of Linton — another tragedy. Fire services around Australia had been talking for years about fitting low-level warning devices so that when your water tank got to a certain level, a bell, buzzer or siren went off.

They had all been talking about it, but when there are only so many dollars in the budget, and you have a fleet of maybe hundreds or a thousand vehicles, it is a high-cost item. The Linton finding showed there had to be a method of alerting everyone that someone is getting low on water, and the fire services picked it up. Now you will see a fire truck going along with red and blue lights on top, and also an amber light. That is the low level warning. The coroner provided the drive, the impetus to make change. Fire services certainly were not refusing to change, but in the grand scheme of things there are only so many dollars that can go around. It is a matter of priorities.

The coroner as an independent, external body can drive change within the fire service. The coroner can also drive it in the broader community. If you look at Coode Island, there were no lives lost, fortunately, but it led to the establishment of the major hazard facility registration — the registration for quality assurance and control on major hazard facilities.

School fires is another one. The coroner is currently looking at school fires. The cost to the community from school fires is phenomenal, and has been for many years. Another example is liquefied petroleum gas-powered vehicles. Following a series of fires involving these vehicles where people were injured — fortunately not fatally — the coroners findings led to the current situation where persons installing LPG systems in a vehicle had to be licensed. It came from the coroner. Various motoring bodies and fire services were saying there was no requirement to be licensed, but the coroner had the inquest and handed down the finding, and the recommendations were adopted.

As I said in relation to the Port Phillip Prison fires in particular, a series of them influenced not only the mattress testing but also the design of furniture and layout in prisons across Victoria.

The discussion paper refers to the West Australian and Queensland models. Talking to my counterparts in these states, in Western Australia, firstly, non-fatal fires, where there is a trend detected, tend to be investigated by the agencies — that is, the energy controller, the electricity regulators, the gas regulators and WorkSafe. In Queensland the power of the coroner to investigate was removed because — and this is a grassroots comment — for every fire that occurred, a brief had to be prepared for the coroner. If ever there were a way to tie up the coroners time, it was this. On a normal Saturday night in Melbourne there would be at least six rubbish bins set fire to down in King Street. That is a fact of life. If that happened in Brisbane, the coroner would have to receive a brief or report from the police on every one of those fires, and it would tie up the courts.

Victoria has a group of people who come together as a single unit in the investigation of fires. That is the group formed under Victorian fire investigation policy and procedures. It provides extremely clear, concise and simple protocols for the investigation of fires, based on the team approach. It provides the coroner with an expert team. The previous speakers are right — the coroner is not skilled in investigating fires. A Supreme Court judge is not skilled in investigating a homicide, but he will hear a homicide case. The coroner is not a pathologist, he has a team of experts at his fingertips; and that is what this policy provides — a skilled team.

The policy originated following the Coode Island fire, where the need for a policy was quickly identified by an MFB investigator and the policeman investigating for the coroner, because it was a public safety, public interest matter. They realised that we were all working in silos, independent of each other, duplicating each other's work for the same end result. The policy arose from Coode Island, which was a very successful investigation, jointly carried out by all players. If Victoria had not had this policy, it is more than likely that the Esso Longford fire would never have been successfully pursued and investigated.

At a time when there was a strong risk of key evidence and personnel absenting themselves from the country, the policy and the joint team approach was able to resolve that issue. I was not involved in that situation, but that is clear fact. On the team of subject-matter experts, just as the coroner might seek my assistance, I have been able to provide to him, as I said, a building surveyor, fire engineers, a risk engineer and structural engineers within the fire service. The coroner builds the team. He does not have to conduct the investigation, but the best possible information comes back to him.

The fire investigation policy is unique in Australia. We have had people from overseas approach us to see if it can be worked — from the United States and from England. The policy is tried and proven. It is almost like the Emergency Management Act. When the emergency services and the parties get together, all of a sudden it just starts running and that is it. The removal of the power of the coroner to investigate fires would have a major impact on the successful operation of this policy — there are no two ways about it — because he is the peak of it, if you like. We believe the combination of the coronial system, the policy and skilled fire investigators in all fire services negates the need for the creation of a new entity. We do not support that.

In terms of data analysis, through the Australasian Fire Investigation Research Group, the national body, we share data daily. Data is no longer an issue. In the case of a series of ceiling exhaust fan fires recently in an aged care facility, by the end of the day I had feedback from every state, and we identified a problem with a particular fan and it resulted in a national product recall. That is how good our data sharing is. Possibly if we have a fault it is that we do not market ourselves and we do not tell everybody how good it is.

As far as death and injury prevention are concerned, finally, we totally support the coroner in this role. Kew Cottages led to safer accommodation and care for vulnerable members of the community. What could be more important? The Mistral fans episode started in Melbourne with data held by the MFB and then supported by data from the CFA and interstate fire services. It resulted in a national product recall. Computer monitors — again there

was a national recall coming from this data that exists. We now deliver numerous public education and fire safety campaigns as a result of coronial findings. Two campaigns are of particular benefit — retire ed, which is education for retired persons; and the isolated elderly program, which is a way of firefighters getting out there and talking to the people who live in your suburb but who no-one even knows exist.

We also have the juvenile fire awareness intervention program for recidivist, firelighting children, and this comes from the coroner. That is the main thrust of where the MFB sees its immediate relationship with the coroner and the Coroners Act. I thank you very much for your time, ladies and gentlemen, and I am happy to answer questions.

The CHAIR — Thank you very much, Ian. I suppose I should pose the devil’s advocate question to you, as we did to the Victorian Volunteer Fire Brigades representatives: why not set up a specialist fire investigations body whose job it would be to investigate non-fatal fires? Why not create a critical corps of expertise whose sole job it is to look at the causes and collect all the data that flows from the various non-fatal fires around Victoria?

Cmdr HUNTER — I would suggest to you that that already exists via the bringing together of all parties under the policy and procedures. All the parties are there — the Cranbourne LPG car fire and fatality, that was the MFB, the CFA, forensics, the arson squad. It was a joint thing. Both services have the people who work together. As recently as yesterday my staff and Country Fire Authority investigators took part in a wildfire skills maintenance training day. It happens. It already exists. It was mooted some years ago by the MFB to the CFA that maybe we could have a joint office. Unfortunately that did not grow very strong legs, partly because there were some industrial issues that would see volunteers precluded and partly because the volunteer associations had concerns about it, with Big Brother overseeing their activities. It was an interesting concept. I am quite pleased to hear the CFA people now supporting it, but I believe the entity exists.

Mr MAUGHAN — There is no doubt the organisations are working very well together. I suppose the question is the time before the conclusion is drawn, when it goes through the coroners office. The argument of previous witnesses was that you would get a conclusion out to the community sooner if you had a discrete unit rather than going through the coroners office. Do you not think that there would be some benefits in getting those conclusions out to the community sooner than we currently do through the coroners investigation?

Cmdr HUNTER — This is a yes and no answer. If I am doing an investigation on the basis of expediency, I get very concerned, because I begin to doubt the quality of the investigation. I know the amount of work that has been put into researching the line-side fires in the Macedon Ranges — unfortunately we are not talking as simplistically as determining the cause of the fire and telling people what caused the fire. We are talking about the long-term, big picture, the major issues that flow on to the community. Investigations do not happen overnight — we know that. One only has to look at the court lists. The Coroners Court is not unique in having an extended period of time from the event to the date of inquest. Any court list shows you the same thing.

I will choose my words here: the ultimate aim is to be able to protect the public, and that should not be put at risk for the sake of getting something out there as quickly as possible. The realities are that everybody knew what the outcomes of Linton were. Prior to the investigation into the Macedon Ranges railway line-side fires everyone knew what the issues were. Agencies are being proactive and landowners became proactive because they could see the problem. The inquest is actually, I suppose you would say, the closing act of the event. It is the formal examination of the facts and the handing down of findings. But in this day and age in the state of Victoria my dealings with agencies show that they are proactive. They realised, ‘This was a shortcoming, a gap, in our work practice or the way we do business. It has been identified. Let us be proactive and do something now’. Agencies in Victoria today, I believe, do not wait for the closing act or for the curtain to come down before they do something, so I do not believe the delay in reaching the inquest is a significant issue. The important thing is for agencies to do something about the issues, which they know — they know what the issues are — to do something about them then and not sit on their hands until we have the inquest.

The MFB had an incident that to our people was just as traumatic as the Linton fires were to the CFA volunteers. It was an industrial accident in which a young man died on CityLink while it was being built. The MFB believed it did everything right, but as the investigation proceeded we realised we had some serious shortcomings, and the board of the MFB made it an absolute priority to ensure that this would never happen again, that we would have new, revised work practices so this would not happen again. We did not sit down and wait for the court case or the inquest to be finished, which was some two years later. Be proactive; once you know what the issues are, do something about them. Do not wait for the inquest - time is not a great factor.

The CHAIR — I think what has been quite valuable in your submission is that you have brought to our attention a whole range of other fires which are not bushfires where the coroner has had a role in investigating their nature and causes. You have talked about the Mistral fire and another where there may or may not have been deaths. But even where there have been no deaths, there has been an investigation of what is causing a series of fires. That has been quite useful. Are there any other questions?

Ms BEATTIE — Would you like to see more power behind the coroners recommendations? Do you think those recommendations should go to government and there should be a report back to the coroner, because at the moment that does not really exist?

The CHAIR — Mandatory response.

Cmdr HUNTER — Yes. These are Ian Hunter's thoughts from a personal perspective: at this stage I would like to see the coroner be able to have his recommendations pursued. The coroner can make recommendations, but if a body to which those recommendations are directed elects not to follow them up, especially in matters of public safety, I have a concern. So from that point of view I would like to see recommendations handed down by the coroner able to be proceeded with through the legislative process and followed up. The coroner has some very good successes. As recently as last week I received a letter from VicRoads, it is a copy of a letter sent to all licensed roadworthiness testing centres. At the time of the Cranbourne car fire the only requirement on an LPG-powered vehicle was, when you went for a roadworthy, to ensure the cylinder was within its test period. Now this car had been passed as roadworthy with the gas leak present and a home-made installation, but there was no requirement to do anything about it.

Fortunately, as a result of Coroner Byrne's inquest, VicRoads has now addressed the issue and has sent out a new standard for conducting a vehicle roadworthiness check on an LPG-powered vehicle. VicRoads picked that one up, but it would be fair to say there would be other recommendations coroners have made in the past where an agency has elected not to pick it up and not to implement change. I would certainly like to see the coroners recommendations able to be moved to another level with a view to introducing change and protecting the community.

The Mercy Hospital on Christmas Day last year was another one. You mentioned the other agencies, the other fire services. The coroner was waiting on our post-incident analysis report and, possibly holding an inquest into that. That was a small fire in effect, a small electrical fire with building issues and various other matters, but it impacted on the state. Where do you put 53 babies in humidicribs? Visualise the demand on the rest of the hospital system. It had a serious impact from what was in effect a very small fire. The coroner was waiting for our research and our report on that. He was satisfied that all evidence had been gained and nothing further would be gained by this. We look at anything and everything.

The CHAIR — We appreciate your taking the time to come and speak to us today and thank you very much for your submission.

Cmdr HUNTER — Thank you for the opportunity.

Witness withdrew.