Introduction

This paper was delivered at the Safer Sustainable Communities Australian Disaster Conference in September 2003. It addresses the significant changes and understanding about the law that applies to emergency management during the last ten years. A decade ago emergency service organisations (“ESOs”) were rarely sued, rarely questioned and rarely thought to be affected by legislation such as Occupational Health and Safety Acts. Today the situation is infinitely more complicated. On the one hand there is a move to codify and simplify the law of negligence, which will probably reduce the potential liability for ESOs attending emergencies. However, as discussed below, changes in both the law and in community expectations have increased the legal responsibilities, liabilities and the legal scrutiny of ESOs.

These changes reflect the themes of the Safer Communities conference. First it can be said that community safety is everybody’s business: even the lawyers and the courts. Secondly these changes can be said to affect or even threaten the sustainability of ESOs, particularly those that are reliant on volunteers.

Scope of this paper

This paper will examine some of the changes in the law as it applies to ESOs. It will also look at how changes in community expectations have influenced the degree of judicial and quasi-judicial scrutiny of ESOs. Finally it will examine the steps that ESOs and government bodies involved in emergency management can take to address these changes and to prepare themselves for litigation and legal inquiries.

It is not the intention of this paper to address counter-terrorism responses or incidents.

A comparison

During the Ash Wednesday bushfires of February 1983, thirteen volunteer CFA firefighters lost their lives in a single incident, whilst fighting a fire in Upper Beaconsfield in Victoria’s urban-rural fringe. The inquest into their deaths was held nine months later. The volunteer firefighter who was responsible for the initial deployment of the firefighters, was the primary witness called at the inquest. He commenced giving his evidence at 11.43 am on the 4th of November, 1983, and concluded at 4 pm. on the same day. Only four other witnesses were called to give evidence about the circumstances leading up to the entrapment.

These firefighters lost their lives whilst on the eastern flank of the fire when the wind changed direction. Serious questions were raised regarding how much information they had been told about the wind change and whether they received crucial radio messages. There were two trucks involved in the entrapment and the theory was that the first vehicle stopped or stalled leaving the inhabitants of the second vehicle helpless.

In contrast in December 1998, again in Victoria, five volunteer CFA firefighters lost their lives fighting a fire at Linton, near the city of Ballarat. In many ways the circumstances of the two tragedies were similar. These fire-fighters were on the eastern flank of a fire and were travelling in a tanker which was following another tanker. The first tanker stopped and shortly afterwards the wind changed. The firefighters in the first tanker survived and had sufficient water to use a fog spray. All the firefighters in the second tanker perished. Similar questions to those raised at the Ash Wednesday inquest arose. Of particular concern was whether important wind change radio messages were received.

The inquest into the Linton deaths commenced 20 months later in July 2000. It was concluded a year later, after 98 sitting days. During this time the court received evidence from 175 witnesses, 94 of whom gave their evidence orally to the Court. 15 major witnesses gave evidence in relation to the entrapment, each witness taking between 3 and 8 days to complete their evidence.
In a similar vein we can compare the legal inquiries into the 1939 bushfires and the 2003 bushfires in Victoria. After the fires on 13 January 1939 the Stretton Royal Commission was appointed. The Commission sat between 31 January 1939 and 17 April 1939 and produced a 36 page report by mid May 1939.

The 2003 Victorian fires burned for 57 days in much the same area. The Victorian Government appointed an inquiry team headed by the Emergency Services Commissioner in March 2003. That inquiry team has received 270 submissions and reported in October 2003. Members of the affected communities also asked the Victorian Coroner to conduct an inquest into the fires. The Federal Parliamentary Inquiry looked into the Victorian fires and has received over 470 submissions.

This comparison demonstrates both the increased scrutiny and the increased complexity that come with the modern inquiry into a disaster. This complexity arises in part because of the ever increasing complexity of the law as it applies to ESOs.

Sources of legal obligations
There are numerous potential sources of legal obligations for ESOs and some of these are examined briefly below.

Negligence
There have been significant developments in the law of negligence over the past decade and these have particular implications for ESOs protecting vulnerable communities. The law of negligence with which you are likely to be most familiar with creates a duty of care to prevent possible harm arising from one's acts or omissions.

In the case of statutory authorities and government bodies the law of negligence can also apply in relation to the exercise of statutory powers and functions. Most ESOs have broad powers and functions which enable them to carry out prevention work and to protect the community. Increasingly courts have held that the failure to exercise such powers and duties, where such powers exist, can amount to negligence.

This particular area of the law of negligence has been said by Justice Kirby on the High Court of Australia ‘to be amongst the most difficult [both for] judges and scholars’ and is ‘conceptually unsettled’. Kirby J has also said that the Court needs to establish a universal principle or approach to give guidance to the community on this matter. It is not the intention of this paper to attempt to summarise the law in this area. About the most that can be said is that an authority may have a responsibility to use the powers conferred on it by government if it knows, or should know, that the exercise of these powers may address a risk for vulnerable persons who may not or cannot take action to protect themselves. The High Court has often identified fire control as one issue likely to attract such a responsibility.

The courts will consider the following factors when determining whether a body owes a duty to use such a power:

- Whether or not the exercise of the power could have prevented the damage or injury complained of;

The High Court has often identified fire control as one issue where the law of negligence can apply in relation to the exercise of statutory powers and functions.

- The extent of the control exercised by the relevant body;
- Whether the power is held exclusively by one body or whether it is shared with other bodies;
- Whether the body concerned has acted to create or increase the relevant risk;
- The ‘nature’ of the power;
- The degree of risk involved;
- The relevant body's knowledge of the risk of damage or injury;
- Whether the persons concerned are involved knowingly in risky activities;
- Whether it is ‘fair, just and reasonable’ to require the body to exercise the power in question;
- Whether the power can be said to have been granted to address a specific risk, such as fire;
- The extent to which the individuals or classes of people at risk understand or recognise the relevant danger and whether or not they can act to reduce that danger;
- Whether a decision about the use of a power was made for administrative or technical reasons or whether it was a policy decision. The latter is less likely to attract liability;
- Whether the exercise of the power will benefit particular individuals or classes of people or the public as a whole. The latter is less likely to attract liability;
- Whether the body has exercised the powers in the past. An authority is more likely to be liable if it uses the powers from time to time rather than if it makes a policy decision never to use the powers;
- The size, resources and the competing demands of the body.

In essence this means that if you are a government body, with powers to inspect or fine in order to ensure compliance with the law and you fail to use those powers you could, potentially, be found negligent. In the context of disasters this may mean that you are found negligent for failing to act to prevent an incident at a major hazard facility or a failing to conduct a flood analysis.

**Occupational Health and Safety (OH&S) legislation**

The OH&S legislation that applies to various ESOs and government bodies differs across states but in general it imposes duties on employers to prevent risks to both employees and others to the extent that this is practicable. For some time it was thought by some in the emergency management community that such legislation did not apply to ESOs. It is fair to say that this assumption was a fallacy. OH&S legislation will generally apply to ESOs and imposes duties in relation to employees, volunteers, other ESO personnel and anyone else who may be at an emergency, including members of the public. The extent of the duty is the crucial question and it is not always clear in hindsight what was “reasonably practicable” in an emergency.

Further it can be said that the traditional hierarchy of controls that apply to reduce OH&S risk is not necessarily suitable for managing OH&S risks at emergencies. The traditional hierarchy of hazard management is:

1. Elimination—controlling the hazard at its source.
2. Substitution—replacing a substance or activity with a less hazardous one.
Corporate Governance

It should be remembered that many of the board members of ESOs who are statutory authorities have corporate governance responsibilities. The Chairman of ASIC, David Knott has described these corporate governance responsibilities as the “mechanisms by which corporations are directed and controlled and the mechanisms by which those who direct and control a corporation are supervised”. They are duties of the highest order and breach of them is taken to be a very serious matter.

The most important duty to focus on in the context of disasters are the requirements for board members to act in the interests of the organisation and hence the public, rather than on behalf of any other constituency. In the case of a representative board this is often not understood, with board members advocating the agenda of their stakeholders in the board room. It is conceivable that the actions of board members may be subject to scrutiny following a disaster and it is important that this important fiduciary duty has not been breached.

Judicial and Quasi-Judicial Hearings and Investigations

There are a number of different bodies that have jurisdiction to investigate the actions of ESOs after disasters, including the police, OHS investigators, Coroners and Royal Commissioners.

In particular Australian coroners also have broad powers to investigate and hold inquests into deaths. Further, all states, bar the Northern Territory and Western Australia, allow for the Coroner to hold inquests into fire, even where no death has occurred. It has not been determined whether the Coroner’s power is to investigate the circumstances of a fire generally, or whether a Coroner can look specifically at all aspects of the fire suppression.

The role of ESO personnel at inquests has traditionally been to assist the Coroner in finding out how a disaster unfolded, why people died and in making recommendations for the future. This role has changed over time and ESO personnel are now increasingly required to justify their actions against real or possible criticisms. Further, in a number of states the Coroner has the power, and often the obligation, to report to either the Director of Public Prosecutions or the Attorney General if he or she believes an indictable offence has been committed. This means that coroners have the power to refer matters to the DPP if they

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3. Engineering—the installation of a protective device such as guards on machinery.
4. Administrative—policies and procedures for safe work practices.
5. Personal Protective Equipment— clothing, eye protection, helmets, respirators, ear plugs, etc

In many disasters personnel cannot eliminate a hazard at its source and must rely on PPE and safe working practices as their primary safety controls. The Victorian State Coroner recognised this during the Linton Inquiry and recommended a rethinking of the hierarchy of controls for emergencies. It will be some time before any such changes makes it way down to the OH&S investigators and inspectors across Australia and ESOs can expect that there may be some confusion and misunderstanding when dealing with these personnel when investigating incidents.

Proposed Industrial Manslaughter legislation

There has been a move in some states to introduce Industrial or Corporate Manslaughter legislation. This has been met with some resistance and fear by ESOs. Currently this crime is governed by the common law. A body corporate will only be guilty of manslaughter if the individual guilty of manslaughter can be “identified as the embodiment of the company itself”.

Victoria was the first state in Australia to attempt to introduce specific legislation in relation to Industrial Manslaughter, the Crimes (Industrial Manslaughter) Bill. The proposed Victorian legislation would have created the offences of corporate manslaughter and negligently causing serious injury by a body corporate. It would have also imposed criminal liability on directors and senior managers of a body corporate (’officers’). The penalties for officers included imprisonment for up to 5 years or a fine of $1.8 million. This bill failed to pass the Upper House. It is not clear whether there will be another attempt to introduce the legislation.

Contracts and outsourcing of functions

The increased outsourcing of key government functions in the emergency services field such as call taking and dispatch imposes a new set of contract management and audit functions on ESOs who may still maintain the statutory responsibility for the function. As demonstrated during the Victorian Metropolitan Ambulance Service Royal Commission, a failure to properly execute those powers can have serious consequences.

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4. Bennetts v Board of Fire Commissioners of New South Wales and others (1967) 87 WN (Pt 1) (NSW) 307.
5. Coroner’s Act 1985 (Vic) s.15, Coroner’s Act 1997 (ACT) s.15, Coroner’s Act 1980 (NSW) s.15, Coroner’s Act 1998 (Qld) s.8, Coroner’s Act 1997 (NT), section 18, Coroner’s Act 1995 (Tas) s.12, Coroner’s Act 1995 (Vic) s.31.
6. Queensland Fire and Rescue Authority v Hall Coroner @ Gatton & Anor [1998] 2 Qd R 162.
7. Section 58 Coroner’s Act 1997 (ACT), section 19 Coroner’s Act 1980 (NSW), Section 3(3) Coroner’s Act 1997 (NT), section 47(4) Coroner’s Act 1995 (Tas), section 27(5) Coroner’s Act 1996 (WA), section 21 and 38 Coroner’s Act 1985 (Vic).
believe there has been a breach of any criminal legislation. In Queensland, the coroner’s power goes further under section 41 of the Coroners Act 1958. If the coroner believes that there is sufficient evidence he or she may commit persons for trial on particular crimes. This dual role of the Coroner at inquests means that ESO personnel should be advised of the Coroner’s powers. Whilst it may seem unlikely to an ESO that their personnel could be criminally liable, it is important that they understand the potential for action against them if they are required as a witness.

Changes in Society

There have also been significant changes in society’s attitudes over the past decade which have affected the legal position of ESOs. Firstly it is probably fair to say that there has been increased media interest in disasters. They are no longer accepted as a fact of life and the media plays an important role in keeping ESOs and government accountable. Secondly, community expectations are higher. The community want to be kept safe and want or demand to be given timely and accurate information, especially in the midst of a disaster.

Further, the increased focus on the PPRR (“prevention, preparation, response and recovery”) spectrum by ESOs has, in turn, led to an increased focus on the legal responsibilities of ESOs across that spectrum. ESOs are now considered more accountable for prevention and preparedness than at any stage in the past.

Finally, there has been an increase in the concern amongst ESO personnel about their statutory immunities and whether or not they might lose the family home following some emergency. As one volunteer firefighter told the Federal Inquiry recently:

“I agree wholeheartedly that the Linton inquiry has definitely put the wind into everybody. Unfortunately, the way the law operates today, if you do something and it goes wrong, you know you are going to cop it—so you don’t do it. People have got the wind up.”

All of these changes have led to perceived and actual fear about the extent of legal liability that may rest with an ESO or its people after an incident.

Applying a risk management approach to legal issues

One approach to identifying legal issues that may affect your ESO is to adopt a risk management approach. In short this involves:

1. Characterising the hazards—this means knowing and understanding the relevant law. This may be a matter of you receiving legal advice.
2. Establishing the community profile—this may involve asking what your people, your stakeholders, your community and your regulators expect from you. What standard are you required to comply with?
3. Determining your vulnerability—this means knowing in what areas you are unable to comply with the law or meet the relevant standards.
4. Analysing risks.
5. Evaluating and ranking risks.
6. Identifying and evaluating treatments.

You should be aware that any documents created during such a risk management audit might become publicly available through a Freedom of Information request. If you are concerned about this risk you should discuss this with your lawyers.

Applying a PPRR framework to legal issues

An alternative means to avoiding legal liability is to use the PPRR framework to develop an action plan to address legal risks. The advantage of this model is that it will be familiar to many in your ESO and encourages them to think about legal risk as just another risk or event rather than as a special and bewildering area of concern.

Prevention

There is much that your organisation can do to prevent findings of legal liability. The most important thing is to ensure that prevention measures are understood and ‘owned’ across your organisation and don’t just sit with legal officers or corporate secretaries. An organisation-wide approach is likely to pick up on a number of areas of non-compliance and will likely make the introduction of change much easier. Among the most practical preventative measures you can adopt are:

- Conduct an audit of your legal responsibilities under all relevant legislation and compare these to your operational policies, standard operating procedures and training documents.
- When making decisions about when you will use statutory powers to address risks make these decisions at a policy rather than operational level. Have your governing body sign off on your approach to these matters.

• Educate the community about your responsibilities and capabilities—ensure that they do not have unrealistic expectations about what you can do to protect them.

• In a similar vein do not use ‘motherhood’ statements to describe your programs or operational response—you can be criticised to failing to meet the high standards you purported to have.

• Keep a library of findings from inquiries into similar ESOs and learn from the outcomes and recommendations of those findings.

**Preparedness**

For most ESOs legal scrutiny should be taken as a ‘given’, that is you can expect it at some time or another. As such you should institute measures now to ensure that you are ready to respond if and when your organisation faces such a challenge. As part of these preparations you should:

• Develop a relationship with and educate relevant bodies and personnel about your organisation. Coroners, Police, Politicians and the Media may not understand how your ESO works and this may hamper any investigation into your ESO. You may need to explain:
  – The emergency service culture and (if relevant) your volunteer culture
  – The challenges and changes faced by your ESO.

You should consider how you communicate this. Do you invite them to participate in a special training course or do you include them in a mailing list for your annual reports and magazines?

In a similar vein you should consider whether your lawyers understand your ESO. They may have to advocate on your behalf and they should be able to do so effortlessly, that is as if they themselves turn out on the trucks or in the ambulances.

• You should have a detailed crisis management plan to deal with a legal investigation into an emergency. Such a plan is most important and should identify trigger points for the activation for your investigation/crisis management team (including your lawyers and your media team).

• Have a policy on legal representation for your personnel stating what support you will provide them with and what you will do when there is a legal conflict of interest that prevents your lawyers from representing them.

• Conduct training for your personnel in legal issues such as the identification and preservation of evidence and the rules concerning dealing with witnesses.

• Know the powers of the Coroner/Police and the limits on their powers so that in an emergency you are not compromised in your operational activities by these regulators.
Have a written policy setting out what debriefs are meant to achieve. As a lawyer acting for ESOs, I have frequently had to explain that debrief minutes are not an “official record” of an incident and may contain inaccuracies. It can be difficult to explain that the rules of a debrief may prevent someone challenging an inaccurate statement or comment.

Response

In the immediate aftermath of an emergency, particularly one where there has been loss of personnel or devastation of a public facility, it may seem odd that you would call in media consultants and lawyers immediately. There is often great resistance to doing so as many in management want to actively manage the situation themselves.

However, it is often the case that your ESO may have little practical control over such a situation, particularly if external regulatory or investigative bodies are called in. The fact that you might normally have a friendly and collaborative relationship with these bodies can make the situation more complicated. It is never too early to call in your lawyers and media consultants. Their role is help you understand what matters might be outside your control and to help you manage the situation as you want to.

Any legal crisis response should be developed with your ESOs specific needs in mind. However it is possible to set out a few general guidelines.

Your investigation

- Ensure that you can conduct your own investigation and debriefs. If you plan to hold your own investigation, say so publicly and get the terms of reference cleared by your lawyers.
- Consider very carefully whether you will participate in multi-agency debriefs and investigations. In serious situations many ESO personnel and managers will be scared about their own reputations and careers.

As such you may end up with a compromised investigation report that reflects the fears and concerns of those involved rather than one which is accurate and has integrity.

- If you are getting legal advice then many of your documents will be protected from disclosure by the doctrine of legal professional privilege. Ensure that you understand what this means and that you don’t inadvertently lose that protection through your actions.
- Consider having your lawyers engage external consultants as this may have tactical advantages in subsequent litigation.
- If you have set up an investigation team, you should ask your lawyers to train team members in:
  - legal professional privilege;
  - dealing with witnesses;
  - note taking and use of log books;
  - admissions;
  - natural justice;
  - OH&S;
  - contempt of court; and
  - the Coroner's jurisdiction.
- You should give careful consideration to whether potential witnesses to any hearing should be on the investigation team. Think about:
  - Which members of management may be called as witnesses?
  - Are you compromising them through a perceived conflict of interest?
  - Can they be objective?

- Provide timely and accurate information about legal issues and investigations to relevant stakeholders:
  - Organise meetings with all witnesses to explain the investigative/inquest process—have your lawyers present to ensure that the legal issues are explained appropriately.
  - Enlist the support of any relevant stakeholders/volunteer leaders who may be outside the process.
  - Establish links with the legal representatives of any family of a deceased person.

Information Management

- Preserve evidence including all notes/paperwork from all relevant witnesses.
- Inform your insurers about any possible claims.
- Control statements to the media and ensure that all media enquiries are fed through one source. Get legal clearance on all media releases.
- Avoid speculating to the media about possibilities as this may colour subsequent reporting and any external investigation of events. Also consider the effect of media statements on potential witnesses. Ensure that your media comments do not void your insurance policy or place your ESO in contempt of court.
• Log all conversations with police/coronial investigators and remember that there is no such thing as an “off the record” conversation.
• Dedicate one person to collecting all press and media reports about the event.

People management
• Consider whether or not any staff/volunteers/witnesses should be warned about self-incrimination and whether there are any actual or potential conflicts of interest between your ESOs and your staff/volunteers/witnesses.
• Talk to CIS about their role and the potential (unlikely as it is) that they might have to give evidence about what witnesses to the event tell them about it.
• Remember log book notes of conversations with witnesses could be evidence so record all conversations accurately.

Response Management
• Co-ordinate all aspects of preparation in one body (such as a Steering Committee) and keep your lawyers, media personnel and HR personnel involved/active across all areas.
• Work out what you want to achieve through your investigation and participation in any legal hearing and then work out what you can realistically achieve.
  – Clearly enunciate your position to government so that it is reflected in any ‘whole of government’ position.
  – Consider strategy—should you ‘fess up’ to mistakes early or defend yourself against allegations until they are proven/explained.
  – Consider how your strategy will affect your ESOs credibility?
  – Consider what your position says to your staff, volunteers and stakeholders?
  – Consider and implement any necessary changes to policy/procedure immediately.

Recovery
In the aftermath of some sort of legal scrutiny you should have a recovery plan. This plan should include provision for the following:
• An audit of the recommendations and issues arising from legal investigations and findings.
• Communications strategies for the community, for stakeholders and for staff and volunteers. Remember that in the aftermath of a legal hearing secrecy can breed paranoia.
• Ongoing support for affected personnel. This may continue for many months or years.
• A strategy to work with relevant stakeholders and government to address issues arising from the hearing or investigation.

What to expect in the next 10 years?
It is difficult to engage in crystal ball-gazing in this area because there are so many political, social and legal issues involved. ESOs should expect that there is not likely to be any reduction in legal scrutiny directed at their performance in the near future. Indeed public scrutiny of ESOs is likely to become more sophisticated with an increased focus on systems, accountability and audits. There will also be an increasing presumption that inter-agency compatibility issues are a thing of the past and have been resolved. It is likely that there will be increased expectations of volunteer organisations and that an OH&S doctrine applicable to emergencies will be developed further.

Hopefully Australia’s ESOs will also become more sophisticated in addressing legal risks and ensuring that they are adequately prepared to deal with and prosper from such increased legal scrutiny.

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