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RESTORATIVE INQUIRIES AND NATURAL DISASTERS

Symposium report

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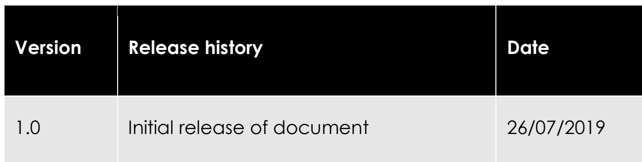

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ACKNOWLEDGMENTS

This is a report on a forum hosted at the Univeristy of Newcastle as part of the *Newcastle as a Restorative City Symposium*. We acknowledgte the assistance of the University of Newcastle School of Law. I also thank Nicole Harman from the ANU College of Law Marketing and Outreach unit for her invaluable assistance in bringing the forum together. Thank you to the Bushfire and Natural Hazards CRC for funding the workshop and finally thank you to the speakers – Euan Ferguson, Ivan Pupulidy, John Braithwaite, Anne Leadbeater, Roger Strickland, Tammy Garrett, Iain Mackenzie and special guest Professor Jennifer Llewellyn.

EXECUTIVE SUMMARY

In October 2016, the Policies Institutions and Governance of Natural Hazards research project released a discussion paper on 'Learning for emergency services, looking for a new approach'. As a result of feedback on that paper a forum was held to discuss the use of restorative practices in post event inquiries.

This forum, held at the Universtiy of Newcastle, identified that:

> Communities and people need to be at the centre of the process. Those affected need to be involved in designing the process and taking responsibilities for implementing the learning. In traditional inquiries the inquiry decides what is important, makes meaning from the evidence and hands down its recommendations to others. It does not have responsibility to implement the recommendations and the findings may not be about what matters to those involved.

This report summarises the presentations and their findings to stimulate agencies and governments to think about alternative ways to conduct post event inquiries.

BACKGROUND

As part of a research project funded by the Bushfire and Natural Hazards Cooperative Research Centre, Professor Stephen Dovers and Associate Professor Michael Eburn conducted research on post-event inquiries. They identified that adversarial proceedings that have been adopted in past inquiries come at a great cost to the agencies involved, and in particular their volunteers and have limited capacity to produce useful learning.[1]

On 13 June 2018, the Australian National University's College of Law hosted a one-day forum to consider the question - can agencies and the State reform post event inquiries by using restorative practices to allow all those involved to tell their story and to allow communities to understand what happened and, collectively determine how they will manage future risk? The Forum was run in conjunction with the University of Newcastle's *Newcastle as a Restorative City Symposium* and with financial support from the Bushfire and Natural Hazards Cooperative Research Centre.

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1 Eburn, M. & Dovers, S. *Discussion paper: Learning for emergency services, looking for a new approach*. (Bushfire and Natural Hazards CRC, 2016).

WHO THE WORKSHOP WAS FOR

This workshop was intended for members of the emergency services. The dworkshop would allow practitioners to hear about alternative ways of learning and consider how the emergency management community might start the process to encourage more restorative learning in the future. Each member agency of the Australian Fire and Emergency Services Authorities Council (AFAC) was invited to send representatives to the forum. Whilst the forum itself was free of charge, agencies had to meet the cost of sending their volunteers or staff to Newcastle.

The workshop was offered as part of the *Newcastle as a Restorative City Symposium* to encourage restorative practice practitioners to attend to inform the discussion and identify ways that they may be able to assist the fire and emergency services and the communities that they serve to learn from events without the learning process causing further harm.

SPEAKERS

The workshop heard from:

1. Euan Ferguson former Chief Officer of the Country Fire Service in South Australia, Chief Officer of Victoria's Country Fire Authority and chair of the *Inquiry into the January 2016 Waroona [Western Australia] Fire;*
2. Ivan Pupulidy, Director of the US Forest Service Office of Innovation and Organisational Learning (Ret'd) who presented (via pre-recorded video) on the 'Transformation from Blame to Learning' within the Forest Service;
3. Dr John Braithwaite from the Australian National University's School of Regulation and Global Governance (RegNet), a recognised world leader in the development of and implementation of restorative justice practices;
4. Anne Leadbeater, community leader who rose to prominence after the 2009 Black Saturday bushfires in Victoria and is now a recognised expert in community recovery;
5. Roger Strickland and
6. Tammy Garrett from Victoria's Country Fire Authority on the implementation of the 'learning review' with the CFA;
7. Iain Mackenzie, Inspector General Emergency Management (IGEM), Queensland on his approach to inquiries and what all agencies can gain from inquiries for continuous improvement across the entire PPRR spectrum; and
8. Professor Jennifer Llewelyn, Schulich School of Law, Dalhousie University, Nova Scotia Canada. Professor Llewelyn was the forum keynote speaker and reported on the implementation of restorative practices in the course of the:
    - Halifax Black Firefighters Association Human Rights Claim for Systemic Discrimination;
    - Dalhousie Faculty of Dentistry Facebook Incident – Campus Harassment Complaint;
    - In-Custody Death of Jason LeBlanc; and
    - The *Nova Scotia Home for Colored Children Restorative Public Inquiry*.

The forum concluded with an open forum to consider how restorative practices may be used in inquiries within the fire and emergency services communities, whether they are looking into local incidents and near misses or catastrophic disasters.

DISCUSSION AND THEMES

Themes that came from the presentations and discussion are:

1. Restorative inquiries focus on relationships and interconnections across all affected stakeholders.
2. 'Blame is a wasted emotion'. To move away from blame their needs to be recognition that everyone involved in an event is affected by that event and everyone has responsibility for helping to identify why the event is important and what the event means for the future. The people who were there and best placed to decide what is important.
3. Communities and people need to be at the centre of the process. Those affected need to be involved in designing the process and taking responsibilities for implementing the learning. In traditional inquiries the inquiry decides what is important, makes meaning from the evidence and hands down its recommendations to others. It does not have responsibility to implement the recommendations and the findings may not be about what matters to those involved.
4. Telling stories – the re-story – is important. People learn from stories. People access other people's perspective from stories. Do not aim to produce 'the' official story of what happened. There are multiple stories and perspectives that need to be told and heard.
5. Focus on human systems.
6. Be intentional. If you want a restorative inquiry it has to be designed that way from the start. Involve everyone in the process. Ensure that people understand that their participation matters and show how it matters. It matters if their participation leads to change and understanding.
7. In order to move forward agencies have to start internally. With the next internal review or near miss adopt a restorative approach. Build a base of knowledge and experience from smaller events to use when the next big event occurs. Identify champions within the judiciary, the bureaucracy and government.

THE PRESENTATIONS

Euan Ferguson[2]

Euan Ferguson was asked to comment on what's good and what's bad with the current inquiry model. As a former Chief Officer of both the CFS and CFA he has been a witness in and then had to implement findings of inquiries. After his retirement he led the *Inquiry into the January 2016 Waroona [Western Australia] Fire*. Euan gave his thoughts on inquiry processes and their value to those who have to implement the findings and recommendations.

As a firefighter (not a lawyer) Euan conducted inquiries (Linton, Victoria, 1998; Waroona, Western Australia, 2016) and was involved as a witness in others (Wangarry, South Australia, 2005; *2009 Victorian Bushfires Royal Commission*). Euan brought the unique experience of 'having had this done to me, as well as the unique perspective of being a special inquirer and thinking I could do this in a slightly different way.' His 'central theme to inquiries and I hope to restorative justice framework is the centrality of the community, the centrality of people to the process.'

When asked to comment on 'what's bad' with the formal inquiry model he said:

> The first point is we get involved in a legal or quasi-legal process. Most people who are involved as witnesses are just ordinary people. The morning before they did not intend an outcome, that would bring them into this process. The legal process is often resorted to by the government of the day because by instituting a Royal Commission or inquiry it buys them time, allows them to say they have done something and gives time for sense making from a political point of view. The person is thrust into the world of statements, meeting with lawyers, swearing on oath, facing an adversarial approach and cross-examination. The theatre can take over. My advice to government is don't move too fast. Take time to develop terms of reference.

Later he added:

> Post Canberra fires – Mcleod Inquiry, no statements or formal processes. Formal processes take time during which media and stakeholders can push their views and ideas in the public debate. During that time, the people from the disaster have to relive the event. People have to go about their business without knowing if they'll keep their job or how they'll be dealt with. Volunteers are saying 'I didn't volunteer for this, I did the best I could and now you're telling me I have to go into a witness box and be cross examined by the best minds in the country'.

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[2] The presentations were recorded. The author then listened to the recordings and made notes rather than transcriptions. The material set out hear as 'quotes' are taken from those notes but may not be a 100% accurate transcription of what was said. Each speaker was given the chance to review this paper prior to publication to verify that the material accurately reflects their view but may not be the exact words used.

There are compelling questions after every event 'a wise government would wait and see what these are before establishing terms of reference'. With any inquiry, there will be a number of different expectations. Agencies, governments, special interest groups all have expectations and the agenda can be set by the media. Victims however need to have a central place in the process.

As a start, you need to hear from everyone to be able to map the expectations and to be aware of where interest groups will appear what they may say and what their expectations may be. With the Waroona Inquiry, Euan reported that they spent 3 weeks scanning 'all the groups who might have something to say. Bring them into the tent. If they are critical of the report you can say that we listened and heard their concern.'

> Blame – in my inquiry report *("Reframing Rural Fire Management" Report of the Special Inquiry into the January 2016 Waroona Fire* (Government of Western Australia, 2016)). I felt the need to write a foreword and to make comments on blame (pp. 11-12):
>
>> It would be easy to look at any shortcomings and be tempted to fall into the trap of finding fault and allocating blame. This must be resisted. In striving for excellence in bushfire emergency management, it must be recognised that there are many parts of the system: the fire, the weather, the terrain and the actions and reactions of people that are subject to sudden and unpredictable change. Under these conditions, much is unknown. Almost everything is shrouded by uncertainty. People make judgements and those judgements are not infallible. Errors can and do occur, despite the best intentions and best efforts of people.
>>
>> Blame is a poor tool for strengthening resilience. Whilst blame is a natural reaction, it is a waste of energy…
>
> It is important to have that conversation with everyone in particular the community. Blame is a wasted emotion. A natural emotion that we need to attempt to remove or steer away from. At p. 11:
>
>> Hindsight is a wonderful thing. But we must act with disciplined caution when exercising this hindsight. It must always be remembered that those who were key players in this fire emergency were not afforded such luxury.

So what's good?

> A culture of accountability (& shared responsibility?) - Hold people to account and they will make reasoned judgement.
>
> A focus on the systems of work –

He was of the view that there is an increasing focus on human factors – what was she thinking when she did this? What was he thinking when he parked the tractor there? What was the team thinking whey the approved the plan without considering these issues? What was the environment they were experiencing? What was their level of skill, competence and experience? How would the

reasonable person view the decision? It is important to have regard to the human factors when setting the terms of reference and conducting the inquiry.

As we move away from prescriptive rules more to a principles based approach to making decisions we need to focus on the principles rather than the rule book.

Telling the story can be a cathartic process. The story may or may not make sense. Focus on mental health consequences of disasters

In the future, we do need to change the culture. Create a conversation to change the culture in the broader community and in agencies to focus on human systems, human factors etc.

Standing capacity. Under the *Public Sector Management Act* (WA) when a major event occurs, they develop terms of reference and appoint special inquiry. The rules are already set. They have thought about how to run an inquiry with a conscious decision NOT to use a Royal Commission. Even though it has the same powers as a Royal Commission it does not create that 'sense of catastrophe that a Royal Commission has'.

We need an inquiry 'system that - maintains trust and respect of the community and…. - doesn't hang our best people'. If the reaction is to sack the chief then people won't apply for the jobs and you'll get people who aren't appropriate as they don't understand the consequences.

Ivan Pupulidy

Ivan described his journey to focus on learning. He described how in 10 years of service with the US Coast Guard he lost two friends; and in one year with the US Forest Service, he lost two friends. Since 1994, the US wildland fire fighting community lost over 400 firefighters in line of duty deaths.

The response to line of duty deaths started with standard approach – there was a failure to follow rules, regulations, policies and procedures. Organisations establish 'life saving rules' and people are held to account to the rules even if they don't mean anything. How, in the moment do you know what is safe enough or aggressive enough? (It's not safe enough if someone dies; it's not aggressive enough if the fire escapes and does damage).

Distrust began to brew at the field level when leadership insisted on compliance with the rules even if they could not be applied.

In the 2001 Thirty-Mile fire, four firefighters died. The Incident Controller was charged and the prosecution relies on the Serious Accident Investigation report. The 'field' began to lawyer up. "Information is the currency of safety" but if people are not talking then they cannot learn.

The statement at the start of the Serious Accident Investigation manual says 'The causes of most accidents are a result of failures to observe established policies, procedures, and controls.' That removes context and without context, there is no ability to learn from an event.

Ivan began to see accidents as 'unintentional outcome of a network of causality'. Map those 'network of influences' to see why it made sense to field operators to do what they did. The Learning Review replaced the Serious Accident Investigation in 2013. The process is to include the people involved and the workforce in understanding the event in focus groups and bring levels of management into the co-creation of recommendations to mitigate against future accidents.

The Occupational Safety and Health Administration (OSHA) used to cite the Forest Service for every accident for failure to ensure the workplace was free from recognized hazards. But wildland firefighter is a hazardous occupation. As part of the learning review, they brought OSHA into the process. When they saw that the Forest Service was working toward safety they haven't been cited again.

They also bring the family into the process to see the report and to identify that there has been learning from their tragedy. The Forest Service hasn't been sued since.

The process was accepted because of the Service leadership reflecting on its own presence, how it leads and what it wanted to lead. Field operators also wanted to find ways for safety. To get a safer workplace the leadership had to enjoin with the workforce. Justice was not simply holding people accountable after the event. The new approach was to focus on learning and 'Learning how to learn'.

John Braithwaite

Restorative justice is a narrative tradition of justice. It is about restoring people's lives; re-narrating disasters. What was said by Euan and Ivan can be seen through a restorative lens.

In his view, nothing turns on the distinction between restorative practices and restorative justice. Started with restorative justice as it is a tradition that came out of the criminal law but some felt uncomfortable with the term when using restorative practices to resolve conflicts in a workplace. But many are philosophical attracted to 'restorative justice' as it and restorative practices are about restoring just relations and a relational form of justice.

Police organisations – what has been written resonates with Euan's presentation. 'Police culture is not a rule book; it's a story book.' As with many institutions, there are multiple rules that no-one reads. If you want to change the culture, you need to change the storybook. One of the outcomes of a restorative inquiry is to change the storybook. The re-narration function. It is about the kind of stories that they swap in the patrol car or mess room and about acquiring systemic wisdom.

He described how in 1991 or 1992 he went to SA to help with their program for young offenders. Some young boys had started a bushfire. This was a youth justice conference with regard to the offending by a 12-year-old boy. The fire caused millions of dollars damage. The boy, some friends, his parents, grandparents and an uncle attended a conference. A bushwalking club member talked about the devastation to the environment and the impact on them. A number of farmers told the story of how they could not insure stock against fire losses and they had lost hundreds of sheep and cattle and fencing. The young boy was responsible for so much so the shame management function was great given the burden he might carry.

The key element is to put the problem in the centre of the circle, not the culpable child. To talk about the problem. Listening is a core restorative value. To listen to the bushwalkers and the farmers and their needs. The agreement was that the boy would help the farmers by working for a large number of hours to help with the fencing repairs (but that still was not much in terms of the loss). The evidence is that type of approach is consistently effective in reducing the risk of reoffending, but not by much (maybe 10%).

If the child is not incarcerated that's good, it saves taxpayers money, and the farmers get something back and 'the child learns to be a better person from the conversation'. There may be a suicide prevention benefit. Children are less likely to commit suicide.

The negative is that much more is required for the fire survivors than this type of conference can provide. 'Need to move on to a more complexly multi-faceted restorative inquiry that is pulling in diversity of resources to meet the need of survivors'.

The move from punitive inquiries to restorative inquiries is less important than the imperative to move from punitive inquiries to preventative inquiries. Restorative justice does embrace preventative inquiries but there is a risk to focus too much on the restoring to repair the harm done rather than preventing future harm.

We can draw on lessons from human made disasters, which is important in disasters caused by natural hazards. There is no clear distinction between human caused and natural hazard caused disasters. If we look at airline safety, an airline crash may be caused by bad weather but human systems might have prevented the crash. Airline safety gives a lot to learn, as the accomplishments are great. In the 1930's getting in a plane was a significant risk; today the safest way to travel 1000kms is by air. Part of the success is the study of near misses. This shows the distinction between a preventative inquiry before the event and restorative inquiry after the event. Air safety moved to a view that there will be a punitive element but the punishment applies if you cover up. If you report a near miss and meet responsibilities to share with the relevant community then you get reputational capital but if you cover up a near miss and don't feed into the learning review systems then those pilots will be out of the industry.

Health is an area where it is often said 'we're going to learn those lessons from airline safety, have root cause analysis where if you admit you did something wrong, you won't be punished but rewarded for being the kind of doctor that improves the quality of the conversation especially on the back of your own errors'.

With respect to policing, look at September 11. FBI agents at street level detected that people were learning to fly but not land. This was reported up the line but the bosses said 'where's the collar [ie arrest] in that?' There was no inquiry into preventive possibilities. The FBI were detecting an epidemic of housing loan frauds from 2004 in their statistical analysis. These were little crimes that were not important enough to get a good arrest and conviction that would build reputations, but represented a systemic issue that was not identified.

In inquiries about disasters, 'cosmopolitanism is important as an ethic'. Timor Sea oil spill in 2009 and less than a year later, Deepwater Horizon. In Australia, we repaired the harm from that disaster in a way that was nationally circumscribed but what could have been done is to identify that Haliburton had the cracked concrete and therefore require a report about how they would prevent a similar disaster worldwide.

Restorative justice: All the stakeholders in a problem, in an injustice, get the chance to talk about the harm or near miss and what may be done to repair the harm or prevent a near miss becoming an actual hit. Listening is a heartland restorative value. And accountability. There is a division of responsibility not the passive response for holding people to account for things done, but active responsibility for finding new ways to put it right into the future. The forward looking vision of responsibility.

Anne Leadbeater

Anne reported on her experience post the 2009 Black Saturday bush fires. There were 624 fires on 7 February 2009 but we know very little about most of them. We know a lot about the 6 that caused the death and losses.

She was working for Murrindindi shire – at its southern edge about an hour from Melbourne CBD. This was the worst impacted municipality on that day as had both Kinglake Ranges and village of Marysville. For 22 years' fire wasn't on the radar – if it wasn't raining, water was dripping off the trees. Fire was not at the front of mind.

> On 8 February 2009 the visual change was quite incomprehensible. The ranges were barely recognisable. 939 properties impacted, 747 homes lost, 46 lives lost including whole families with little kids. A primary school, a community centre, childcare centre, shops and businesses were burned; the 23,000km national park burned in its entirety. Burnt cars and animals lined the roadside. Emotionally and visually charged.
>
> Mark Crosweller talks about failure of imagination. It's not that plans fail but we can't imagine what the experience will be like. Murrindindi was criticised for not having enough foresight to think about what this may have looked like and not being able to respond as effectively as it should have been able to do but I question the legitimacy of that, how do you plan for something you can't even imagine? I reckon if we'd run an emergency exercise and included a scenario like this we'd have been criticised for being a bit overly hysterical. I just don't think this is where our minds go when we think about how you get ready for something like this.
>
> We needed information to make sense of what happened. We were trying to piece together a narrative, a chronology of the event. The need to tell stories, speak with each other, and get information and expert advice was critical. What I experienced less of is questions about 'whose fault was it?' When the class action against SP Ausnet was announced, the SP Ausnet guy got a standing ovation for announcing that power had been reconnected between Kinglake and Kinglake West. We didn't need to know more about the cause, we were much more interested in understanding the effect and how we would manage that.
>
> We need to be empowered to share information with the community. With adversarial matters people are busier circling the wagons and getting 'on the one page' on what they are going to talk about rather than be able to bravely, and courageously and honestly share the information that the community needs.
>
> Adversarial processes have quite an influence in establishing priorities. Getting kids back to school was important. Middle Kinglake Primary burnt down, the other two schools were undamaged but it took 16 days to get the schools open and children returned. In the days after the fire a teacher wanted to get the kids together at school to reconnect. Handwritten signs promoting a play session for all kids at the local school. It was reported via

The Age as an excellent process but the teacher was censured for taking people onto the school property without waiting for the school to open.

The issue of getting rid of waste. The RC was announced in two days. On the Monday after the fires, we knew there would be a Royal commission into the cause, but they were dealing with the effect of the fires. What was more important was 'would there be a coordinated clean up?' The priorities can be prescribed by the political or the legal or the blame agenda and I wonder if that takes away from our capacity to deal with the matters of importance to the people who had been affected.

You will be most useful if you can put the book away, listen to the issue and then see what you can do about it. Need an adaptive leadership model to manage events beyond our imagination. If we're going to persecute people for adopting that adaptive leadership model I'm not sure where that gets us in terms of community recovery. For example the woman from Vic Roads who was able to put in a pedestrian crossing where they had been unable to get one for 15 years. It was her ability to get the job done. Imagine trying to get it done if we had to ring VicRoads. If we're going to persecute people who did what needed to be done that's not where we need to be.

I've now worked for a number of recovering communities including Christchurch. What helps and what gets in the way? In emergencies, we fixate on the event and not much on what's going to happen after the event. We can't do much about the disaster, when, how long, how big but we can make a big difference about what comes after it. They may be in the disaster for a day or perhaps a week for floods but they'll be in recovery for years.

We categorise disaster by impact on human beings so it makes sense to have the concerns of people central to the work we do to understand the lived experience. Impact of disaster is the loss of control over your life. Irrespective of how it occurs the impact is quite similar. Try to imagine what the next bit of your life will look like and there's nothing there off the map, all the routines, structures, processes and rules that you apply to keep safe and move through life are disrupted or perhaps entirely swept away. That's the space we are in and the space we are requiring people to make decisions in.

The attractiveness of blame is that gives some semblance of control. If I can find whose fault it is perhaps I'll feel better. Inverse relationship to accountability – if we find the person to blame we nailed them to the cross – we don't go to learn or change systems and processes that failed us. Apply hindsight to an uncertain situation. If you want to make people accountable, you need to enter a relationship with the person and try to understand things from their point of view. Different to 'you stuffed up, it's your fault'.

In terms of the process diagram, the attribution of blame at any point does not add value. Exacerbate the frustration and make the climb out the trough longer and harder. Think about if we want a community centred, positive

> sustainable recovery is blame something we can afford to indulge in? It's hard enough without adding a layer of blame.
>
> Stages of grief – we understand that when people have personal losses, they have to move through issues before moving on. Impacted communities go through it as well. For people working in the area it's difficult as you're doing everything to help and they're reacting with despair, anger etc. We see the pain and feel it should be someone's job to remove it so if people are still experiencing it then someone's not doing their job but this is the work of recovery so we have to let people have the emotions but it's painful to watch and it's hard not to feel the need to jump in and make something happen. The narrative is that someone's not doing their job so someone gets a kick because the decision maker doesn't want to see the pain everyday.
>
> The counterpoint to blame is guilt but everyone feels guilt – for surviving, for keeping their homes, for only losing homes not loved ones. Emergency services because they couldn't stop the fire or save homes. Into the melting point of grief and distress, we want to add blame which is not going to be a path to any improvement. All we'll do is compound the guilt.
>
> A holistic view of recovery – fault and blame can put that out of balance. Focus on one part at the expense of some other.
>
> Recovering communities need partnerships. Build on new and existing relationships. Depends on trust and collaboration and that is hard to maintain when you are looking for someone to point the finger at. The idea of shared responsibility is great but we're not seeing shared control. Blame and litigation issues goes along with that. It's not that communities don't want to be resilient but processes may not allow it.
>
> Communities operate as a system. Adapt to changed circumstances. The chaos is not an absence of leadership, but if you wait community structures re-emerge but we find fault in the chaos rather than seeing it as a systems response. Don't feel the need to come in and fix things.
>
> Communities don't go to blame as an automatic response (but that may not be true for those bereaved). The Royal Commission wanted to arrange live streaming to the community but is that were we are? No-one went. It's not where people are.
>
> The nature of disasters is that things go wrong. We want to learn and recognise them not find blame. If everything worked it wouldn't be a disaster it would be something else. We know a lot about the circumstances of the people who died; but very little about the people who didn't die and what they were doing. An incomplete analysis of the story.

Anne gave a telling story of giving evidence before the Royal Commission. She gave a statement to Royal Commission staff that was edited and returned to her so she could sign it as her 'sworn' testimony. Material that she considered germane was removed, as the staffer did not think it was important. As Anne said – "the problem is I was there and you weren't" so it was up to her to determine what was

important to her and her story. If they did that to others, what else did they not see and hear? Rather than hear from witnesses they saw a 3rd person interpretation of what matters.

Roger Strickland

Roger Strickland and Tammy Garrett reported on the process to adopt the Learning Review from the US Forest Service.

Roger found students remembered little from training but he found that stories are a powerful method to communicate the message. Everyone wants more stories; they find them memorable and useful. His motivation is to make firefighters more effective and to stay alive. Frustrated by effectiveness of training and the absence of human factors in training. Stories were useful and often generated in accident reports but people could not read them due to legal privilege or distribution limits to sensitivity.

> Those that were subject to investigation were aggrieved by the process they had been put through. How much learning do you get from people who leave? He studied human factors and the work of the US Forest Service.

During the 'Black Saturday' (7 February 2009) fires there were many civilian deaths but no fire fighter deaths. One fire crew had a very bad season that started before Black Saturday. The fire impacted on the town and houses were lost. The firefighters felt that as a personal failure. There was fury over the fire and the brigade members were traumatised by the whole season. Could we help the fire brigade?

> Create an environment where all can tell their story. Everyone's story will be different but that is normal. Memories and perspective are complex. The stories are different but each builds to the whole picture of the fire/event. Everyone gets to speak and everyone has his or her own, valid story. No blame as errors are learning opportunities.
>
> The result was the members came up and said 'that was the first time I got to see the big picture'. The first time I heard what was happening elsewhere. The brigade got no food for 48 hours but not aware that the district had 18 other fires at the same time. 'What could you do to help yourself?' They came up with 26 learnings most of which they could manage themselves.

The next incident occurred after Black Saturday. A fire crew were overrun by fire. They survived in their state of the art tanker but the tanker was destroyed.

> They were interviewed formally. Their feeling was 'deep aggrievement' – they were angry, bitter and wouldn't talk to me. I had to do a lot of work to get them to the table. Had a night in neutral territory where they had control of the meeting, no blame, focus on them and learning about fire. They learned a lot and wanted to tell others for the first time. Had briefings and spoke to other firefighters. What firefighters take notice of is what other firefighters tell them. Equipment was modified and those firefighters felt they'd make a contribution.

> Every time using those principles we get a better result than asking 'what sops did you break?' and you need more training.

Tammy Garrett

Tammy continued the CFA story. She used the Facilitated Learning Analysis method from the US Forest Service to:

> … investigate brigade that wanted to do fuel management work and reduce the risk to their town. The Brigade received a grant for $95 000 over two years to conduct weed and fuel reduction.

There was community consultation and a steering committee but minimal contact with the CFA District level. They did engage a contractor but didn't get advice from the steering committee but it was, in their view, lining up. They began their fuel reduction work and promoted that as a community risk reduction. The LandCare group complained that the Brigade had taken out three endangered plants. The Brigade did not know that they had done this as they didn't look at and identify all the vegetation. The Catchment Management Authority asked the works to cease. Tammy was asked to go and 'investigate'. Work had been done on 15 properties. The grant was rescinded as the work was considered out of scope and the brigade was asked to repay money. They Brigade hadn't discussed the project with an ecologist and didn't have a permit to remove native vegetation. They spoke in general terms with council, DEWLP etc and got a generic 'yes' to their proposals rather than actually file an application and obtain approval. They received media attention.

> The LandCare people were trying to keep the story in the press. Roger suggested the use of a learning review. It changed my approach to the process – changed language, it was a review not an investigation. No one goes out to rip out an endangered plant. I wanted the brigade members to tell their story not respond to me.
>
> People are told the CFA Act 'covers you for everything' which it may do during a fire but not when have to comply with local government laws. The project manager had no experience in fire or vegetation managements. LandCare know of the plants but didn't mention it in the grant. The Brigade misunderstood Council website – failed to read the asterisk that said 'unless you intend to remove native vegetation'. Maps were out of date. There were time and weather pressures and had to spend ½ the grant in the first 12 months. The brigade was so focused on weed removal that they looked at weeds, not other plants.
>
> We had to deal with financial obligations, possible penalties and damage to CFA brand. Talking to the brigade found they did have a plan, they were willing to share their story, communicate issues to Yarra Council. Residents were supportive, able to preserve relationship with CMA. Found that grants are being applied for by Brigades and district doesn't know. How can we work with brigades to support them and help them with project management? We were able to rehabilitate the site (a 3 year plan). Support the brigade with their 15 year plan. Re-establish relationship with LandCare.

Identified the map of influences that led to the forest mulcher being put on the site. I would not have learned that with a 'big stick' and 'what have you done?' Look at all the human factors, all those pressures. Story telling allowed us to unpack this.

Iain Mackenzie

Iain Mackenzie is the Inspector General of Emergency Mangement, Queensland, He set out to explain 'what IGEM does, how we go about it and why we do it that way'.

> The word 'restory' – it's part of what we do. But it's not all restorative it's also preventative. In any inquiry, the event has happened.

Note his photo of destruction on the Bruce Highway (shown in the slides reproduced in the appendix, below)– there are no emergency services.

> We need to capture the community stories of how they got on with the problem without the emergency services.

Aim is to drive a culture of excellence. If it was just about the event, he can say what the next recommendations will be:

- Command control and communication;
- Interagency cooperation and collaboration;
- Communications systems;
- Training;
- Number of resources;
- Radio systems that don't work across the state or in smoke.

We know what they are so why don't we do something about them now and eliminate them?

Our assurance activities are focused on what we do before anything happens and measured against emergency management standards that are outcome based. What can we do before the event?

In order to determine what can be done before the event the IGEM conducts annual plan assessments for each Local Disaster Management Group and gives feedback on strengths and weaknesses. They

> Go in and try to be supportive and collaborative to create a learning journey so they already know strengths and weaknesses and what requires attention. If I can deliver a report that they accept regardless of its content (good bad or indifferent) then we know we've had a positive impact for that community.
>
> In After Action Review, we sometimes use the Facilitate Learning Analysis process but sometime we just sit and listen. We use market research firms to gather information. We name incidents and reports so they are not adversarial. Always try to report the good practice. Group into general themes but will make specific recommendations when required.
>
> Cultural interoperability is the key for me. It's about us all being willing to pay nice in the same sandpit and avoid the blame, deny and justify. Share risks, data, success and failures. We don't own the data, it's government data. Share ideas – we see too much competition …. There's nothing new – there's no major disaster that's going to happen that hasn't happened before even if not within our memory.

Jennifer Llewellyn

Restorative inquiries in Nova Scotia emerged out of insights from people who had visions for what that 'right thing' was and over time, creating space to ensure processes and institutions could match those instincts of the right way to learn.

Why do people want inquiries? They have some significant advantages but they are usually when all else fails and people want justice so they call for a public inquiry.

> They come out of this real desire for change for something to get better, for something to be fixed. But they are a stunning process of dampening that desire by the tedious process and length so by the end of it you're glad it's over and you take what you can get which is a version of the story of what happened and hopefully at least a moment of feeling like you can wave a report in the air. But that's fleeting and increasingly we're starting to notice the damage that they do to those that are engaged and involved within them. They struggle to understand what really matters to people in particular circumstances and increasingly we're seeing those who are either victims or survivors or most harmed not wanting to participate in those processes.

It is fundamentally about

> … thinking about letting *why* we're doing *what* we're doing drive what we do… How could we capture what matters most about this opportunity to learn what happened to make it matter and bring real change? And if that's our intention, examine against that the structures, the procedures, the strategies the processes that are operative at the moment and that are in inquiries we put together to try and bring this change. Then you're not so weeded to particular structures and processes.
>
> A restorative inquiry model is fundamentally concerned with taking a relational approach what… Take a relational view as a mode of analysis as a way of looking at what happened, what's going on, what needs to happen. This invites us to start from the premise that things are always interconnected. At the inter-personal level and nested in connections amongst groups, communities, institutions, systems, structures… The human and environmental factors feed into disasters but we don't tailor responses to look in those relational ways. We carve them up and look at criminal liability, or civil liability. The further you get from the disaster the more luxury we have to return to divided silos so by the time you get to the Royal Commission you're getting clinical system accounts that are transactional rather than seeing how the ecosystems work.
>
> What processes would look like that would be more adept at understanding situations and circumstances? What would it look like to take a restorative approach? How do we ensure that we are able to be intentional about that without being rigid? Commitment to a common sense of principles for a way of working. The principles have helped guide us in Nova Scotia (see the slides reproduced in the appendix, below). Being relationally focused leads them to being holistic and comprehensive about what matters.

> It is what is attractive about stories. Human beings can learn complicated and integrated ideas if they combine head and heart through stories. The processes need to be attentive to what is connected, cannot look at one issue or topic. Move away from the idea that you need to find one story, the official version of the facts. If you want to know what matters about the facts you need many more stories. The Royal Commission recommendations may sit on the shelf but you get 'the' version of events. That version may be important but what matters most is understanding a more complex version of how those facts were perceived and understood [by the people who were there].
>
> This way of working is about fashioning just relations. You need to be more inclusive and participatory. More than having the right people in the room but it has to make a difference that *those* people were in the room. Inquiries should operate so that it matters that people are able to participate in ways that are meaningful and do not do more harm. Not orientated to blame and not backward looking. It is hard to collaborate if you are being identified as the problem. It is easier if people can say 'I've been part of the problem so I can get in the boat and be useful in the solution'. When they are orientated to what happens next, to the responsibility people have to be part of what happens next. That accountability for what happened is part-and-parcel for carrying forward that responsibility for what happens next. Focused on that notion of responsibility rather than laying blame.
>
> In Nova Scotia inquiries are fundamentally about discovering what happened together but it has to be purposeful, so we can understand in order to do something about it together. You always start with the question 'what happened?' but what matters about what happened? Because we don't know what to do next so it's not just about outcomes. We can't ask people to collaborate on deciding what happened if they can see no meaningful way to be part of what happens next. They need to be action orientated. That's the way we've approached restorative inquiries and we need to be flexible and responsive in the approach.
>
> There will be moments that look like critical incident debriefs to allow those with relationships or connections to share stories with each other. One of the first steps is spend some time working intra-parties with first responders, members of the community. Not to create 'sides' but to layer people's understanding to allow them to have a more complex appreciation of the perspectives even amongst themselves and to identify their needs in terms of how they experienced this.

Jennifer said it is important to work with those affected to develop a structure to work intentionally in a restorative way. But don't impose that structure, the affected parties need to identify the structure they need to make meaning and to be part of the solution. From her experience '…. we began to look intentionally at what a restorative inquiry might look like'. In the table below she compares the traditional public inquiry with an inquiry that adopts a restorative approach:

Traditional Public Inquiry	**Restorative Approach**
Government or legal authority determines scope, terms of reference.	Affected parties (government, former residents, community partners) work together to design the process.
Sole commissioner (often a retired judge) or small panel selected to lead inquiry.	Process guided and overseen by a council of all parties affected – everyone has a stake.
Meetings/hearings are judicial in nature – often held in a courtroom.	Meetings held in a flexible variety of settings, from small groups to wider gatherings, depending on need.
Process focuses on what happened, what went wrong – "finding blame".	Process examines bigger context: what happened, why it happened, why it matters for the future.
Proceedings can have an adversarial feel, with "witnesses" enlisting legal counsel for support.	Process takes a holistic and participatory approach, so participants feel safe and welcomed to give their perspectives.
Witnesses can be subpoenaed to appear in a court setting.	Subpoenas will be largely unnecessary in a collaborative approach where all parties have a say in the process. They will be used only as a last resort, with participants prepared and supported beforehand.
Commissioner/small panel develop report and recommendations at the end of the Inquiry.	Affected parties represented on Reflection and Action Team that helps determine next steps. Information will be developed and shared and action can be proposed/enacted throughout the process.
Commission delivers report and recommendations to government, with no authority to make change or ensure follow-through.	All parties, including decision-makers and community leaders, have a stake and role in developing and following through on recommendations. Final report will share actions already taken within the process as well as action steps for the future.
Outcomes typically involve new or updated policies/procedures for public agencies	Outcomes should include improved relationships between agencies and communities, better ways of working together. End result will be not only actions but a capacity for and commitment to sustainable change.

With respect to the report and recommendations, she says:

> They do all the learning. All the information comes to them. All the sorting and hard choices all the figuring it out. They are the knowledge holders, they make the meaning, they make sense out of everybody's story and testimony and decide what should happen. They hope that once they know and understand you will see the wisdom in what they say. It produces a 'you should' result.
>
> In a restorative approach, some of this is different. Affected parties work together to design the process. Oversee the process by a council of parties affected or a range of people who represent the stakeholders. Meetings use a variety of means depending on the need. By taking a holistic and participatory approach gathering the people who need to know as they are the ones who have to carry it forward.
>
> They have subpoenas but they have not been used much but when they are, it is to give permission to people to share. Facilitative rather than adversarial. Government departments have to be part of it and report to the elected leaders on the real time changes made from the learning. Everyone has a role in developing recommendations. The final phase is to try and make things happen. A plan on how to make it happen. Our report should tell a story that is recognisable and reflects the multiplicity of stories of those involved – their understanding of what happened and why it matters and focus on why it matters and the story of what we've done about it here's what actions have been taken, here's what's coming, who's involved etc…
>
> A restorative approach then does have significant implications for the process– focus on having all the facts and details but also why the reason for finding those facts and details is clear – a part of the process is to making sense of those and identifying what matters from those. It doesn't involve reaching agreement but understanding different perspectives. Aim to be about justice whether that's recovery and healing or that sense of commitment about how to move forward. The primary value of approaching inquiries in this way is to look beyond inquiring into the facts and the bridge between knowing what happened and making a difference in the future. How do we use that truth to step into the future?
>
> Ask what matters most then facilitated conversation for a deeper understanding of the issues before asking what should happen… Good commissioners work out how to move from what happened to what should happen but that is not owned or shared by or serve as any foundation of anyone else to understand the recommendations or develop the capacity to carry them out. When the objective is to ask people to come together to ask what do you understand about what's happening then they come to a more informed conversation about 'if these are the issues and why it's happening what can we work on together?'
>
> We get better information. People tell us more as we're asking and they think it might matter. Get different information, as people are able to hear

one another to generate their own account and sharing of insights from what they hear from others. They can piece it together in ways that a commissioner could never do… There is something richer and helpful having people talking to move from facts and information to what matters about that and what needs to happen.

In lots of complicated circumstances people can be both harmed and have responsibilities particularly responsibilities about what they may do next. Those that have significant responsibilities for what happened are also significantly harmed by what happened. Need to hold those two things as true.

When you give up on blame you don't need to protect people by calling them victims and allowing them only to be harmed and not responsible because it turns out you can be responsible for being part of the solution without being named as part of the problem. Better outcomes as people more likely to follow through if the recommendations make sense.

Panel Session

How does the bureaucracy persuade government? In the Australian context after 'Black Saturday', the conversation with the Premier was 'nothing short of a Royal Commission can be used to address this. We need to be able to examine and cross examine under oath for justice to be served'. Do not deny what government says they want; if they want an inquiry with the profile of a Royal Commission, look at how it could work. How adversarial do they need to be? Do not be adversarial or aggressive unless you have to be.

If the Royal Commission into Institutional Responses to Child Sexual Abuse wanted to treat everyone as if they were a special guest, why not the same for emergencies?

> The trick is to lift that up and ask why all the human beings who are invited into those processes to share knowledge and information are not similarly responded to. Emergency Service personnel have also put themselves in great jeopardy and harm and if it's been a disaster they've been in the middle of those pictures and if you want information from them and you want people to continue to do those jobs should probably treat them as you would treat anyone who you immediately identify as blameless or victims. That's part of moving out of blame see and encounter human beings with meaning not simplistically on one side or the other.

If you cannot move government off the idea that it has to be a judge, try to find a judge who can do it differently. Something about people who are used to presiding over processes rather than designing them.

Champions are required within the judiciary, within the bureaucracy and then a champion within government, the Premier or Minister.

Legislative change may be important but you can do it without them. For example why don't agencies reshape themselves to do restorative practices so in the next small (early warning) or near miss event they can do it and build knowledge. Organise before the next big event. Need to show people that restorative inquiries are not a soft option. Demonstrate a culture of doing it right so we don't need people with a big stick to come in over the top.

Use restorative practices when you have the smaller event and then you can show that it is possible at a micro level. This gives capacity to demonstrate 'this is how it can work and what can be achieved'. Build a basis of knowledge and experience. Maybe it is possible for agencies to have the conversation themselves and be strategic to get processes set up before the next event. Perhaps an AFAC working group to develop a model terms of reference. No blame, look forward, identify lessons that can be implemented. Identify principles and factors to be considered. 'Terms of reference' or principles that can be taken off the shelf.

Avoid the toxic work environment that comes with long-term judicial processes. No-one can learn well when you hate the people around you or are actively sabotaging each other. If you don't build the relationships or capacity to learn better.

It is difficult if it is not clear what has happened. Design processes so people can see the difference they are making. Include regular reporting. Commitment to sharing understanding along the way. No all the hearings are in public, but the process and learning were public.

Look at how you deal with organisations outside the agencies – lead by example. AFAC are 'in' but agencies interact with those outside. Many organizations look at the bit they're comfortable with which is what they do but perhaps not with the relationships outside. How do we deal with other people and what are the relationships with them?

Agencies are trying to be restorative. Victorian IGEM publicly advocates a restorative approach to his inquiries. Can they build a pool of evidence and experience? Talk about, before the next event, what is going to make things better? How do people learn lessons? If people can see a difference and real change then other people may need this too.

The media says we need a royal commission but what people want is change and they think they'll get it from holding people to account but that's not what happens. Accountability includes accountability to learn and change.

The media do like conflict. Stories are hard to write so we need to work with journalists to help them write good stories. A pre-emptive education role to deal with the media. Good news stories are hard to tell.

How to sell it? Have stories to tell.

APPENDIX
SPEAKER'S POWERPOINT SLIDES

Euan Ferguson

26/07/2018

What's good and bad with current inquiries?

A Chief Officer's Viewpoint

Euan Ferguson AFSM

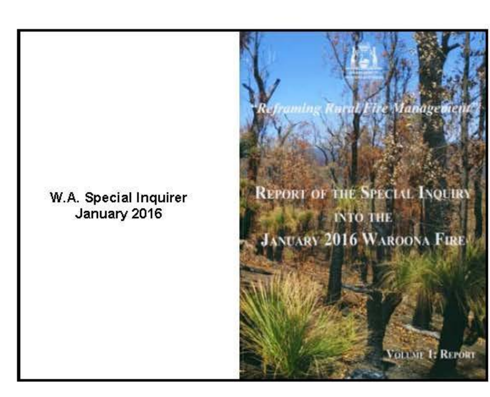
"Good decisions come from wisdom, knowledge and experience. Wisdom, knowledge and experience come from bad decisions."

- Anon

Linton 2 Dec 1998

Wangary 11 Jan 2005

W.A. Special Inquirer
January 2016



Maintaining the trust and respect of the community

Agenda
(From a Chief Officer's viewpoint…)

- What's bad?
- The role of the "Chief" / Commissioner / Exec Director
- What's good?
- Options for the future….
- 6 tips for "Resilience Thinking"

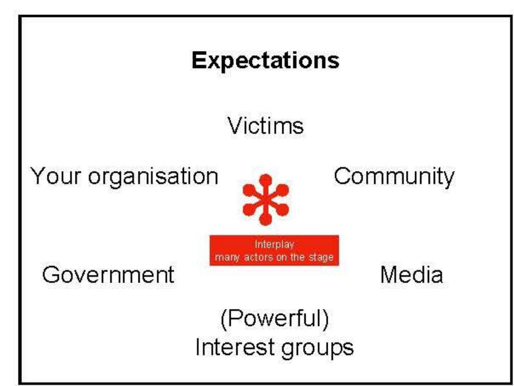
1

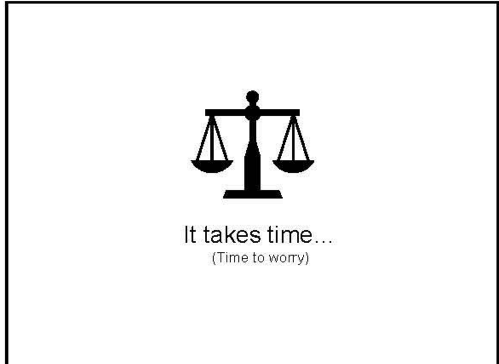
26/07/2018

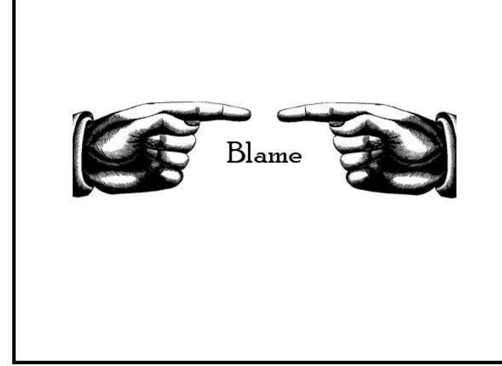
What's bad with current inquiries?

Compelling questions…

Who was in charge?
What happened?
Were past lessons heeded?
How this happen?
Were actions appropriate?







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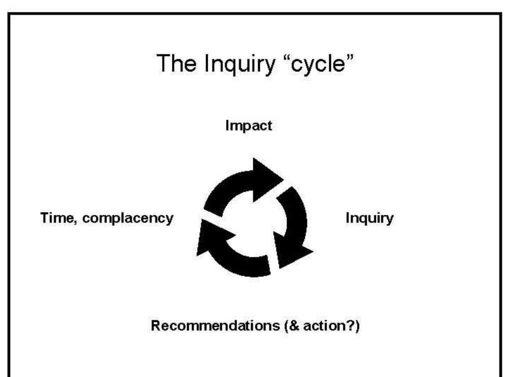
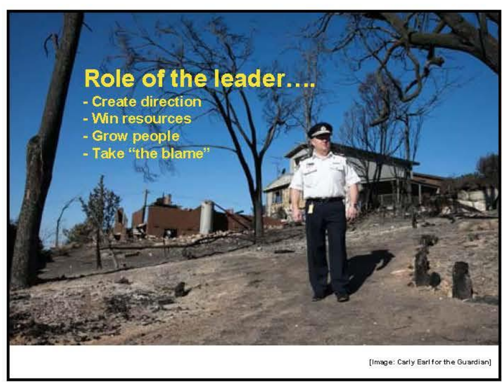
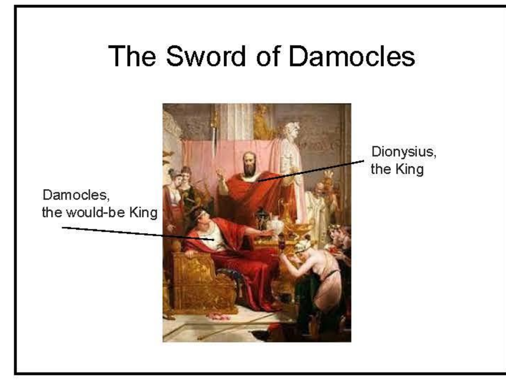


So, what's bad with current inquiries?

- The legal process
- Threat of further litigation
- Compelling questions
- Community expectations
- Time taken
- Blame
- Hindsight bias
- Inquiry "cycle"





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26/07/2018

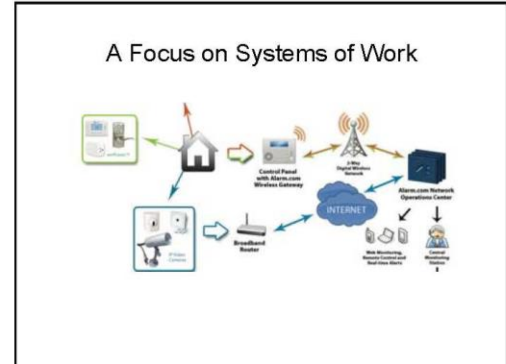
What the Coroner Anthony Chappel said:

The task that is performed by the CFS is a very difficult one and would not have been made any easier by the intrusion of this inquiry into its activities. Notwithstanding this, at no stage, at any level, be it volunteer or otherwise, did I detect any resistance to scrutiny." (Page ii)

"Thus it is that much of the work that I might otherwise had to perform as far as recommendations for change are concerned, has been done."

"… it would be remiss of me not to say that in my opinion the performance of the CFS since the Wangary incident in terms of its recognition of the need for change and the implementation of that change has been exemplary." (Recommendations, Page 6)

What's good with current inquiries?



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26/07/2018

Agency Sponsored "Lessons Learned" Reviews

Leadership

"Blame no-one
Expect nothing
Do something."

– *Stuart Ellis*

Human factors

Decision Making

"Even in daring, there is still wisdom and prudence"

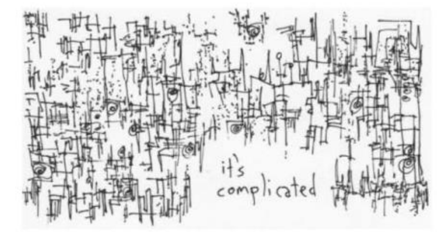
- Karl Von Clausewitz

2009 Bushfires Royal Commission: Paul 't Hart

"Effective responses in such extreme circumstances are necessarily improvised, flexible and networked (rather than planned, standardised and centrally led)."

"They are driven by the initiative of operational leaders and the strength of the pre-existing ties between teams…"

Recognising Complexity



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26/07/2018

Rules vs Principles

Telling the story…

[Image: SBS]

A "Just" culture

So, what's good with current inquiries?

- A culture of accountability
- Focus on systems of work
- Agency "Lessons Learned" processes
- Leadership
- Human factors
- Risk based decision making
- Principles based guidance
- Recognition of complexity
- Telling the story
- A "Just" culture

A "Just" Culture

"Sometimes bad things happen to good people."

–Anon

For the future…

- Change the culture
- Develop a "standing" capacity to undertake reviews - both big and small
- Pre-determine who and how an inquiry will occur
- Ensure "experts" and "peers" are involved
- A system that
- maintains trust and respect of the community and….
- doesn't hang our best people

6

26/07/2018

6 Tips for "Resilience Thinking"

1. Act with absolute integrity
2. Know your stuff
3. Take responsibility
4. Be inclusive
5. Future focussed
6. Be humble

"Our greatest glory is not in never falling, but in rising every time we fall."

– Confucius

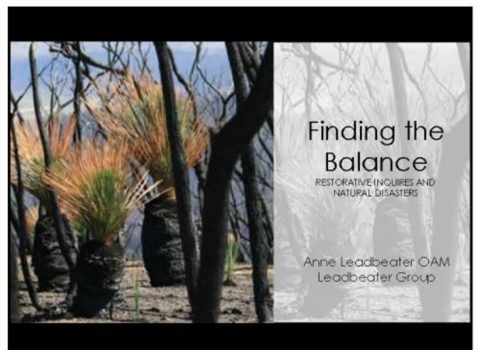
7

Ivan Pupulidy
US Forest Service

https://youtu.be/L-nK6Kd8dB4

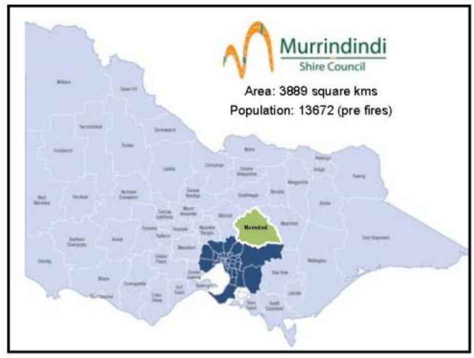
Anne Leadbeater

26/07/2018



'Black Saturday' – 7 February 2009

- Preceded by a severe heatwave and a prolonged period of drought
- 50 locations in Victoria experienced record temperatures
- Melbourne's hottest day on record - 46.4° C
- Strong, dry winds, low humidity and high temperatures resulted in extreme fire conditions



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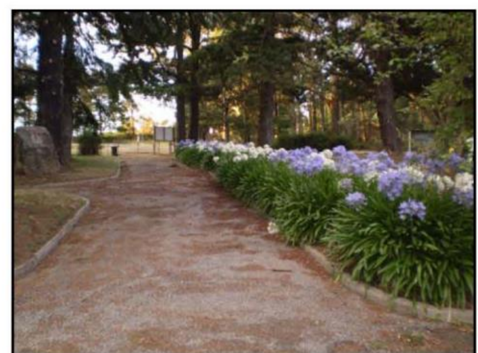

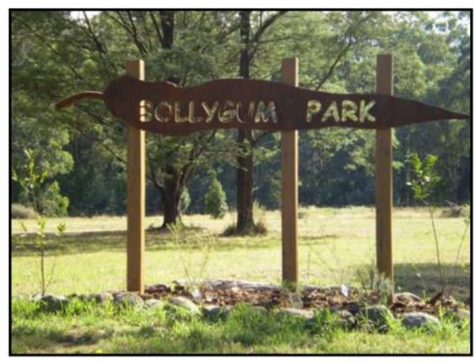

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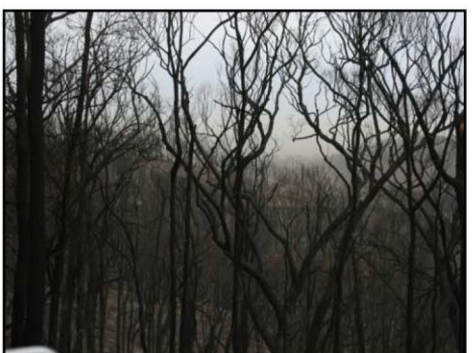

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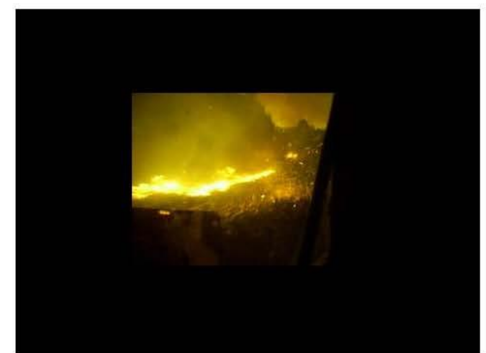

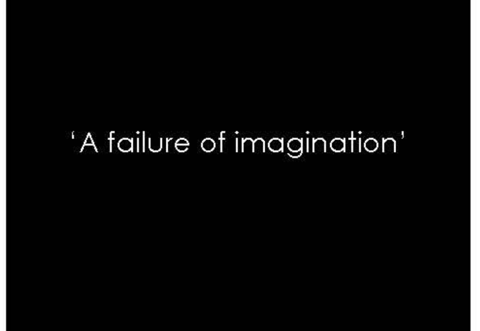

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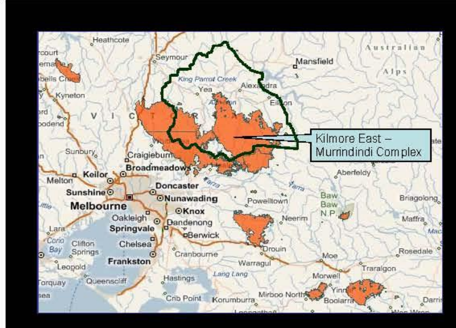

Effects of Black Saturday on Murrindindi Shire

- 95 lives lost
- 1,539 km^2 of land area burnt (40% of shire)
- 43,780 hectares of farmland and 3,533 kms of fencing
- 2687 farms and businesses affected
- 1495 farm / domestic animals and 160 tonne farmed fish
- 1,397 homes destroyed
- Community and council facilities destroyed:
  - 5 community halls
  - 3 kindergartens
  - 1 childcare centre
  - 2 primary schools
  - 1 police station
  - 1 retirement village
  - 1 caravan park
  - 1 transfer station depot
  - 3 maternal and child health centres

Sometimes, if the event is bad enough, providing information is all we can do...

- What we know
- What we don't know
- What we are doing
- What we need you to do

Setting priorities

Undamaged schools re-opened: 16 days
Coordinated Clean-up: 21 days
Royal Commission announced: 2 days

Multi-Agency Committee:

- CFA
- Victoria Police
- Dept Human Services
- Army
- Local Government / MAV
- State Emergency Service
- Vic Roads
- Dept Primary Industries
- Dept Sustainability & Environment
- Red Cross
- Telstra
- SP Ausnet
- Community Health
- Centrelink
- RSPCA
- Ambulance Victoria
- Chaplaincy Australia
- Local Volunteers

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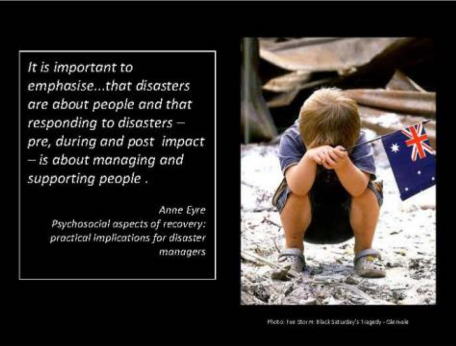
Other communication partners:

- Department of Education
- Australian Taxation Office
- Small Business Council of Australia
- Bushfire Legal Service
- Insurance Council of Australia
- Westpac
- Victorian Farmers Federation
- Insurance companies
- Kildonnan Family Services
- Registry of Births, Deaths and Marriages

Information

- Honest
- Consistent
- Accessible
- Timely
- From trusted, reliable sources
- Continuously available



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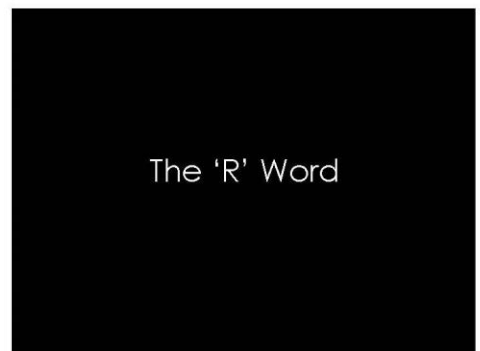

Partnerships

Looking for opportunities to build on new and existing relationships within the community

Drawing on local knowledge, experience, capacity and skills

Adopting an asset-based approach to recovery – building on strengths

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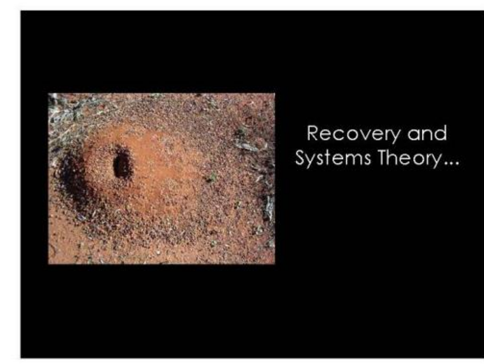
- Report of the Inquiry into the 2002-03 Victorian Bushfires – 2003
- A Nation Charred: House of Representatives Select Committee into the recent Australian Bushfires – October 2003
- Council of Australian Governments (COAG) National Inquiry on Bushfire Mitigation and Management – March 2004
- Inquiry into the Impact of Public Land Management Practices on Bushfires in Victoria – June 2008
- Victorian Bushfires Royal Commission Final Report – July 2010
- Review of the 2010-2011 Victorian Flood Warnings and Response Final Report – December 2011
- A Shared Responsibility: The report of the Perth Hills Bushfire February 2011 Review – June 2011
- Review of the Operations of Bushfires NT – 2012
- Bushfires Royal Commission Implementation Monitor Final Report – July 2012
- Environment and Natural Resources Committee Inquiry into Flood Mitigation Infrastructure in Victoria – Aug 2012

One consistent theme which emerged during the community consultations was a strong desire for community involvement in all phases of emergency management: planning, preparation, response and recovery.

Concern was often expressed that communities had not been actively engaged in this process and invaluable local knowledge was not adequately considered.

There was a prevailing sense that local communities had been disempowered by the state within the emergency management framework.

Review of the 2010-2011 Victorian Flood Warnings and Response Final Report – December 2011 p. 5



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Roger Strickland

26/07/2018

Learning from Incidents

- result of a changed approach in the Country Fire Authority Victoria

My reasons for being:

To help firefighters be more effective.

To help fire fighters stay alive.

All about *learning*.

Drivers for change

1. Dissatisfaction with effectiveness of training
2. Lack of training in 'human factors'
3. Few investigation reports generated learning products
4. Too often, survivors felt aggrieved post investigation

NOT ENOUGH LEARNING.........

Two examples of changed approach

1. Boolara, Delburn fire 2009
2. Nixon Road fire 2009

Smoke rises from a bushfire in Boolarra in Victoria's Gippsland region on January 31, 2009.

Town in fury over bush arsonist

Every loss was felt personally by the members.

The fire Brigade was hurting badly....

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Held **Facilitated Learning Analysis** with the members

FLA rules:
- Create an environment where *all can tell their story*
- Errors are seen as learning opportunities
- No blaming

RESULT
- Members saw 'big picture' for first time
- Mood changed from hopelessness to hope
- 26 'lessons' developed *by the members*

- 11 manageable by the Brigade itself
e.g. "comradeship amongst Brigades so important to build trust"
- 11 manageable through collaboration with District staff
e.g. "have a local person with incoming strike teams"
- 4 required external intervention
e.g. "external replacement crews need fatigue management"

NIXON ROAD FIRE

2 weeks post Black Saturday, wildland-urban interface

New tanker destroyed, crew barely survived

10

Survivors 'interviewed' by:
- **Agency**
- **Royal Commission**
- **Coroner**

1. Formal interviews
2. Only answer questions from panel
3. Some answers not believed
4. No supportive advocates
5. Focus on 'human error' rather than system problems

RESULT:

Bitterness, anger, and *"would do the same again"*

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Conducted Facilitated Learning Analysis

Rules:

1. Survivors have control of session
2. Neutral territory
3. Psychological safety – supportive panel
4. What, not who
5. No counter-factuals, (but corroborating evidence)
6. Focus on learning:
   - fire behaviour information
   - messages for peers and agency

RESULT

- *Survivors* better understood how incident occurred
- *Survivors* delivered 12 briefings to 1000 fire-fighters
- Response from audiences- "everyone should hear this"
- Equipment modified as a result of survivor advice
- Survivors felt valued for contributions – improved their recovery

SINCE THEN…

Additional investigations using survivor-centred learning approach

- decreased stress on survivors, improved understanding

-survivor contributions to learnings and case studies

-four *Learning Review* workshops by Dr Ivan Pupulidy

-*LR* adaptable for non-fire incidents

Tammy Garrettt

26/07/2018

Background

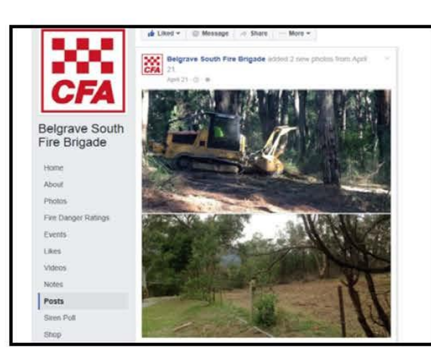
- Belgrave Heights & South FB - $95,000 grant from PPWCMA
- 2 year project to deliver a 'weed reduction and fuel reduction' project
- Overall 15 year plan scoped by brigade including planned burns
- Stakeholders: CFA (Brigade), Property owners, Yarra Ranges Council, DELWP, Parks Vic, Landcare, PPWCMA, Project Manager
- Grant monies used to engage contractor to undertake works on fuel break construction

Learning Review: Belgrave South Fuel Reduction

Background cont.

- Community consultation and steering committee initiated
- Minimal contact with District/Region/HQ staff. Preliminary planning conversations, incl draft plans for future burns.
- Landowner approvals obtained
- No advice to steering committee of vegetation removal works beginning
- Forest Mulcher used to:
  - Construct fire access tracks – existing and new
  - Level uneven ground
  - Remove dangerous tree, stumps and lower limbs on trees

Learning Review: Belgrave South Fuel Reduction



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Complaint and Review Instigation

- Landcare sent an complaint letter to PPWCMA & Yarra Ranges Council
- Complaint made in relation to 1 property in Belgrave South and concerns about fuel reduction works, large scale soil disturbance and the destruction of native vegetation, particularly Emerald Star-bush
- Emerald Star-bush – listed as threatened on *Vic FFG Act 1988* and under consideration for listing under *Fed EPBC Act 1999*
- PPWCMA ordered works to cease

Learning Review: Belgrave South Fuel Reduction

Key Review Findings and Fallout

- Subsequent discussions with brigade revealed similar works conducted at additional 14 properties
- PPWCMA Grant rescinded as works deemed to be 'out of scope'
- Brigade failed to seek vegetation assessments by ecologist
- Brigade failed to gain permits to remove native vegetation
- Brigade proceeded upon verbal 'approvals'
- Media attention – local newspapers, The Age, Herald Sun and 3AW

Learning Review: Belgrave South Fuel Reduction

Assumptions and Errors

- CFA Act coverage
- Project manager engaged did not have fire or vegetation knowledge
- Landcare did not forward on known information about plant species
- Brigade misread Yarra Ranges Council website information
- DELWP mapping (BIM) not up to date
- Time, weather and expenditure pressures
- Brigade focus on weed removal: looking past other veg

Learning Review: Belgrave South Fuel Reduction

Implications

- Financial
  - PPWCMA Grant Repayment – out of scope costs $37,000
  - Contractor Invoices $22,000
  - Rehabilitation $50,000 (incl consultant, re-planting, off-set market)
  - Ongoing monitoring $TBC
- Legal
  - Threatened with Dept of Environment (Aust Govt) penalties
  - Threatened with Yarra Ranges Council penalties
  - Threatened with FFG Act (Vic) penalties
- Brand and Reputation Damage

Learning Review: Belgrave South Fuel Reduction

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Positive Outcomes

- Fuel Management Plan
- Brigade willing to share 'lessons learnt' with other brigades
- Yarra Ranges Council – complementary of CFA's proactive approach to rehabilitation of site
- Residents supportive of brigades work and intentions
- Relationship with PPWCMA preserved
- Awareness of other brigades being issued with similar grants

Learning Review: Belgrave South Fuel Reduction

Recent and Next Steps

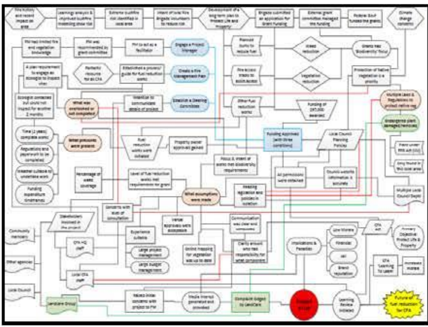
- Ecologist engaged to conduct 'in field' investigation of extent of damage
- Letters sent to affected land owners – seeking approval to access properties and maintain fire breaks into the future (if legal)
- Meeting with 'affected' residents
- Onsite inspections and preparation of rehabilitation plan
- 3-5 year project for rehabilitation and monitoring
- On-going engagement with Landcare

Learning Review: Belgrave South Fuel Reduction

Future Actions

- Review and/or development of policies relating to brigades applying for external grants
- Review legalities and pressures associated with external grants
- Register of brigades awarded grants
- Clarity of information about CFA Act, Planning Schemes, other relevant Legislation
- Strengthen relationships with brigades and awareness of support VMOs can provide
- Fuel management processes – any improvements

Learning Review: Belgrave South Fuel Reduction



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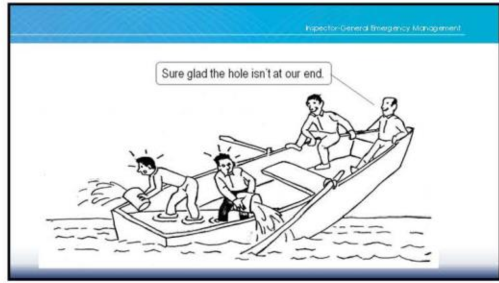
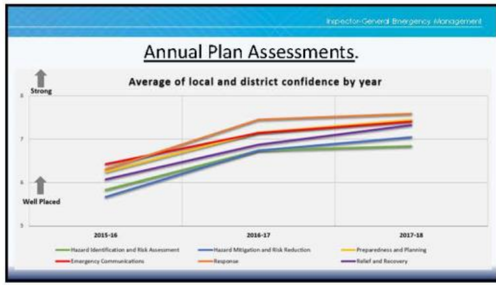
Iain Mackenzie

26/07/2018





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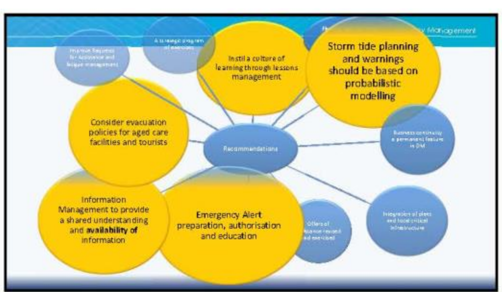

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Jennifer Llewellyn

26/07/2018

Restorative Inquiries and Natural Disasters

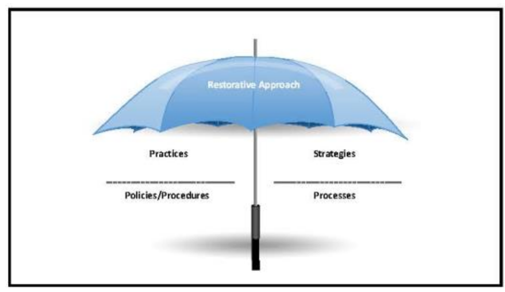
Professor Jennifer Llewellyn
Yogis & Keddy Chair in Human Rights Law
Schulich School of Law
Dalhousie University

Cole Harbour wildfire 'under control,' mandatory evacuation order lifted

Traditional Public Inquiries

- Public
- Focus on individual and systemic issues
- Focused on blame and responsibility
- Backward looking investigation
- Often adversarial
- Victims role often unclear - witnesses
- Remedies – **recommendations** for action
- Depends on public attention & moral authority for power
- Impact often politically managed

- RESULT – often not much real change



Restorative Inquiry Takes A Relational Approach

- Rooted in a relational idea of human beings and the world
  "We live in and through relationships with others"
- Concerned with all levels of relationship (interpersonal, social, institutional)
- Relationship can be healthy or unhealthy, harmful or positive
- "Restored" relationships focused on conditions in relationship needed for wellbeing
- Relationships that are based on equal respect, concern/care and dignity

Restorative Principles

- Relational focus
- Holistic/comprehensive
  Understand the harms in broader context/causes/circumstances
- Justice-seeking
- Inclusive and Participatory
  Support healing - do no harm - Responsive to participants' needs
- Collaborative
- Future focused / Action-oriented

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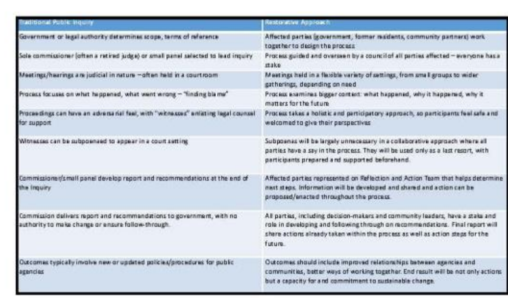
A Flexible Approach to Practice

- Processes based on dialogue to facilitate sharing of truths, experiences and perspectives, to develop understanding of what happened and develop collaborative plans and actions in response.
- Guided by facilitators
- Different processes and setting as necessary
- Public and private processes
- General and issue-specific processes
- Work with individual parties and between among parties.



Traditional Public Inquiry	Restorative Approach
Government or legal authority determines scope, terms of reference	Affected parties (government, former residents, community partners) work together to design the process
Sole commissioner (often a retired judge) or small panel selected to lead inquiry	Process guided and overseen by a council of all parties affected – everyone has a stake
Meetings/hearings are judicial in nature –often held in a courtroom	Meetings held in a flexible variety of settings, from small groups to wider gatherings, depending on need
Process focuses on what happened, what went wrong – "finding blame"	Process examines bigger context: what happened, why it happened, why it matters for the future
Proceedings can have an adversarial feel, with "witnesses" enlisting legal counsel for support	Process takes a holistic and participatory approach, so participants feel safe and welcomed to give their perspectives
Witnesses can be subpoenaed to appear in a court setting	Subpoenas will be largely unnecessary in a collaborative approach where all parties have a say in the process. They will be used only as a last resort, with participants prepared and supported beforehand.
Commissioner/small panel develop report and recommendations at the end of the inquiry	Affected parties represented on Reflection and Action Team that helps determine next steps. Information will be developed and shared and action can be proposed/enacted throughout the process.
Commission delivers report and recommendations to government, with no authority to make change or ensure follow-through.	All parties, including decision-makers and community leaders, have a stake and role in developing and following through on recommendations. Final report will share actions already taken within the process as well as action steps for the future.
Outcomes typically involve new or updated policies/procedures for public agencies	Outcomes should include improved relationships between agencies and communities, better ways of working together. End result will be not only actions but a capacity for and commitment to sustainable change.

DESIGNING RESTORATIVE INQUIRY

Nova Scotia Home for Colored Children Restorative Inquiry

Premier's Office established a 15-member design team to work collaboratively to establish terms of reference.

Group called UJIMA, meaning "collective work and responsibility."

The Design Group included:
- 3 Former Residents (VOICES)
- 5 representatives from government
- 2 Members of the NSHCC board
- 3 members of the African Nova Scotian community
- 1 facilitator

Design process took 15 months

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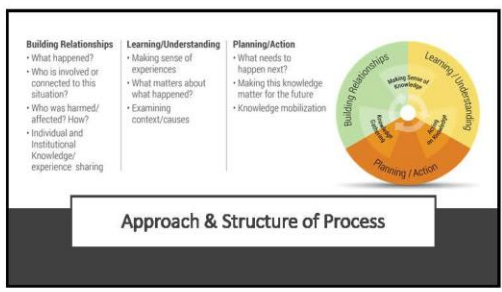

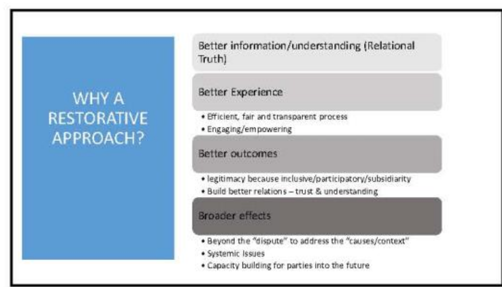

FURTHER READING

The following publications produced during this project and an earlier project funded by the bushfire crc are relevant in explaining the need for a new way of learning.

- Eburn, M and Dovers, S 'Reviewing high-risk and high-consequence decisions: finding a safer way' (2017) 32(4) *Australian Journal of Emergency Management* 26-29.
- Cole, L., Dovers, S., Gough, M and Eburn, M, 'Can major post-event inquiries and reviews contribute to lessons management?' (2016) 31(3) *Australian Journal of Emergency Management* 34-39.
- Eburn, M and Dovers, S., 'Discussion paper: Learning for emergency services, looking for a new approach' (2016) *Bushfire and Natural Hazards CRC* <http://www.bnhcrc.com.au/publications/biblio/bnh-3054>.
- Eburn, M. and Dovers, S., 'Learning lessons from disasters: alternatives to Royal Commissions and other quasi-judicial inquiries', (2015) 74(4) *Australian Journal of Public Administration* 495–508.
- Eburn, M. and Dovers, S., 'Legal Aspects of Risk Management in Australia' (2014) 4(1) *Journal of Integrated Disaster Risk Management* 61-72.
- Eburn, M. and Dovers, S., 'Australian wildfire litigation' (2012) 21(5*) International Journal of Wildland Fire* 488-497.
- Eburn, M. and Jackman, B., 'Mainstreaming fire and emergency management into law' (2011) 28(2) *Environmental and Planning Law Journal* 59-76.