STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Daniel Howard Inquiry into the fire at the Occidental Hotel, Cobar
Hearing dates:	13-16 March 2017,11-12 September 2017
Date of findings:	16 February 2018
Place of findings:	NSW State Coroner's Court, Glebe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – structural fire; training for retained fire fighters
File numbers:	2014/242390 & 2014/244944
Representation:	Mr L Fernandez, counsel assisting, instructed by Ms J Murty, solicitor Crown Solicitor's Office Ms K Dobbie solicitor, for the NSW Commissioner of Police Ms D Ward of counsel, instructed by Ms P Lenehan, solicitor for Fire & Rescue NSW Mr N Newton of counsel instructed by Zacchary Carrigan, solicitor Curwoods for the Rural Fire Service Mr P Jones of counsel instructed by M Corbett-Jones, solicitor for Daniel Howard's family Mr C Simpson of counsel for Cobar Shire Council

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Introduction

1. Daniel Howard died while bravely fighting a large structural fire at the New Occidental Hotel at 1 Marshall Street, Cobar on 17 August 2014. A wall from that hotel collapsed on him, causing a serious crush injury to his head, chest, abdomen and pelvis. At the time of his death, Daniel was working as a retained fire fighter (RFF) for Fire & Rescue New South Wales (FRNSW). His death is a terrible tragedy and the grief felt by his family and community is ongoing.

2. The fire also destroyed the New Occidental Hotel and seriously injured another fire fighter.

3. I commend Daniel and the other fire fighters from FRNSW and the Rural Fire Service (RFS) who served their community on that day. Daniel's contribution and courage will not be forgotten. He is remembered as a brave fire fighter and as a valued family member, friend and colleague.

The role of the Coroner and the scope of these proceedings

4. Given the circumstances of these events it was considered appropriate to hold the inquest into Daniel's death concurrently with the inquiry into the fire at the Occidental Hotel. [1]

5. The role of the coroner in relation to the inquest is to make findings as to the identity of the nominated person, and in relation to the date and place of death. The coroner is also to address issues concerning the manner and cause of the person's death.[2] In addition, the coroner may make recommendations in relation to matters that have the capacity to improve public health and safety in the future.[3] In this case, there is no dispute in relation to the identity of Daniel Howard, or to the date and place or medical cause of his death. For this reason the inquest focused on the manner or circumstances surrounding Daniel's death.

6. Arguably this was a mandatory inquest, because Daniel's death occurred "during the course" of a police operation.[4] However, there was some disagreement with this approach, with NSW Police arguing that the incident was a "combat agency response by the legislatively appointed agency, being Fire and Rescue, New South Wales. NSW police officers present were merely members of an assist agency at the legislative direction of the Officer in Charge (NSW Fire and Rescue)".[5] Practically little turns on the issue. The concerns raised in relation to the manner and circumstances of Daniel's death were sufficient in themselves to call for a close examination of what occurred and to require an inquest.

7. In relation to the fire inquiry, the coroner's role is to establish the cause and origin of the fire.[6]

8. An issues list was circulated prior to the inquest commencing. However, as the inquest progressed certain issues originally identified became less prominent and other concerns

[1] While I have considered my tasks pursuant to both inquest and inquiry separately, for convenience I intend to refer to the proceedings jointly as an inquest in these written findings.
[2] Section 81 *Coroners Act* 2009 (NSW).
[3] Section 82 *Coroners Act* 2009 (NSW).
[4] Section 23 *Coroners Act* 2009 (NSW).
[5] Letter from NSW Police Force to Deputy State Coroner Grahame dated 15 September 2015.
[6] Section 81(2) *Coroners Act* 2009 (NSW).

emerged. To a large degree, the inquest focussed on whether there was adequate control of the fire scene by Deputy Captain Walkinshaw, the nature and adequacy of the training provided to retained fire fighters by FRNSW and the extent to which that impacted on their ability to manage the fire they faced, the adequacy of the communication between FRNSW fire fighters on the scene and elsewhere and whether the Cobar Shire Council needed to improve local systems to support fire fighters in the field.

9. The purpose of an inquest in these circumstances is not to apportion blame or criticise individuals but to see if it is possible to identify opportunities to reduce the kinds of risk that are involved in the work Daniel was engaged in at the time of his death.

The evidence

10. The court heard oral evidence over six days in both Cobar and Sydney, and received extensive documentary material including over 80 witness statements. The court also received reports, photographs and recordings. A view of the site was conducted, which included examining the relevant fire hydrants and the site of the now demolished hotel.

11. A conclave of experts was convened in the second part of the inquest. Mr Unsworth and Mr Phillips, authors of the Incident Cause Assessment Methodology (ICAM) report gave evidence with Mr Holton who had been briefed by the Howard family. This was followed by the evidence of Assistant Commissioner McGuiggan.

12. At the end of the evidence the matter was adjourned for submissions. Written submission were received from counsel assisting, the Howard Family, FRNSW, the Rural Fire Service and Cobar Shire Council. All the material provided has been carefully considered.

13. Section 81(1) of the *Coroners Act* 2009 (NSW) requires that when an inquest is held, a coroner must record in writing his or her findings. These are my findings in relation to the death of Daniel Howard and the fire at the Occidental Hotel.

Background

Daniel Howard

14. Daniel Howard was born on 7 January 1977. He was one of three children born to Genevieve and Jeff. At the time of his death, Daniel was living and working in Cobar. He had a girlfriend, Jenna.

15. Daniel had his own business as an electrician and he worked as a contractor at the Peak Hill Gold mine. He had also been a retained fire fighter for FRNSW for approximately five years. Daniel was well known and respected in town, his funeral was attended by 3000 people[7]. He was a former captain of the Cobar Camels Rugby club and people were said to gravitate towards him. Daniel is also remembered as a valued member of the Cobar fire fighting community. One of his colleagues described his positivity and friendliness, summing up the esteem in which he was held very simply by saying – "everyone loved him".[8]

[7] Letter of Genevieve Howard, 5 September 2017

[8] K. Fugar, Transcript 14/3/17, page 9 at line 7 onwards. See also Assistant Commissioner McGuiggan's evidence in this regard, Transcript 12/9/17, page 76 at line 16 onwards

Fire Fighting in Cobar

16. Cobar is small town in central western NSW. The closest large town is Dubbo, about 300 kilometres away. Cobar is classified as "remote Australia" according to a standard developed by the Australian Bureau of Statistics.[9]

17. Cobar does not have the kind of facilities or resources usually available in regional centres or metropolitan areas. The fire station (Brigade 256 Cobar) for example, is a fully retained station, which means that there are no permanent fire fighters based in Cobar. This is common in rural and remote areas. The retained fire fighters (RFFs) are "on call" rather than working regular shifts. They only attend the station when responding or returning from incidents, attending drills or training or when they are performing other authorised duties such as checking equipment or doing administrative work.[10]

18. It is not surprising that organisations such as FRNSW need to make difficult decisions about where to dedicate permanent staff across the state, taking into account which areas demonstrate the greatest ongoing need. FRNSW records indicate that most call outs in Cobar during the year preceding the fire at the Occidental Hotel were for minor fires or automatic alarms. Approximately once a year a more significant fire will occur in the area. It is apparent that there had not been a structural fire of the magnitude of this incident for over ten years.[11]

19. In 2014, Brigade 256 Cobar was comprised of 14 retained fire fighters in total and led by Captain Brad Lennon and Deputy Captain Walkinshaw. RFFs are paid a monthly retainer for being on call and hourly rates for call outs to incidents and for attendance at training. However it is important to note that for many RFFs the payment they receive for their work in this role is significantly less than the money they would receive in their permanent employment.[12] There is no doubt that many join the brigade as a RFF altruistically, primarily as a service to their community.

The New Occidental Hotel

20. The New Occidental Hotel was built in 1879.[13] It contained a licensed pub with accommodation, a beer garden and a caretaker's flat.[14] There was a metal awning which surrounded the building on the eastern side and most of the southern side.[15]

21. In May 2008, Western Fire and Safety did a general fire audit of the New Occidental Hotel.[16] A report was produced which identified essential fire service work required to meet the requirements of the Building Code of Australia.[17] In December 2008, Cobar Shire Council gave development consent for the building to be used for public entertainment. One of the

[9] Statement of P. McGuiggan, Tab 66, para [50]
[10] Statement of P. McGuiggan, Tab 66, para [61]
[11] For discussion of these issues see ICAM report, Tab 74, page 750
[12] Statement of P. McGuiggan, Tab 66, para [25]
[13] Statement of G McKervey, para [316].
[14] Building Code of Australia Report – New Occidental Hotel, p3.
[15] Statement of G McKervey, paras [14]-[15].
[16] Statement of D Jones, para [4].
[17] Western Fire and Safety Report dated 8/05/08.

conditions of the consent was the installation of automatic smoke detectors and an alarm system throughout the entire building.[18] A fire alarm system was installed and tested at the hotel on 15 January 2009.[19]

22. Bob Bruce became the licensee of the Hotel in December 2013. In February 2014, Stephen Poulter from the Cobar Shire Council inspected the building at the request of Mr Bruce, as Mr Bruce sought to make minor alterations.[20] Mr Poulter reported that due to the age and construction of the building it did not comply with current building standards.[21] Mr Poulter made a number of recommendations relating to the upgrade of the building regarding fire safety.[22]

23. Mr Bruce also spent a considerable amount of money trying to upgrade the electrical works within the Hotel. Daniel Howard's business had been involved in work costing somewhere between $30 000 and $40 000.[23]

24. The Hotel had smoke and thermal alarms installed. They were subject to regular inspection. The last inspection, before the fire occurred was on 24 July 2014. It appears that the alarms passed that inspection, although there was a note made which said "thermal detector to change in hallway".[24]

Brief chronology of events[25]

25. It is necessary to set out a brief chronology of what occurred around the time of the fire. However, it is important to stress at the outset that these dangerous and ultimately traumatic events remain difficult to summarise with any degree of certainty. Some of what happened can be established by independent records and photographs, at other times the court must rely on the memories of witnesses who were under considerable pressure. In these circumstances it is not unusual for honest witnesses to remember what happened somewhat differently and in particular for those witnesses to recall conversations and the timing of events with differing emphasis and detail. Understandably this is particularly true in relation to the period just before the collapse. The scale and force of the fire was extreme and each of the participants who survived to give evidence was focussed on their own task at hand, rather than on remembering exactly what happened and what was said for future proceedings.

26. For this reason, the chronology is brief. It is in my view unnecessary to make detailed findings of fact where minor discrepancies appear to exist. Ultimately, I offer no individual criticism of any of the fire fighters involved on the day. In my view, they were faced with a dangerous situation and fought as bravely as they could.

[18] Letter of G Ryman to D Stanbury dated 23/12/08.
[19] Alpex Fire Protection Pty Ltd, Commissioning Test Report dated 15/01/09..
[20] Statement of S Poulter, para [6].
[21] Statement of S Poulter, para [6].
[22] Building Code of Australia Report – New Occidental Hotel, pp26-28.
[23] Interview of B.Bruce, Tab 22, Q215.
[24] Fire Detection Report, Tab 103.
[25] This chronology relies on a document prepared by those assisting me. I thank them for their detailed work summarising the evidence before me.

The events of 17 August 2014

27. On Saturday 16 August 2014, the hotel had a normal crowd of 40 to 60 people in the bar.[26] Mr Bruce was working along with three bar staff and two security guards. An open fire was burning in the hotel's dining room.

28. The hotel closed at 3 a.m. There were a number of guests staying the night at the hotel including Ms O'Sullivan, Brett Hallcroft, Wade Cowan, Dylan Dejong, Naomi Jesse-Huston, Kelvin Wilding and Moran Meagher.[27]

29. At approximately 7:35 a.m. the following morning, Michael Bannister was driving past the hotel when he saw smoke rising from the building.[28] It looked like it was coming from the vicinity of the open fire in the dining room.[29] Mr Bannister ran to the flat at the hotel where he knew Mr Bruce would be staying. He banged on the window and yelled *"Get up Bob"*. From the flat, Mr Bruce and Mr Bannister could not see smoke but as they moved through the hotel and on to Marshall Street, they saw smoke rising over the street.

30. They entered the dining room and Mr Bruce noticed the roof was reddish,[30] there was fire in the air vents and the paint on the ceiling was starting to blister.[31] Mr Bannister also saw the air conditioning vents over the open fire area and noticed that the inside of them appeared to be full of flames.[32] Mr Bruce ran to get his master keys so that he could open the guests' rooms. Mr Bannister grabbed a fire hose.

31. At 7:48 a.m. Mr Bannister called triple zero[33] and then continued to fight the fire in the air conditioning vents with a fire hose. Mr Bruce went from room to room in the accommodation area to get everyone out.[34] As he did he noticed flames and liquid dripping down from a manhole in the ceiling.[35] Mr Bannister moved along the hallway and could hear the roof cracking. He knew it was going to collapse.[36] The hotel guests were all evacuated from the building.[37]

32. At 7.49 a.m. Deputy Captain Tony Walkinshaw of FRNSW received a message on his pager and mobile phone from Fire Communications (Fire Com). The regular captain for the Cobar fire station, Captain Lennon, was away in Sydney. Deputy Captain Walkinshaw had never been an incident controller before.[38] Deputy Captain Walkinshaw drove to Cobar fire station and met the other fire fighters as they assembled. Once at the station he gave orders as to what the each of the fire fighters was to do. He then received a notification from Fire Com that someone had called and reported that the fire had entered the roof space.

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[26] A stocktake had been conducted on this day which revealed $80,000 worth of stock. See ROI with B Bruce dated 18.8.14, Q&A 253-254.
[27] ROI with B Bruce dated 18/08/14, Q&A 38-81.
[28] Statement of M Bannister, para [11].
[29] Statement of M Bannister, para [12].
[30] ROI with B Bruce dated 18/08/14, Q&A 15.
[31] ROI with B Bruce dated 18/08/14, Q&A 120-123.
[32] Statement of M Bannister, para [15].
[33] Statement of M Bannister, para [18].
[34] Statement of M Bannister, para [18].
[35] ROI with B Bruce dated 18/08/14, Q&A 134.
[36] Statement of M Bannister, para [19].
[37] Statement of Rosemary Wells, para [5]; Statement of A O'Sullivan, para [7]; Statement of D Dejong, para [6]; Statement of N Jesse-Huston, para [9]; Statement of W Cowan, para [10].
[38] Statement of T Walkinshaw, page 2.

33. At 7:53 a.m. Captain Anthony Lord of the RFS was notified by Fire Com of a structural fire at the Occidental Hotel. He was advised that FRNSW from Cobar were present and that FRNSW from Nyngan was on its way.[39]

34. FRNSW Fire Fighters Peter Vardanega, Mark Aumua and three other fire fighters, Khan Fugar, Jamie Peters and Vincent Gilbert, along with Deputy Captain Walkinshaw, drove to the scene and arrived at 7:57a.m.[40] They had two trucks. One truck parked on Louth Road and the other on Marshall Street.[41]

35. Deputy Captain Walkinshaw saw that there was a large amount of black and white smoke coming out of the hotel roof but could not see any flames. There were no other emergency services in the area.

36. At 7:57 a.m. he called Fire Com and stated *"We're in attendance. The roof cavity is well alight. We need the Duty Commander and Hazmat 280 from Dubbo"*. One minute later he called Fire Com again and stated *"We need police for urgent road closures and the ambulance"*.[42] Deputy Captain Walkinshaw and other fire fighters prevented people from entering the hotel.[43]

37. At 8:03 a.m. Ambulance Officer Matthew Bradley from the NSW Ambulance Service arrived.[44] Ambulance Officer Matthew Bradley was the forward commander with the responsibility to make relevant decisions and to liaise with other agencies such as FRNSW and police.[45] Ambulance Officer Anita Hodgkinson arrived a few minutes later.[46]

38. Deputy Captain Walkinshaw directed fire fighters Fugar and Gilbert to conduct a search of the accommodation rooms of the hotel.[47] As they were checking the rooms they noticed the fire getting worse.[48] When they were in the hallway they heard a crash from the front middle section of the hotel and Fire Fighter Fugar assumed that it was part of the roof.[49] They immediately left the building.

39. Fire Fighter Fugar reported what occurred to Deputy Captain Walkinshaw and said *"We don't think it's safe to go in there"*. Deputy Captain Walkinshaw responded *"Yeah, no worries. If it's not safe, don't go in there"*.[50] Deputy Captain Walkinshaw states he made a direction to the fire fighters in the area that *"No-one is to enter the building. It'll only be external fire-fighting from now on."*[51]

40. Fire Fighter Gilbert states that he told Deputy Captain Walkinshaw that part of the roof came down and Deputy Captain Walkinshaw acknowledged it and said *"Go on the defensive"* but did not make a specific direction to the fire fighters not to go in the building.[52]

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[39] Statement of A Lord, para [10].
[40] Statement of K Fugar, para [12].
[41] Statement of K Fugar, para [16].
[42] Statement of T Walkinshaw, page 4.
[43] Statement of T Walkinshaw, pages 4-5.
[44] Statement of M Bradley, para [4].
[45] Statement of A Hodgkinson, para [5].
[46] Statement of A Hodgkinson, para [5].
[47] Statement of T Walkinshaw, page 6; Statement of K Fugar, para [25].
[48] Statement of K Fugar, paras [29]-[32].
[49] Statement of K Fugar, para [34].
[50] Statement of K Fugar, para [37].
[51] Statement of T Walkinshaw, page 7.
[52] Statement of V Gilbert, paras [28]-[30].

41. At 8.08 a.m. the RFS crew arrived[53] and Captain Lord positioned both RFS units in the western car park.

42. Deputy Captain Walkinshaw asked Captain Tony Lord to set up external fire-fighting on the western side.[54]

43. Deputy Captain Walkinshaw continued to move around the building. At numerous times he saw people trying to enter the operational area to take photos or to ask questions of the fire fighters. He told them to leave the area. The area was not cordoned off.[55]

44. At 8:13 a.m. Detective Senior Constable Gregory McKervey arrived at the scene. He could see smoke but no flames.[56] He did not carry a police radio, as the equipment locker at the police station was locked and he didn't have a key.[57] He could only access the police radio inside the unmarked police car he was driving.[58] Around this time he contacted the Bourke supervisor and requested the recall of general duties officers to the scene to assist with traffic control.[59]

45. Daniel Howard arrived on the scene in his own car.[60] He was wearing work clothes from the mine and so he phoned his girlfriend, Jenna to bring his uniform from the fire station to the scene.[61]

46. Daniel asked Deputy Captain Walkinshaw if the power had been turned off. Deputy Captain Walkinshaw told him that it had not and that the power company had not yet arrived.[62] Daniel, as an electrician who had previously worked on the hotel building, asked to be able to enter the building to turn off the power, but Deputy Captain Walkinshaw stated *"No. No-one is to enter the building"*.[63] Daniel did not enter the building, as directed.

47. At about 8:40 a.m. Ambulance Officer Anita Hodgkinson suggested activating the SES and getting Cobar Shire Council to set up road blocks. She made those arrangements herself.[64]

48. Mark Cohen from the Cobar Shire Council arrived. Deputy Captain Walkinshaw asked him to set up road blocks. Mr Cohen went away to set the road blocks up.[65] Detective Senior Constable McKervey states that road blocks were set up at approximately 8:45 a.m.[66]

49. Captain Lord advised Deputy Captain Walkinshaw of cracks he had observed in the building. Consequently, Captain Lord states he directed the RFS crews to set up an exclusion zone of 10 metres.[67]

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[53] Statement of A Lord, para [15].
[54] Statement of T Walkinshaw, page 6.
[55] Statement of T Walkinshaw, page 8.
[56] Statement of G McKervey, para [12].
[57] Statement of G McKervey, para [7].
[58] Statement of G McKervey, para [9].
[59] Statement of G McKervey, para [18].
[60] Statement of T Walkinshaw, page 8.
[61] Statement of T Walkinshaw, page 8.
[62] Statement of T Walkinshaw page 8.
[63] Statement of T Walkinshaw, page 9.
[64] Statement of G McKervey, para [26].
[65] Statement of T Walkinshaw page 10.
[66] Statement of G McKervey, para [28].
[67] Statement of T Lord dated 23.1.15, para [3]-[4].

50. At this time Fire Fighter Marshall sent a radio message to Deputy Captain Walkinshaw saying that flames had started coming through the windows at the front of the building, and that a gold coloured Toyota Camry (owned by Melissa Coughlan) parked at the side of the building could be affected soon. Fire Fighter Marshall did not get a response.[68]

51. At about this stage Fire Fighter Hill saw Daniel for the first time that day. He states that Daniel was in his uniform but did not yet have his helmet on. Fire Fighter Hill said to Daniel *"Helmet Buddy"*. Daniel responded *"Yeah, yeah, I've got it"* and pointed towards the truck.[69]

52. At about this time, Fire Fighter Marshall spoke with Daniel. Daniel asked him to check that his flash hood and collar were tucked in. Fire Fighter Marshall checked Daniel's uniform and tucked in his flash hood and collar. By this time, Daniel had his helmet and breathing apparatus on and the helmet strap was apparently secured under his chin.[70]

53. Deputy Captain Walkinshaw states that around this time he said to Daniel: *"Once Khan returns from the RSL, you and him can take a line of hose to the front of the RSL and spray water over the car outside it to protect it from the heat. Don't go near the hotel because the power lines that run along the side of the building are still energised… The building's fucked. If we can save the car it's a bonus."*[71]

54. It appears that Fire Fighter Hill heard part of this conversation. He states that Daniel replied with words to the effect of *"Yeah, I want to go down there. It should be right"* and pointed to the front of the hotel. Fire Fighter Hill heard Deputy Captain Walkinshaw say *"Nah"* and also say *"Stay in front of the car"*. Fire Fighter Hill did not hear Daniel's response.[72] At about this time Captain Lord also states that he had a conversation with Deputy Captain Walkinshaw about protecting the gold coloured Toyota Camry parked on Marshall Street.[73] At some point Captain Lord heard Deputy Captain Walkinshaw yell to Daniel *"Howey, protect the car"* and to be careful of the overhead power lines.[74]

55. It appears that Deputy Captain Walkinshaw left the immediate scene around this time to check what was happening on the other side of the building.

56. At some point, Fire Fighter Fugar and Daniel took the hose to the extreme left of the front of the building on Marshall Street.[75] Fire Fighter Fugar remembered asking Daniel if the power had been turned off, to which Daniel replied that it had.[76] It appears that from at least this point Fire Fighters Fugar and Howard were directing their hose to towards the building, not the car. Photographs indicate that there were also members of the RFS nearby.

[68] Statement of C Marshall, para [40].
[69] Statement of A Hill, para [31]; R Bruce Jnr states he helped the deceased put on his uniform: Statement of R Bruce Jnr, para [12].
[70] Statement of C Marshall, para [42].
[71] Statement of T Walkinshaw, page 11.
[72] Statement of A Hill, para [32].
[73] Statement of A Lord, para [30].
[74] Statement of A Lord, para [31].
[75] Statement of K Fugar, para [57].
[76] Statement of K Fugar, para [56].

57. Fire Fighter Fugar noticed that an air-conditioning unit had fallen from the third window from the left front of the building. He told Daniel that they should be careful that the air-conditioners did not fall on them. He states that Daniel agreed.[77]

58. Fire Fighter Fugar and Daniel took turns at the front and rear of the hose, directing water onto windows at the front of the building on Marshall Street. The water did not appear to be making any impact on the strength of the flames, with large amounts of flame coming from the front windows of the building.[78]

59. Fire Fighter Fugar left to replace his breathing apparatus cylinder as his oxygen levels were becoming low. He walked to the staging area on Marshall Street.[79]

60. Fire Fighter Fugar returned to Daniel who had moved to the extreme right of the front of the building on Marshall Street. The gold coloured Toyota Camry that Deputy Captain Walkinshaw had referred to was parked directly outside this area of the hotel. Daniel was kneeling in the footpath gutter, about four metres from the front of the building, directing the hose into an area of the wall at the front right of the building which had been burnt out.[80]

61. Fire Fighter Fugar recalls that Daniel's helmet strap was not done up and informed him that they better be careful of the walkway roof in case it collapsed. Daniel stated *"Yeah, I put a bit of water on it and it looks pretty stable"*.[81]

62. Fire Fighter Fugar crouched next to Daniel while he handled the hose on his own. After about two minutes Daniel stood up and started walking closer to the hotel. Fire Fighter Fugar noticed that Daniel appeared to be running out of hose, so Fire Fighter Fugar followed the hose line back around to the front of the car. Fire Fighter Fugar pulled what hose they had left and returned to the back passenger side of the car.

63. Fire Fighter Fugar stayed there as he was concerned about the stability of the awning and could not see it clearly due to a large tree being in the way and due to the strength of the fire thought that it may be unsafe. He was about two metres behind Daniel[82] who was standing at the front of the building on the right hand side and directing his hose into the wall section which had been burnt out. Daniel was about two to three metres from the front of the building and was under the awning.[83]

64. Fire Fighter Fugar states that the supports of the awning were engulfed in flames and he believed there was a risk of the awning collapsing.[84] After about a minute or two he decided to say something, however the awning started to fall before he could. Fire Fighter Fugar yelled *"Howey!"* Daniel turned around and looked up at the awning as it fell. Daniel dropped the hose and started to run in the direction of Fire Fighter Fugar.[85] Fire Fighter Fugar saw a large section of the front wall start to fall towards him and he started to run back towards Marshall Street.[86]

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[77] Statement of K Fugar, para [58].
[78] Statement of K Fugar, para [64][66].
[79] Statement of K Fugar, para [68].
[80] Statement of K Fugar, para [69].
[81] Statement of K Fugar, para [70].
[82] Statement of K Fugar, para [72].
[83] Statement of K Fugar, para [73].
[84] Statement of K Fugar, para [74].
[85] Statement of K Fugar, para [75].
[86] Statement of K Fugar, para [76].

65. Deputy Captain Lord and Fire Fighter Snelson dropped their hose and ran onto Marshall Street. Deputy Captain Lord was hit in the back of his legs by falling bricks.[87] The rubble around Daniel was cleared and he was moved.

66. Daniel had no pulse, was not breathing, was unresponsive and had significant head trauma.[88] His helmet had somehow come off and was lying nearby. Ambulance Officer Shane McGregor commenced CPR. Daniel was taken to Cobar Hospital where he was examined by Dr Deon Heyns at approximately 9:30 a.m. At 9:45 a.m. Dr Heyns formed the view that there was no possibility of reviving Daniel and he stopped resuscitation.[89] At 10 a.m. Dr Heyns pronounced Daniel's life extinct.[90]

Cause of death

67. An autopsy was performed on Daniel by Dr Rexson Tse from the Newcastle Department of Forensic Medicine on 21 August 2014. He stated that the direct cause of Daniel's death was a crush injury to the head, chest, abdomen and pelvis.[91] In Dr Tse's view the nature of the injuries was such that his death was "rapid and inevitable".

The cause and origin of the fire

68. There was no real conflict between the parties in relation to the cause or origin of the fire, and for that reason I intend to deal with the issue briefly. I accept the evidence of Mr Apps that the fire is likely to have originated in and around the chimney flue in the ceiling cavity.[92] This is certainly consistent with witness observations that the flames were first seen in the air-conditioning vents and then in the roof area. A metal flue had been retro-fitted into the original chimney at some stage and it is possible that the flange failed allowing a spark into the older brick chimney. However I also accept that the collapse of the building means that it is impossible to determine the exact cause of the fire with one hundred per cent accuracy.

69. There is evidence that a wood fire had been burning that night. In evidence, Mr Apps also noted that soot can be deposited within a flue over time and the deposits can become a fuel source themselves. It is possible that a stray spark or ember may have escaped from some point within the chimney in the space between the ceiling and the roof lining. The fire is likely to have developed in the roof void for a period of time before smoke entered the rooms and was detected. Once the supports of the ceiling were sufficiently weakened, they collapsed, increasing the supply of oxygen and therefore the intensity of the fire, which then spread throughout the remainder of the premises. At the time the awning collapsed the fire may have been burning for over one hour and 45 minutes.

70. There is no evidence before me to shed any light on why alarms, which were fitted, did not alert those in the hotel at an earlier time.

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[87] Statement of T Lord, paras [9]-[10].
[88] Statement of M Bradley, para [10].
[89] Statement of Dr D Heyns, para [3].
[90] Statement of A Hill, para [47]; Certificate pronouncing life extinct.
[91] Autopsy Report.
[92] Apps, Transcript 11/9/2017, page 28, line 16 onwards. See also Apps Report Tab 73.

71. Having considered all the evidence, I am well satisfied that the fire was accidental and that no suspicious circumstances exist. There is no evidence to suggest an electrical fire or arson. The fire originated in the ceiling area, around the chimney flue.

Issues for consideration

72. At the commencement of the inquest, a list of issues was circulated and as the proceedings developed other issues emerged for consideration, some having particular interest to Daniel Howard's family. I intend to deal briefly with each of the following in turn.

The nature and adequacy of the training provided to retained fire fighters by FRNSW

73. One of the big issues arising from this inquest was the adequacy of the training currently provided to the retained fire fighters. The nature of this particular fire meant that the main area of focus was whether the fire fighters who attended the Occidental Hotel were properly trained in relation to the risk of structural collapse.

74. It became clear that a lack of knowledge about the possibility of structural collapse was evident across the board. Fire Fighter Fugar stated that during phase one or phase two of his training he remembered that one instructor had spoken about brick walls on top of roofs being heavy, and that fire fighters needed to be aware of their weight. Fire Fighter Fugar also said that he vaguely remembered training about safe working spaces and exclusion zones during phase one training. He agreed that there was no mention of structural collapse in subsequent training.[93]

75. Fire Fighter Fugar also gave evidence that, to his knowledge since returning as a retained fire fighter, there had been no training offered on structural collapse[94]. However, it needs to be remembered that Fire Fighter Fugar had only been involved to a limited respect with the Cobar Fire Station since his return from injury.

76. Fire Fighter Marshall gave evidence that he could not remember the specific details about the training he received on structural collapse before the fire at Cobar.[95]

77. Fire Fighter Hill gave evidence that he had received training on structural collapse in private enterprise, and not during his training as a retained fire fighter.[96]

78. Fire Fighter Peters gave evidence that the training he received on structural collapse occurred in phase two of his training and that was approximately two years before the fire at Cobar. Fire Fighter Peters agreed that at the time of the fire at Cobar there was nothing in the forefront of his mind about the danger of structural collapse.[97] Fire Fighter Peters said that he had received training on structural collapse since the fire at Cobar.

[93] Fugar, Transcript, 13/03/17, page 41, page 56.
[94] Fugar, Transcript, 13/03/17, page 44.
[95] Marshall, Transcript, 14/03/17 page 67-68.
[96] Hill, Transcript 14/03/17 page 77.
[97] Peters, Transcript, 14/03/17, page 93.

79. Deputy Captain Walkinshaw gave evidence that at the time of the fire at Cobar he did not have training on structural collapse and was not alert to the possibility that the Occidental Hotel might collapse on that day.[98]

80. Superintendent Adam Dewberry gave evidence that training on structural collapse was given in phase one of training. He could not remember what specific knowledge this training equipped fire fighters with, or whether it included training on brick walls.[99]

81. Mr Holton's opinion was that the fire fighters who attended the Cobar fire had a general lack of structural collapse awareness and that this was a key element in events unfolding as they did at the Occidental Hotel. I accept his opinion on this issue. Mr Holton stated that this lack of awareness about structural collapse was likely to be more common in rural fire fighters, who might not get as much exposure to complex fires as city based fire fighters.

82. Mr Unsworth described structural collapse awareness as a foundational skill that all fire fighters who attend fires, including safety officers should be equipped with. He characterised structural collapse as one of the many workplace risks that fire fighters have to manage.

83. Mr Phillips agreed that the general level of structural awareness of fire fighters was poor, and noted the recommendation contained in the ICAM report to increase training accordingly. He also made the point that while structural collapse knowledge is important, it cannot be isolated from all the other information that fire fighters need to be aware of at any given location. To focus solely on training and knowledge of structural collapse would be misplaced. Both Mr Unsworth and Mr Phillips emphasised that the entire strategic framework that fire fighters use to manage risk at any given scene needs to be evaluated.

84. Following an analysis of the events at the Occidental Hotel, there was clear recognition on the part of FRNSW that the organisation needed to grapple with improving the training for fire fighters in relation to structural collapse. Evidence at the inquest demonstrated that there is still a great deal of work to do in this regard. It appeared that there was still a limited understanding about how fire duration and conditions can affect structural integrity.

85. The court's attention was drawn to a Safety Bulletin (Safety Bulletin 200/7 Structural Collapse) which included a guideline for safe fire fighting and referred to an area of one and a half times the height of a building as an appropriate exclusion zone.[100] Unfortunately, this guideline was rescinded in 2011 and replaced by a more limited guideline (SOG 4.20 Concrete Wall Panel Construction) referring only to concrete wall panel constructions. This appears to have been an oversight, rather than a considered policy adjustment. I note that the issue has now been addressed by FRNSW with the completion of a new Standard Operating Guideline on Structural Collapse. The court was informed that a corresponding e-Learning package and "Toolkit" had now been developed to make sure the information reaches those on the ground.[101] I am satisfied that the organisation has taken seriously the need for further training in relation to both structural collapse and the need for exclusion zone guidelines. However, given that it was generally agreed by all experts and senior fire fighters that structural collapse was a critical issue, it remained surprising that the level of knowledge

[98] Walkinshaw, Transcript, 15/03/17, page 17.
[99] Dewberry, Transcript, 14/03/17, page 33-34.
[100] While just a guideline, not a rule the Bulletin served to draw the fire fighter's attention to the risk and effect of structural collapse.
[101] See McGuiggan, Tab 66A [7-10].

was still so low. The issue raises the need for FRNSW to more thoroughly audit its fire fighters' knowledge to identify the knowledge gaps and resulting training needs.

Whether there was adequate control of the fire scene by Deputy Captain Walkinshaw, given his level of training and supervision?

86. Deputy Captain Walkinshaw had been a retained fire fighter for about seven years as at the time of the fire at the Occidental Hotel. This was the first incident of any significance at which he was required to take on the role of incident controller.[102] He gave evidence at the inquest and impressed as a thoughtful and reliable witness.

87. In my view he performed the role of incident controller with great care and skill, given the difficult circumstances that confronted him and his general lack of experience. I do not intend to review in detail all of his actions and decisions. It is sufficient to record that he assumed control of the scene quickly and attended to a very wide variety of tasks, which included calling for additional assistance from a variety of sources; evacuating residents and others nearby; organising the power to be isolated and verbally ordering an electrical exclusion zone; establishing a control centre; correctly identifying a number of risks, such as that posed by the LPG cylinders; liaising with other agencies that could assist in crowd control and with road blocks and dealing with a number of operational issues, such as that posed by the fire hydrants. He remained calm in the face of a huge fire, with only limited resources under his control. Not all the fire fighters had radios and his focus was necessarily extended over a fairly large geographical area.

88. To his credit, Deputy Captain Walkinshaw quickly and correctly identified that the fire must be fought in a defensive manner. He did his best to ensure the safety of his men. I note that there was no criticism of him from any fire fighter, either from his own team or from the RFS who had been present on the day. I offer no criticism of him, but it appears that he could have been better supported and better trained by the organisation he worked for.

89. The ICAM report identified five recommendations arising out of the tragedy at the Occidental Hotel. One of these recognised the need for further training for Incident Controllers like Deputy Captain Walkinshaw. Specifically the report recommended the development of an incident management course for Captains, Deputy Captains and senior RFFs, recognising among other factors, the resource constraints they face. This course has now been implemented in the form of a new training program that includes an e-Learning element followed by a two day Incident Management Training Package including "fire simulation training that applies the theory in practice". These role play situations are "based upon participants having available to them the staff and appliances that they would typically have access to in their town."[103]

90. This is a positive development and will mean that someone in the unenviable position Deputy Captain Walkinshaw found himself in on that day is likely be better equipped to deal with the situation he faced. It should be remembered that Deputy Captain Walkinshaw was on his first significant outing as Incident Controller, he faced a fire of a size and complexity that had not been seen in Cobar for over a decade. He needed more training than he had to make the decisions he was called upon to make.

[102] Walkinshaw, Transcript 15/3/17, page 9, line 11.
[103] See McGuiggan, Tab 66, page 20-22.

91. The evidence arising from the inquest suggests that as well as formal training courses, someone in Deputy Captain Walkinshaw's position may benefit from further mentoring and exposure to the work undertaken by professional fire fighters.

Should Deputy Captain Walkinshaw have appointed a safety officer?

92. A specially dedicated safety officer has the capacity to look at the larger picture to determine exactly what is going on. Their function is essentially to ensure the safety of fire fighters, by standing back from the action and taking in the whole situation. They are able to take into account the issues that may present risk to fire fighters, such as electricity, building collapse, asbestos, or the existence of hazardous material.[104] They may intervene if a situation is life threatening and if necessary even override a task given by the Incident Controller.[105] The position was described as "incredibly advantageous"[106], but resource intensive.

93. The relevant Standard Operating Guideline provides that a safety officer should be appointed at complex fires. However it is clear that the guideline has been drafted with a metropolitan environment in mind and is less relevant in the arduous conditions that can at times face a rural brigade who are working with greatly limited resources.

94. Counsel for the family submitted that "there is a significant likelihood that if a properly (sic) safety officer had been appointed at this fire, he/she would have been able to take in the bigger picture and identified the risk to structural integrity, such as to withdraw fire fighters Fugar and Daniel"[107] It would have been Deputy Captain Walkinshaw's job to appoint such an officer.

95. I have carefully considered the issue of whether Deputy Captain Walkinshaw should have appointed a safety officer and reviewed the expert and other evidence in this regard.[108] In my view he was faced with a difficult situation. He did not have the resources to comfortably take one fire fighter out of active duty. In any event it appears that while he had heard of a safety officer, he had limited knowledge or training about how such a role would work in practice. He did not know exactly when a safety officer should be appointed and he did not consider doing it on 17 August 2014.[109] In all the circumstances, I do not offer any criticism of Deputy Captain Walkinshaw in this regard. While it is clear that RFFs could benefit from further training in relation to the benefits of appointing a safety officer, it is also clear that in rural and remote areas the lack of resources may mean it is not always possible.

96. It is also important to note that the presence of a safety officer does not necessarily guarantee a safer environment for fire fighters. Counsel for the family conceded that even if one had been appointed on that day, given the lack of knowledge in the Cobar Brigade in relation to structural collapse, it may not have averted the tragedy which subsequently ensued.

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[104] For discussion of this issue see for example Transcript 14/03/17, page 16 onwards
[105] Unsworth 12/09/17, page 27, line 26 onwards
[106] Unsworth 12/09/17, page 28, line 24 and following..
[107] Written Submissions of Family, 2.1
[108] See both the Holton Report and the ICAM report in this regard.
[109] Walkinshaw, 15/03/17 page 19, line 30.

97. There will be times when the appointment of a safety officer is appropriate in a fire controlled and fought by retained fire fighters. However, it is crucial to be aware of the particular problems faced by fire fighters in regional and remote areas. Fire fighters may face a complex fire, with limited resources. The Incident Controller's options and operational decisions may be constrained. Each situation will involve carefully weighing up the potential risks and benefits.

98. The ICAM report properly identified a need for FRNSW to review the voluminous Standard Operating Guidelines to take into account the restraints experienced by regional and remote brigades compared to fully professional metropolitan brigades. Guidelines with more direct relevance to retained fire fighter brigades should be emphasised in training. It was also recognised that there should be further input from representatives from regional and remote areas when new operating guidelines are developed or amended.

The adequacy of the communication between FRNSW fire fighters on the scene and elsewhere

99. Deputy Captain Walkinshaw appropriately sought expert assistance. The Court heard from Inspector Mark McKay who was the Duty Commander, based in Dubbo at the time of the fire. He had to make his way to Cobar, receiving various updates as he drove. As is common in western NSW, he was confronted by a long road trip, where communication was difficult.

100. The ICAM report identified some of the issues that can arise when an Incident Controller working in a remote area needs advice and guidance from a Zone or Area Commander who is not immediately available because of distance or communication challenges.

101. In evidence Mr Unsworth illustrated the difficulties of a Zone or Area commander who may be driving to a remote fire to assist. On the trip, not only may communication be hampered as the car goes in and out of telephone range, but the Commander is clearly unable to consult useful checklists and focus fully on the problem at hand whilst driving.[110]

102. As a result, the ICAM report recommended expediting an already proposed Intelligence Cells Situation room to provide expert advice and Incident Management Team support for retained fire fighters at significant incidents. The need for this development is clearly demonstrated by the facts arising in this inquest.

The adequacy and timeliness of the Rural Fire Service response to the fire

103. The Court has carefully considered the adequacy of the response by the Rural Fire Service to the events at the Occidental Hotel. There appear to be no issues that require detailed discussion. Captain Lord liaised appropriately with Deputy Captain Walkinshaw and offered any support he could.

[110] Unsworth Transcript 11/09/17 page 57, line 7 onwards.

The adequacy and timeliness of the response of the NSW Police Force to the fire and its subsequent investigation

104. In my view, Detective McKervey was greatly hampered in what he could achieve by the lack of timely back-up and by his lack of a personal radio[111]. Despite numerous requests for assistance, he remained unsupported until 9.15am. This meant that others had to assist with traffic redirection, crowd control and the creation of a physical safety barrier. It was lucky that he received the assistance of the Ambulance Service and the Shire Council in this regard. While it is difficult to establish exactly what effect this had on fire fighters, it was Detective McKervey's view that they were distracted by the growing crowd.[112]The lack of general duties police available was unfortunate in this respect.

105. The Howard family were also concerned with the difficulties faced by Detective McKervey in his role investigating the fire after the events. Detective McKervey set about investigating the fire but he was unable to interview the RFF present on the day. He told the court that he was informed that FRNSW "claimed legal professional privilege". Statements were ultimately prepared with the assistance of an organisation called Procare, which was retained by FRNSW. It appears that this practise was also adopted in another matter, but is not currently usual practise.

106. Statements for coronial matters are frequently prepared by lawyers for hospitals and other agencies and in that respect the practise is not unheard of. There was nothing before me to suggest that any of the statements taken did not reflect the opinion of the witness who gave it and I was satisfied that while the practise is somewhat unusual in relation to a fire, it did not compromise the reliability of the evidence before me.

107. Significantly, the court also had the benefit of hearing from the authors of the ICAM report. The preparation of this report involved inspection of the fire site the day after the blaze, interviews with RFFs who had been present and with Captain Tony Lord. The authors of the report were impressive witnesses and showed a willingness to identify areas of improvement available for FRNSW.

The availability and effectiveness of the Cobar Shire Council fire hydrants

108. Fire fighters experienced a number of issues on the day with respect to Cobar Shire fire hydrants. These included the fact that some fire hydrants were not working properly at the time of the fire. There was at least one fire hydrant filled with clay and poor water pressure was experienced.[113]There was a need to return to the station to obtain an extra tall standpipe because some hydrants were too deep to be accessed by normal standpipes.

109. Since the fire at the Occident Hotel, Cobar Fire Station has been provided with a Mobile Data Terminal that shows the locations of the different fire hydrants in Cobar.[114] However, it

[111] It appears that Detective Senior Constable McKervey was unable to access the equipment locker as he did not have a key, Statement of Detective McKervey, Exhibit 1, Tab 6, page 23[7]
[112] McKervey 13/3/17 page 23, line 10 onwards.
[113] For discussion of these issues see Marshall, Tab 57, page 565 and Marshall Transcript, 14/03/17, page 49, line 20.
[114] Marshall Transcript, 14/03/17, page 49, line 46, page 50, line 8.

became clear during the inquest that the Mobile Data Terminals currently available may not have been entirely up-to-date in listing where working hydrants were located.[115]

110. The inquest was greatly assisted by the participation of Mr Vlatko, who took over as General Manager of Cobar Shire Council in May 2016. He accepted responsibility to drive change and was responsive to the failings as they emerged in the evidence.

111. Mr Vlatko took a number of significant steps including directing the establishment of a fire hydrant maintenance program for all hydrants under Council's responsibility; facilitating the establishment of proper lines of communication in relation to local hydrants between FRNSW and Council; ordering a public works survey to record and analyse the state of the Cobar Council Water Pipe System to ensure that all works, repairs and flows are understood and maintained; recruiting a Sewer and Water Manager who will, among other duties, regularly review the maintenance program.[116] Mr Vlatko's professional response to the issues arising from this inquest was commendable.

112. During the view, the court also received information about the Mobile Data Terminals. This was supplemented by further written and oral evidence from Assistant Commissioner McGuiggan.[117] Currently, in a state wide program, the location of hydrant and water mains layer data is provided by the relevant water authority or Local Government to Spatial Services' Emergency Information Coordination Unit (EICU). Spatial Services are a component of the Department of Finance, Services and Innovation of New South Wales and their role is to ensure that the emergency management sector has the best spatial and related data available when dealing with emergency situations. Currently the EICU consolidate and standardise the data and provide it to FRNSW every 6 months. FRNSW takes the hydrants and mains layer data and uploads it to the Emergency Services Computer Aided Dispatch System, MDTs are then updated on a quarterly basis. While Cobar Shire Council is willing to fully participate in the process, the overall system appears to be let down by some other Local Government authorities (some ten to twelve currently) who have not provided the necessary information to Spatial Services and therefore emergency services in those areas rely on "dots on maps that are historical in nature."[118] Evidence arising from this inquest indicates the valuable nature of this information for fire fighters in emergency situations. All councils and local authorities should be encouraged to participate.

The prompt identification of "next of kin" and appointment of a support person

113. Genevieve Howard found out about the death of her son several hours after the incident, via a third party despite being clearly recorded as his next of kin in information held by FRNSW. This caused her great pain and affected her ability to visit the hospital where he died in a timely manner. Ms Howard also believes that she was left "out of the loop" in subsequent communications with FRNSW, the Coroner's Court and other authorities after Daniel's death.[119]

114. Mrs Howard's pain in relation to this issue was significant. She estimated that many hundreds of people knew her son was dead before she did and that even once she had

[115] See for example, Marshall, 14/03/17, page 72, line 32.
[116] Transcript, Vlatko, 11/09/17 page 6 onwards; Exhibit 12: Statement of P Vlatko.
[117] Second statement of P McGuiggan; McGuiggan, Transcript, 12/09/17, page 59 onwards.
[118] McGuiggan, Transcript, 12/09/17, page 61, line 1.
[119] Letter from Genevieve Howard to State Coroner's Court, 1/02/17.

heard from other sources, she never got "official notification".[120] She remained hurt and dissatisfied by the treatment she received.

115. Assistant Commissioner McGuiggan was asked about the question of notification in evidence and, while he didn't know the specifics of this situation, acknowledged the challenges and intricacies of personal relationships.[121] He appeared open to examining mechanisms to improve the notification procedures.

116. Counsel for the Howard Family also submitted that a "next of kin support person" be put in place to assist families when tragedies such as Daniel's death occur. Such a person could assist and guide family members through the investigative process. They would be available to answer questions and provide support. They would serve as a point of contact for the grieving next of kin. I consider it appropriate to make a recommendation that FRNSW conducts an audit in relation to its processes for the notification and support of next of kin in relation to tragedies of this kind.

Findings in relation to the death of Daniel Howard

117. The findings I make under section 81(1) of the Act are:

Identity

The person who died was Daniel Grahame Howard.

Date of death

He died at approximately 10am on 17 August 2014

Place of death

He died at Cobar District Hospital, Cobar NSW.

Cause of death

He died from crush injuries to the head, chest, abdomen and pelvis.

Manner of death

Daniel Howard died while bravely fighting a fire in his role as a retained firefighter for FRNSW. He suffered catastrophic injuries after a wall of the New Occidental Hotel at Cobar collapsed on him during the fire.

Findings in relation to the fire at the Occidental Hotel

118. The findings I make in relation to the fire are:

119. The cause of the fire was an accidental ignition of combustibles in the ceiling by either conducted heat or an escaped spark that originated around the portion of the chimney flue that was within the ceiling.

[120] Letter from Genevieve Howard to State Coroner's Court, 1/02/17.
[121] McGuiggan, Transcript, 12/09/17, page 73, line 25.

Recommendations

120. I have carefully considered the need for recommendations in this matter. In my view it is greatly reduced by changes that have already been made by FRNSW and by Cobar Shire Council, in direct response to the tragedy which occurred in Cobar. They are to be commended for their action to date.

121. Nevertheless, in my view a limited number of matters remain for further consideration.

122. Accordingly I make the following recommendations

To Fire & Rescue NSW

123. That FRNSW provides a copy of these coronial findings to their Education and Training Unit and requests that consideration is given to using the facts of this tragedy as a case study in the training of RFFs in relation to both structural collapse and incident control, in accordance with the new policies which have been developed.

124. That FRNSW develop a mentoring program between PFFs and RFFs to support and encourage professional development of RFFs, particularly at the level of Captain and Deputy Captain.

125. That FRNSW review organisational capability statements every 12 months (including local critical risks) with a view to identifying gaps in essential knowledge so that appropriate evaluation and training programs can be effectively implemented.

126. That FRNSW provide a copy of these coronial findings to the Emergency Information Coordination Unit, Spatial Services NSW, with a view to encouraging all relevant parties to assist in obtaining up-to-date spatial information across New South Wales immediately and to facilitate the ongoing update of such information on a quarterly basis.

127. That FRNSW audit its internal policies to ensure that the timely notification of the official next of kin occurs in tragedies of this kind and considers instituting a system where a support person is appointed to the next-of-kin where a casualty occurs.

Conclusion

128. In conclusion, I offer my sincere condolences to all of those affected by Daniel's tragic death. In particular I express my sorrow for the fire fighters he worked with. A number of those men gave evidence before me and their grief and respect for Daniel was palpable in the court room. I thank them for their contribution to fire fighting and I honour the strength of those who continued to work, even after knowing that their colleague was seriously injured or dying.

129. I express optimism by the positive approach taken by those representing FRNSW in relation to the issues raised in this inquest. I note that Assistant Commissioner Mark McGuiggan was present throughout the entire proceedings and I respect the open attitude taken to the

opportunities for improvement as they emerged. It is also pleasing that the new General Manager of Cobar Shire Council took responsibility for some of the shortcomings that existed with Council infrastructure at the time of Daniel's death and that since his appointment has worked to make meaningful improvements in this regard.

130. Finally, special mention must be made of Daniel's mother, Genevieve. She attended each day of the inquest to make certain no wrongful criticism was made of her son. These findings make it clear that none is warranted. Daniel worked courageously in extremely difficult circumstances, his significant contribution was recognised by the Assistant Commissioner before me.

131. Ms Howard's anger at how she was informed of Daniel's death is understandable and I hope that further reflection on the issue by FRNSW will mean that these systems are continually improved. In the age of social media, prompt contact with the next of kin is increasingly crucial.

132. Daniel's mother was also fighting for improvements in training and support for retained fire fighters, such as her son. In my view her voice has been heard by FRNSW.

133. Once again, I offer Ms Howard my sincere condolences for the heartbreaking loss of her son in these tragic circumstances. I cannot help but to admire the strength she has shown in facing such adversity.

134. I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner
16 February 2018
NSW State Coroner's Court, Glebe