Commissions of Inquiry Act 1950 (Qld)

IN THE MATTER OF
THE GRANTHAM FLOODS COMMISSION OF INQUIRY

AND IN THE MATTER OF
***COMMISSIONS OF INQUIRY ORDER NO. (3)* 2015 ESTABLISHING THE**
"GRANTHAM FLOODS COMMISSION OF INQUIRY"

SUBMISSIONS BY THE STATE OF QUEENSLAND

Contents

Introduction

1. Pursuant to Order in Council being, *"Commissions of Inquiry Order No. (3)* 2015 *dated 11 May 2015"* a review or investigation by the Commission was to be conducted of:

> *"(a) the flooding of the Lockyer Creek between Helidon and Grantham on 10 January 2011, with specific reference to any natural or man-made features of the landscape which could have altered or contributed to the flooding;*
>
> *(b) whether the existence or breach of the Grantham quarry caused or contributed to the flooding of Grantham;*
>
> *(c) whether the existence or breach of the Grantham quarry had a material impact on the damage caused by the flooding at Grantham;*
>
> *(d) whether the breach of the Grantham quarry had implications for evacuation of Grantham;*
>
> *(e) how these matters were first investigated and how eyewitnesses' accounts were dealt with, particularly by State Government agencies and Emergency Services."*

2. On 2 June 2015, leave was granted to the State of Queensland to appear in relation to Terms of Reference (d) and (e).

A Miscellaneous Submission in Respect of Term of Reference 3(a)

3. Before the State deals with the matters upon which it has been given leave to appear, a miscellaneous issue ought be addressed. The legislative regime governing the quarry ought be addressed. There was some dispute in the evidence[1] between the State and the Lockyer Valley Regional Council as to the monitoring and regulation of the conditions pursuant to which the Grantham Quarry operated.

4. In respect of this issue, the State relies upon the affidavits provided by Susan Ryan, Stephen Johnston and John Black, all of which were dated 17 July 2015. Ms Ryan is the Deputy Director General, Department of Natural Resources and Mines. Mr Johnston is the Acting Director General, Department of Infrastructure Local Government and Planning and Mr Black is the Director General, Department of Environment and Heritage and Protection. Each affidavit exhibits a document which is headed, *"an overview of the regulatory framework applying to the quarry … between 1981 and 2011".*[2] This document sets out the State's evidence and statement of the effect of the applicable legislative regimes with respect to the quarry. None of this material was the subject of challenge. It may be of some assistance to amplify some of the matters contained therein.

5. Pursuant to the *Water Act* 1926, the *Water Resources Act* 1989 and the *Water Act* 2000, the State had, and has, control of the bed and banks of all watercourses in Queensland. The State possessed the necessary authority to consent to the construction of works associated with the watercourse, such as levee banks, and the power to investigate and undertake compliance activities in relation to activity in the watercourse which would necessarily involve the construction of levee banks/bunds or the extraction of the quarry material.

6. It appears from the records of the State, that this quarry commenced operation in the early 1940s. It then operated within the bed and banks of Lockyer Creek. A permit was issued under the *Water Act* 1926 in accordance with the *Gravel and Sand Material Regulations* 1935. This permit was renewed annually.

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1 See Transcript 917.8 and onwards.
2 Being Exhibit 1 to each affidavit.

7. In about August of 1968, the State issued permits for riverine quarrying in Lockyer Creek under the *Water Act* 1926 in accordance with the *Controlled Quarrying Material Regulation* 1968. Such permits were also renewed annually under Section 8 of those Regulations.

8. In January 1978, the State indicated that no further permits would be issued or renewed for the extraction of quarry material within the bed and banks of Lockyer Creek from 30 June 1978. There was, however, a six month riverine quarry permit issued on 1 November 1984 for the removal of 2,500 cubic metres of material. Only 425 cubic metres were removed pursuant to this permit. Further, two quarry permits were issued of one month's duration on 30 August 1989 and 17 October 1989 under the *Water Act*.

9. It appears, from records held by the Department of Natural Resources and Mines, that from 1981 those that operated the quarry[3] relocated the quarrying activities to land adjacent to the bed and banks of Lockyer Creek. An approval of the relevant local authority, being the then Gatton Shire Council, was required. An application was made to that local authority. The Shire Council asked Queensland Water Resources Commission for comment in respect of this application. As Exhibit 1 notes,[4] *"it is not clear whether the State's advisories were questioned because of the proximity of the quarry activities to Lockyer Creek or because of the State's technical expertise."*

10. In any event, the State's advice was sent to the local authority which incorporated in it conditions attached to the approval which was issued by the local authority on 20 October 1981. The conditions included Condition 10 under the heading, *"Workings Made Safe"* which stipulated that overburden was not to be placed so as to form a levee bank unless approval was obtained from the QWRC (the Queensland Water Resources Commission).

11. It does not appear, from records held by the Department of Natural Resources and Mines, that any such approval for the construction of a levee was ever sought or obtained.

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3 Sullweis Pty Ltd

4 See para 19.

12. It appears that the approval of the local authority was renewed on a number of occasions. On each occasion, Condition 10 was maintained.

13. At no stage was the approval, with this condition, given as a result of the exercise of any statutory power exercisable by a State government department or agency. It was, at all times, the act of the relevant local authority which granted the approval subject to the condition which had initially been incorporated in 1981. There is no evidence to suggest that the State was ever made aware of the making of the approval which contained the relevant clause.

14. The initial approval of 20 October 1981 was a town planning consent issued under and in accordance with the existing Gatton Shire Town Planning Scheme.[5] The consent imposed the condition. The local authority took the view that the State, through the Queensland Water Resources Commission, was, *"the agency responsible"* and that any compliance issues would be the responsibility of the Queensland Water Resources Commission or some other State agency.

15. It is submitted that such a view is misconceived. The condition was imposed pursuant to the provisions of the relevant planning scheme as authorised by the *Local Government Act* 1936.[6] It was, at all times, a condition which arose as a consequence of the act of the local authority. Whilst the State maintains an interest in the watercourse, the *"extractive industry"* regulated by the town planning scheme and the then Gatton Shire Council, was not an activity conducted in the watercourse, that having ceased in 1978, but was one conducted adjacent to it. The State had no jurisdiction in respect of this activity unless it affected the watercourse. The State, through the Queensland Water Resources Commission, had made recommendations which protected the waterway by ensuring a 40 metre boundary between the quarrying activity and the banks of the watercourse and a suggested requirement with respect to the disposition of overburden.

16. New regulations applying to the construction of a new or the modification of an existing levee were introduced in May 2014. Under these regulations, local

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5 See Chapter 28 Part 2 of the Town Planning Scheme for the area of the Shire of Gatton gazetted on 13 June 1981.

6 See s.33.

authorities are responsible for assessing all levee applications. Levees which fall into the highest risk category are referred to the State Government to assess against the State Code. In this instance, the disposition of overburden which acted as a levee was an activity regulated by the local authority. This has always been the case.

17. The State was not aware of the making of this condition.

18. It was, at all times, a matter for the Council to regulate the conditions it had imposed as part of its approval process. Mr Flint's evidence[7] misconceives the jurisdiction of the then Gatton Shire Council and its successor. The evidence is indicative of a failure to regulate those activities which were the subject of the local authority, approval which may have allowed the bunds, adjacent to the Lockyer Creek, to be constructed.

19. Exhibit 1 of the statement given by Ms Ryan and Messrs Black and Johnston indicates that the Department of Infrastructure Local Government and Planning and its predecessors had no role in relation to the approval, in 1981, or subsequently. Any ongoing monitoring and inspection to ensure compliance with any local authority imposed conditions was not within the administrative jurisdiction of a State agency.

20. The notion that a State agency would monitor a condition of which it did not know had been imposed, in respect of land over which it had no control, nor any ability to regulate the activities on that land, is a misconception of the functions that were to be discharged by the local authority under the *Local Government Act* 1936 and its town planning scheme.

21. It is clear from Exhibit 1[8] that the State has, through various legislative Acts regulating the environment,[9] sought to protect the watercourse. But this is a different issue to that which is presently being considered. The erection of the bund did not have an environmental impact on the watercourse.

22. It can be seen that the golden thread which runs through all of the environmental legislation is that the State's paramount concern is to protect the watercourse and ensure that its integrity is maintained. Accordingly, activities which are not relevant

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7 See para 16 of his statement of 11 June 2015 (Exhibit 94).
8 See paras 114 and following.
9 See the *Clean Air Act* 1963, *Clear Waters Act* 1971 and *Environmental Protection Act* 1994.

to the watercourse, as such, are not the subject of regulation by the State.

23. Perusal of this legislative scheme as set out in Exhibit 1 further indicates that the local authority is the relevant entity to regulate the activities occurring within its jurisdiction. Any matter outside the watercourse, or which does not affect it, is not a matter upon which the State has any jurisdiction.

Term of Reference 3(d)

24. The evidence of Dr McIntosh[10] is that the presence of the quarry delayed the closure of the three identified evacuation routes by up to two minutes. This evidence ought be accepted. It was not contradicted.

25. Having regard to the nature and extent of the event under consideration, and the times involved noted by Dr McIntosh, it could not be said that the presence of the quarry had any implications for the evacuation of Grantham.

26. The evacuation of Grantham was a matter which was under the control of the local disaster management group,[11] not the State of Queensland.

27. It was noted by Counsel Assisting that issues in relation to preparedness for a disaster were matters dealt with by the Queensland Floods Commission of Inquiry. Counsel Assisting made the following observations:

> *"The Queensland Floods Commission of Inquiry reviewed the disaster management preparation of state agencies in the Lockyer Valley Regional Council, it did so in its interim report. That report was delivered on 1 August 2011 and was intended to provide recommendations in advance of the next wet season to improve responses. It is 266 pages long.*
>
> *It specifically considered issues that arose in the Lockyer Valley. It noted deficiencies in relation to, among other things, awareness about the roles and responsibilities of local government, the Queensland Police and other disaster agencies during a disaster, local government capability to respond to disasters and communication between the local district and state disaster management groups during a disaster. It made recommendations to address those issues in that interim report. It made many other recommendations to improve the capabilities and responses of state agencies to disasters such as the Queensland floods.*
>
> *As to the Lockyer Valley Regional Council, the Queensland Floods Commission noted that better planning and preparation would have assisted in the response to the disaster. As an example, the makeshift evacuation centres that sprung up around the Lockyer Valley, including the*

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10 See Exhibit 144 at paras 70 – 83 of report dated 11 August 2015.

11 See Subdivision 1 of Division 3 of Chapter 1 of the *Disaster Management Act* 2003 and, in particular, Section 30 of that Act.

> *evacuation centre at the Grantham school, where you will recall many of the witnesses who have given evidence during this inquiry had to find shelter. It noted that because the school was not an official evacuation centre, it lacked essentials: showers, cooking facilities and communications equipment. There was no power. Generators were obtained from locals to run water pumps, lights and other equipment.*
>
> *The report notes that the Lockyer Valley Regional Council's evacuation plan was a pro forma document into which no substantial detail had been inserted, that there had been no formal nomination of evacuation sites published by council, and that the consequence was that Lockyer Valley residents had no knowledge of where to congregate or evacuate to apart from the Gatton Hall, and communities throughout the Lockyer Valley had little option but to establish their own makeshift evacuation centres. It found this lack of planning caused unnecessary confusion and emotional upset for the community. It recommended that the Lockyer Valley Regional Council should identify those areas vulnerable to flooding within its region, should identify appropriate evacuation collection points and centres accordingly, and consider whether it should make those known to the community. Those investigations in relation to those very important issues have been made and they were made by the Queensland Floods Commission of Inquiry.*
>
> *Let me now return to the evidence that you will hear over the next few days."*

28. Therefore, the implications of the state of preparedness or otherwise by the local disaster management group was not a matter that was considered relevant to this Commission. It is a view that the State accepts.

29. In the final analysis, if the quarry was to have any effect on the evacuation of Grantham, it allowed a greater opportunity for the residents of Grantham to flee, whether pursuant to a disaster management plan or not.

30. It is the submission of the State of Queensland that the breach of the quarry had no adverse implications for the evacuation of Grantham. The existence of the quarry provided some marginal amelioration of the situation by providing a slightly greater opportunity to evacuate. However, that opportunity was probably not able to be effectively utilised by the citizens of Grantham due to an underlying disbelief, existing within the community, that a disaster of the magnitude that it was, was then about to befall them.

Term of Reference 3(e)

31. The reference to, *"these matters"* in the term of reference under consideration must, it is submitted, be a reference to the terms of reference which proceed it, being the flooding of Lockyer Creek between Helidon and Grantham on 10 January 2011 and

whether the existence or breach of the quarry caused or contributed to the flooding of Grantham or otherwise had a material impact on the damage caused and whether such a breach had implications to the evacuation of Grantham. It is the investigation of these four issues which is to be examined.

32. In respect of this matter, the State relies upon the affidavit of Brett Schafferius dated 11 June 2015, affidavit of David Richard Isherwood dated 17 June 2015, affidavit of Bradley John Wright dated 17 June 2015, affidavit of Andrew Peter Massingham dated 17 June 2015, affidavit of Debbie Haworth dated 13 July 2015, affidavit of Hayley Ann Munro dated 14 July 2015, affidavit of Shane Brennan dated 14 July 2015 and affidavit of Mark Patrick Wheeler dated 14 July 2015.

33. On 12 January 2011, Detective Inspector Isherwood was appointed one of the management team of *Taskforce Galaxy.* This taskforce was established by the Queensland Police Service to conduct investigations into the loss of life during the flood event on behalf of the Coroner. The Coroner conducts investigations of death pursuant to Section 11 of the *Coroners Act* 2003 which is in the following terms:[12]

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[12] A reportable death is defined in Section 8 as follows:

> *"(1) A person's death is a **reportable death** only if the death is a death to which subsection (2) and subsection (3) both apply.*
> *(2) A death is a **reportable death** if—*
> *(a) the death happened in Queensland; or*
> *(b) although the death happened outside Queensland—*
> *(i) the person's body is in Queensland; or*
> *(ii) at the time of death, the person ordinarily lived in Queensland; or*
> *(iii) the person, at the time of death, was on a journey to or from somewhere in Queensland; or*
> *(iv) the death was caused by an event that happened in Queensland.*
> *(3) A death is a **reportable death** if—*
> *(a) it is not known who the person is; or*
> *(b) the death was a violent or otherwise unnatural death; or*
> *(c) the death happened in suspicious circumstances; or*
> *(d) the death was a health care related death; or*
> *(e) a cause of death certificate has not been issued, and is not likely to be issued, for the person; or*
> *(f) the death was a death in care; or*
> *(g) the death was a death in custody; or*
> *(h) the death happened in the course of or as a result of police operations.*
> *Examples of police operations—*
> • *a police motor vehicle pursuit for the purpose of apprehending a person*
> • *an evacuation*
> *(4) However, a death that happened outside Queensland is not a reportable death if the death has been reported to a non-Queensland coroner.*
> *(5) For subsection (3)(b), an unnatural death includes the death of a person who dies at any time after receiving an injury that—*
> *(a) caused the death; or*
> *(b) contributed to the death and without which the person would not have died.*
> *Examples—*
> • *a person's death resulting from injuries sustained by the person in a motor vehicle accident many months before the death*
> • *a person's death from pneumonia suffered after fracturing the person's neck or femur*

*"**11 Deaths to be investigated***

(1) This section outlines—

(a) the type of deaths that may be investigated under this Act; and

(b) the type of coroner who conducts the investigations.

(2) A coroner must, and may only, investigate a death if the coroner—

(a) considers the death is a reportable death, whether or not the death was reported under section 7; and

(b) is not aware that any other coroner is investigating the death.

(3) Also, a coroner must investigate a death if the State Coroner directs the coroner to investigate the death.

(4) The State Coroner may direct a coroner to investigate a death if—

(a) the State Coroner considers the death is a reportable death; or

(b) the State Coroner has been directed by the Minister to have the death investigated, whether or not the death is a reportable death.

Example—

The Minister might direct the State Coroner to investigate the death of a Queensland person that happened overseas, even though the death was investigated by a coroner overseas, if the Minister is concerned that the overseas investigation was not comprehensive enough.

(5) Also, a coroner must investigate the suspected death of a person if the State Coroner directs the coroner to investigate the suspected death.

(6) The State Coroner may direct a coroner to investigate a suspected death if—

(a) the State Coroner—

(i) suspects that the person is dead; and

(ii) considers the death is a reportable death; or

(b) the Minister directs the State Coroner to have the suspected death investigated.

(7) Despite subsection (2), a death in custody, or a death mentioned in section 8(3)(h) that is not also a death in custody, must be investigated by—

(a) the State Coroner; or

(b) the Deputy State Coroner; or

(c) an appointed coroner or local coroner, approved by the Governor in Council to investigate a particular death in custody, or a death mentioned in section 8(3)(h) that is not also a death in custody, or any death in custody, or a death mentioned in section 8(3)(h) that is not also a death in

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- *a person's death caused by a subdural haematoma not resulting from a bleeding disorder"*

custody, on the recommendation of the Chief Magistrate in consultation with the State Coroner."

34. The Queensland Police have a duty to assist the Coroner conduct his investigations. Section 794 of the *Police Powers and Responsibilities Act* 2000 provides:

> *"**794 Helping coroner investigate a death***
>
> *(1) It is the duty of police officers to help coroners in the performance of a function, or exercise of a power, under the Coroners Act 2003, including—*
>
> *(a) the investigation of deaths; and*
>
> *(b) the conduct of inquests.*
>
> *(2) Without limiting subsection (1), it is the duty of police officers to comply with every reasonable and lawful request, or direction, of a coroner."*

35. Section 45 of the *Coroners Act* 2003 provides that findings that the Coroner must, if possible, make. Section 45 is as follows:

> *"**45 Coroner's findings***
>
> *(1) A coroner who is investigating a suspected death must, if possible, find whether or not a death in fact happened.*
>
> *(2) A coroner who is investigating a death or suspected death must, if possible, find—*
>
> *(a) who the deceased person is; and*
>
> *(b) how the person died; and*
>
> *(c) when the person died; and*
>
> *(d) where the person died, and in particular whether the person died in Queensland; and*
>
> *(e) what caused the person to die.*
>
> *(3) However, the coroner need not make the findings listed in subsection (2) if—*
>
> *(a) the coroner is unable to find that a suspected death in fact happened; or*
>
> *(b) the coroner stops investigating the death under section 12(2).*
>
> *(4) The coroner must give a written copy of the findings to—*
>
> *(a) a family member of the deceased person who has indicated that he or she will accept the document for the deceased person's family; and*
>
> *(b) if an inquest was held—any person who, as a person with a sufficient interest in the inquest, appeared at the inquest; and*
>
> *(c) if the deceased person was a child—*
>
> *(i) the family and child commissioner; and*
>
> *(ii) the chief executive (child safety); and*

(d) if the coroner is not the State Coroner—the State Coroner.

(5) The coroner must not include in the findings any statement that a person is, or may be—

(a) guilty of an offence; or

(b) civilly liable for something.

(6) This section applies whether or not an inquest is held."

36. Further, the Coroner can make *"comments"* as articulated in Section 46 of the *Coroners Act* 2003. This provision is as follows:

> ***"46 Coroner's comments***
>
> *(1) A coroner may, whenever appropriate, comment on anything connected with a death investigated at an inquest that relates to—*
>
> *(a) public health or safety; or*
>
> *(b) the administration of justice; or*
>
> *(c) ways to prevent deaths from happening in similar circumstances in the future.*
>
> *(2) The coroner must give a written copy of the comments to—*
>
> *(a) a family member of the deceased person who has indicated that he or she will accept the document for the deceased person's family; and*
>
> *(b) any person who, as a person with a sufficient interest in the inquest, appeared at the inquest; and*
>
> *(c) if the coroner is not the State Coroner—the State Coroner; and*
>
> *(d) if a government entity deals with the matters to which the comment relates—*
>
> *(i) the Attorney-General; and*
>
> *(ii) the Minister administering the entity; and*
>
> *(iii) the chief executive officer of the entity; and*
>
> *(e) if the comments relate to the death of a child—*
>
> *(i) the family and child commissioner; and*
>
> *(ii) the chief executive (child safety).*
>
> *(3) The coroner must not include in the comments any statement that a person is, or may be—*
>
> *(a) guilty of an offence; or*
>
> *(b) civilly liable for something."*

37. Having regard to the ultimate findings and comments that the Coroner could make, the Coroner wished to capture all potential evidence appertaining to any matter that could be seen to have contributed to the cause of the death of persons as a result of the flood event.

38. *Taskforce Galaxy* was established to assist the Coroner in discharge of the statutory duty that the Queensland Police Service has in that regard.

39. The taskforce also considered whether there was any criminal activity which might have been uncovered pursuant to the investigation of the deaths the subject of the Coroner's investigation.

40. After the State Coroner visited the Lockyer Valley on 12 January 2011, an investigation plan was devised. The objective was to establish circumstances surrounding each loss of life and included:

    (i) the matter, any appropriate advice, warning being given to, acted upon by any emergency management group or authority;

    (ii) the response in terms of capacity, competence and delivery;

    (iii) the actual occurrence, circumstances, contributory factors or causation of each individual fatality;

    (iv) in each individual fatality, the manner of opportunities for preventable intervention, either directly, by early warning or directly by personnel; and

    (v) any matters of criminal negligence.[13]

41. The investigation was to move forward as follows:

> *"13. The investigation will move forward in a number of phases. The investigative cell has been established within the current Major Incident Room and will remain operating under that arrangement whilst search and recovery continues. It will eventually establish itself as a stand alone investigation / operation when search and recovery operations end.*
>
> *14. An agreed protocol, approved by the Coroner, has been developed in relation to the location of any deceased person ensuring optimal continuation of the search and recovery teams with handover to DVI and investigative staff. SOCO and forensic support will be engaged at each recovery. All coronial reports will be coordinated through the Investigative Cell.*
>
> *15. The initial investigative response will operate along two parallel paths. In so far as the event it will focus on the identification and capture of all relevant information sources to ensure thorough investigation at the appropriate time both in so far as emergency*

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13 See Exhibit DRI3 to affidavit of DR Isherwood.

(prevention and) response; and the circumstances surrounding each specific fatality. Focus will also be aimed at gathering current aerial imagery of scenes to enable informed recreation. Through the Coroner steps will be taken to capture relevant logs from the respective emergence management platforms that were operating at the time of, and in then in response to, the event.

16. *The foregoing will happen in tandem with coordinating the appropriate investigative scene response to each deceased person located.*

17. *Immediate attention will be given to capturing relevant witness information to the event and specifically the episodes that led to death through:*

    - *Identifying & debriefing all Emergency Services staff as their engagement concludes;*
    - *Engaging with evacuation coordination to see each of the evacuated residents from Grantham & Murphys Ck are given a 'response' document to be completed that provides some essential detail for future follow up at a less traumatic time – to be developed with the assistance of the Counsellors provided by the Red Cross and the input of the Coroner*
    - *Recovery of all official and non-official imagery and relevant media*

18. *This phase will provide the information necessary to undertake detailed interviews statements and analytical examinations aimed at meeting the aims of the investigation."*[14]

42. Independent cells already in existence, namely the Search and Rescue Major Incident Room and the Victim Liaison/Missing Persons cell and a District Disaster Management cell, assisted the taskforce. These cells performed specific roles. The search/recovery role was governed by the Major Incident Room which performed overarching management of the actual event. The missing persons cell concentrated on identifying those persons who were missing.[15] A Family Liaison cell was also established. The role of this cell was to minimise the grief to victims of families which may have arisen through the process throughout the investigation. These officers were able to be contacted by victims' families at any time of the day or night.

43. When the body of a victim was located, a crime scene would be established at that location with normal investigative forensic processes implemented. Scenes of crime officers would examine the location of the deceased. Local investigators conducting the initial investigation in respect of the death. There was further engagement of the use of a Disaster Victims' Identification Unit to formally have the body identified.

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14 See Exhibit DRI-3 to affidavit of DR Isherwood.
15 See Transcript page 759.37 and following.

A police report was completed and forwarded to the State Coroner.

44. Initially, focus was given to debriefing evacuees and emergency services personnel who responded to the flood event. This was done to ascertain any evidence that might relate to loss of life. To that end, *Taskforce Galaxy* personnel attended at evacuation centres to speak to victims who would recount their version of events. A questionnaire was formulated.[16] This form enabled personnel from the taskforce to review the completed questionnaires and make any decision as to what evidentiary value could be gained from conducting a more formal interview. Some 245 witness questionnaires were completed.[17] Drop-in centres were established at the Gatton Community Centre, staffed by taskforce personnel. Victims and witnesses could attend at the drop-in centre in a less formal environment to have their statements taken or to raise other issues of concern with members of the taskforce.

45. Significant imagery of the flood event was made available to the Queensland Police Service. The strategy adopted by the taskforce encouraged persons and organisations to supply, as part of its investigation, imagery related to the flood event. If an image was produced during the course of a statement being given by a person, then it would be immediately copied by the investigator and the original returned. The taskforce retained the copy. The volume of material which was collected by the taskforce necessitated the establishment of a specific cell within the taskforce. This cell created a folder on the fileserver which held over 190 folders containing some 95 gigabytes of imagery. These 95 gigabytes of material contain 10,481 files of imagery which did not include the further 176 discs of material which the taskforce gathered.[18]

46. One piece of imagery belonging to Tracey Anne Smith was delivered to the Queensland Police Service by Shane Brennan on or about 16 January 2011. This imagery was misplaced. Mr Brennan handed to Senior Constable Haworth a videotape which had been given to him by a member of the community. The receipt of this videotape was recorded on the running log kept by Senior Constable Haworth.[19] Senior Constable Haworth gave the tape to Constable Munro who recalled lodging the item as, *"found property"* rather than as an exhibit. The tape

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16 See Exhibit 90 for an example.
17 See para 23 affidavit of DR Isherwood.
18 See Transcript page 803.16 and following.
19 See Exhibit 87.

has not subsequently been able to be located.

47. Detective Inspector Isherwood did not consider that the misplacement of the video caused any prejudice to the investigation by the taskforce.[20]

48. It is submitted that the misplacement of the video by Constable Munro was an oversight. It was a matter of no consequence to the overall investigation, especially having regard to the volume of imagery ultimately obtained and to the images which were apparently recorded on the tape that was misplaced.

49. The volume of imagery obtained, recorded and maintained by the Queensland Police Service, and the conditions under which those images were gathered attests to the organisational skill of the service. In being able to obtain and secure such an enormous volume of imagery and manage it so that it was able to be used in subsequent investigations, and be made available to this Commission, is commendable.

50. On 17 January 2011, by Commissions of Inquiry Order (No 1) of 2011, the Queensland Floods Commission of Inquiry was established with the Honourable Justice Catherine Holmes appointed as Commissioner. The inquiry was to investigate the following matters:

> *"a) the preparation and planning by federal, state and local governments; emergency services and the community for the 1020/2011 floods in Queensland,*
>
> *b) the performance of private insurers in meeting their claims responsibilities,*
>
> *c) all aspects of the response to the 2010/2011 flood events, particularly measures taken to inform the community and measures to protect life and private and public property, including:*
>
> - *immediate management, response and recovery;*
> - *resourcing, overall coordination and deployment of personnel and equipment;*
> - *adequacy of equipment and communications systems; and*
> - *the adequacy of the community's response.*
>
> *d) the measures to manage the supply of essential services such as power, water and communications during the 2010/2011 flood events,*
>
> *e) adequacy of forecasts and early warning systems particularly as they related to the flooding events in Toowoomba, and the Lockyer and Brisbane Valleys,*
>
> *f) implementation of the systems operated plans for dams across the state*

[20] See Transcript page 804.14 and following.

and in particular Wivenhoe and Somerset release strategy and an assessment of compliance with, and the suitability of the operational procedures relating to flood mitigation and dam safety,

g) all aspects of land use planning through local and regional planning systems to minimise infrastructure and property impacts from floods,

h) in undertaking its inquiries, the Commission is required to:

- *take into account the regional and geographic differences across affected communities; and*
- *seek public submissions and hold public hearings in affected communities."*[21]

51. The Coroner was concerned as to the ambit of his investigation having regard to the Terms of Reference of the Commission of Inquiry that had just been established.

52. The Coroner considered Section 4A of the *Commission of Inquiry Act* 1950. This provision is in the following terms:

> *"**4A Interaction of commission with courts etc.***
>
> *(1) Whenever, by a commission of inquiry issued by the Governor, by and with the advice of the Executive Council of this State, under the Governor's hand and the public seal of the State—*
>
> *(a) a commission constituted by a judge of the Supreme Court, or whereof such a judge is chairperson, is appointed to make an inquiry; and*
>
> *(b) the matter or matters into or with respect to which that inquiry is to be made includes or include any matter or matters, or the making directly or indirectly of inquiry into or with respect to any matter or matters, into or with respect to which a court, tribunal, warden, coroner, justice or other person (other than the Supreme Court or the Industrial Court and other than a judge of the Supreme Court or the president of the Industrial Court) is required or authorised under or pursuant to any enactment or law of this State to inquire; then that court, tribunal, warden, coroner, justice or other person shall have no jurisdiction to and shall not make, continue or proceed with that inquiry thereinto.*
>
> *(2) The Attorney-General may inform a court, tribunal, warden, coroner, justice or other person that the Governor in Council has under consideration the matter of the issue of such a commission of inquiry as is specified in subsection (1) to make an inquiry the matter or matters whereof will include—*
>
> *(a) any matter or matters; or*
>
> *(b) the making directly or indirectly of inquiry into or with respect to any matter or matters; into or with respect to which that court, tribunal, warden, coroner, justice or*

[21] See Exhibit DR1-4 to affidavit of DR Isherwood.

other person is required or authorised under or pursuant to any enactment or law of this State to inquire.

(2A) The Attorney-General may so inform any of the aforesaid by the Attorney-General's agent, by prepaid post letter, or by telegram.

(2B) The information shall be sufficiently given to a court or tribunal if it is given in any manner aforesaid to the registrar or clerk thereof or the person by whom it may be constituted, or, if it may be constituted by 2 or more persons, any of them.

(2C) Upon being informed as aforesaid a court, tribunal, warden, coroner, justice, or other person shall have no jurisdiction to and shall not make, continue or proceed with the inquiry to which the information relates during the period of 1 month next following the giving of the information or, if the commission of inquiry is issued before the expiration of that period, at all.

(3) A certificate by the Attorney-General stating that the matter or matters into or with respect to which inquiry is to be, is being, or has been made pursuant to such a commission of inquiry as is specified in subsection (1) includes or include—

(a) any matter or matters; or

(b) the making directly or indirectly of inquiry into or with respect to any matter or matters; as specified in that certificate into or with respect to which the court, tribunal, warden, coroner, justice or other person mentioned in that certificate is required or authorised under or pursuant to the enactment or law of this State referred to in that certificate to inquire shall be admissible in evidence and shall be conclusive proof of all and every the matters aforesaid certified to therein.

(3AA) Such a certificate may be published in the gazette and thereupon and thereby shall be deemed to have been put in evidence before a court, tribunal, warden, coroner, justice or other person affected thereby (whether mentioned therein or not) and shall bind that court, tribunal, warden, coroner, justice or other person accordingly.

(3A) Every court, tribunal, warden, coroner, justice or other person referred to in subsections (1) to (2C), including those courts notice of—

(a) the identity of the Attorney-General at the time information is given under subsection (2) or a certificate is made under subsection (3); and

(b) the signature of that Attorney-General on any notification of information given under subsection (2); and

(c) the authorisation by that Attorney-General of the giving of information under subsection (2) or the publication of a certificate under subsection (3).

(4) A commission may continue to make and complete its inquiry and report and may do all such acts and things as are necessary or expedient for those purposes notwithstanding that any other proceedings may be in or before any court,

> *tribunal, warden, coroner, justice or other person and notwithstanding any order made by a court with respect thereto.*
>
> *(5) The provisions of this section apply according to their terms whether the inquiry (other than that to be made by a commission) or proceedings referred to therein commenced before or after the issue of the relevant commission of inquiry."*

53. The Coroner considered that notwithstanding Section 4A of the *Commissions of Inquiry Act* 1950, Section 45 of the *Coroners Act* 2003 still applied to require him to make findings as to whether persons suspected of dying in the floods were in fact dead, the identity of those who died, how they died, when they died and the medical cause of those deaths. However, the matters appertaining to his many comments that could be made by the Coroner pursuant to Section 46 of the *Coroners Act* 2003, referred to above, were then considered to now be beyond the jurisdiction of the Coroner. Accordingly, the ambit of the investigation undertaken by *Taskforce Galaxy* was narrowed on or about 28 January 2011. [22]

54. Having regard to the Terms of Reference, the decision to abandon broader issues of *"causation*" might be thought to have been in error. In any event, that narrowing occurred and broader issues of causation were not further canvassed by members of the Queensland Police Service as part of the operation of the *Taskforce Galaxy* investigation.

55. The investigation nevertheless continued. As a result of which, apart from the amount of imagery that has previously been the subject of comment in these submissions, some 854 formal statements were taken. Of them, 365 statements were utilised and incorporated in the coronial brief of evidence.

56. The members of the Queensland Police Service not only took the statements and questionnaires identified and gathered the imagery referred to, but also investigated missing persons. There were 532 reports of persons missing. All but three of those persons have been accounted for.

57. The spreadsheets contained in Exhibit 81 identify the work that was undertaken by the members of the Queensland Police Service in endeavouring to locate persons

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[22] See para 35 affidavit of DR Isherwood.

who were reported or otherwise believed to have been missing.

58. Further, the members of the Queensland Police Service investigated some 767 vehicles in Toowoomba and the Lockyer Valley which were involved in flooding or were otherwise submerged. The ascertainment of the ownership of the vehicles was related to the investigation of missing persons. Of that, there were 162 vehicles that were located in and around Grantham that were the subject of investigation. The spreadsheets relating to the investigations associated with these vehicles is contained in Exhibit 82.

59. The work undertaken by *Taskforce Galaxy* was one of the most extensive and voluminous investigations undertaken by the Queensland Police Service. It rivalled the investigation into the murder of Daniel Morcombe but the Morcombe investigation extended over almost a decade. Whereas this investigation was concluded by early August 2011.[23] Up to 48 members of the Queensland Police Service were involved in the taskforce.

60. Of course, only part of the material was provided to the Coroner, but the results of *Taskforce Galaxy* were provided to the Queensland Floods Commission of Inquiry pursuant to 10 Notices to Produce directed to the Queensland Police Service.[24] Further, the *Taskforce Galaxy* material has been made available for inspection to this Commission of Inquiry.

61. Within the ambit of what they were required to investigate, the Queensland Police Service conducted a thorough, diligent and professional investigation which enabled the Coroner to discharge his function under Section 45 of the *Coroners Act* 2003.

62. Broader questions of causation may have been considered had not the Coronial Inquiry been narrowed. Issues of hydrology and warnings were clearly contemplated by those in command of the taskforce.[25]

63. As to broader issues of causation which were left to the Queensland Floods Commission of Inquiry, those matters were dealt with by it. However, the observation can be made that perhaps a more complete lengthier inquiry might have been undertaken had not the view that was expressed by the Coroner in late January

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23 See Transcript 812.28 and following.
24 See para 41 affidavit of DR Isherwood.
25 See Transcript 780.12 and 799.4 and following.

2010, with respect to causation, been expressed. In any event, no criticism can be directed towards the members of the Queensland Police Service for this interpretation. The investigative function that they discharged was virtually flawless.

64. It is submitted that the members of the Queensland Police Service discharged their functions with professionalism and sensitivity. Skill, diligence and care were applied when confronting challenging and onerous tasks. All of this indicates that the people of Queensland were served by a highly sophisticated, professional organisation which was motivated to ensure that all relevant facts were brought to the attention of the Coroner.

The Exclusion Zone

65. An issue was raised by Mr Jones, Mayor of the Lockyer Valley Regional Council, as to the exclusion of the populous from the township of Grantham.[26]

66. Mr Jones had difficulty understanding why the entrance point to the exclusion zone was at the Quarry Access Road. He considered that this was too far west. He noted that persons that died in other communities such as Postman's Ridge and Murphy's Creek which did not result in those areas being shut down.

67. Further, Mr Jones noted[27] another difficult time was when residents were allowed to return to their homes. Mr Jones was concerned with the lack of communication between him and the then Assistant Commissioner Gollschewski before this occurred.

68. The evidence, with respect to these matters, is dealt with in two affidavits. Firstly, that of Superintendent Mark Kelly dated 10 July 2015, being Exhibit 89, and an affidavit of Stephan William Gollschewski, sworn 31 July 2015.

69. Superintendent Kelly was the overall commander for the search of missing persons at Grantham. Superintendent Kelly arrived at Grantham on the morning of Wednesday, 12 January 2011.

70. Superintendent Kelly notes that Grantham is one of a number of search areas that he commanded following the floods. The search area started at Spring Bluff and

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26 See statement of Stephen Jones dated 30 June 2015, Exhibit 96 at para 13 and following.
27 See para 17.

extended to the Brisbane River. The search area was of some 663 square kilometres and contained 131 kilometres of creek line. Grantham was included in that search area.

71. A cordon was established around the township of Grantham which was maintained by roadblocks in addition to geographical boundaries, such as creeks and railway lines. Police were placed on point duty on access roads that could still be traversed by vehicles after the floods.[28] To the west, officers were placed on the Gatton/Helidon Road just to the east of the railway underpass, being the link between the Gatton/Helidon Road and Lawlers Road and to the west of the Quarry Access Road in the vicinity of property located at 1703 Gatton/Helidon Road. Superintendent Kelly explained the reasons for the western boundary as follows:

> *"Yes?---In terms of that the child, Perry, was located on the grain bin. That was spoken about earlier.*
>
> *Yes?---When we arrive our situation or awareness, we haven't got the film and those other pieces of information but we do know that that grain bin is from Dorrs Road. Dorrs Road is about 400 metres east of Quarry Access Road and there was definitely properties affected there. We knew that. The quarry, there was definitely water there so we needed to come back before that. We tried to look at where the debris lines were in terms of the flooding. Obviously there was water everywhere, as has been depicted, but we chose that location there because further past Dorrs Road was the first house, and as I spoke about, a car in a tree. That was, I think that was at 1478 Gatton-Helidon Road. So, that became that area and I think the number of the house is 1703. It's on a bend just before the stop was so obviously you can't stop people on a bend so you go past 1703 and then there's a straight after that. It's done for safety as well where you can pull cars over. You don't want them coming up to a corner, in either direction, so that area was established there. So, we knew that that child was located in that location just east of Dorrs Road where the bin was from and those affected premises were there. It's just not about the search. Obviously there are some difficulties, you know, with scenes like this. Certainly on the first day we were sending police into premises and even the ones that were later assessed as being, "Don't go into them," police on the first day were making sure, checking those premises. Our first fear of arriving at a house was that someone may be unconscious - - -"*[29]

72. Later, Superintendent Kelly gave the following evidence:

> *"In terms of picking the road points where you were going to cut them off, that would be subject to a site safety assessment. Is that right?---Yes, they were, and it would have got more sophisticated. We had assistance from the State Traffic Task Force. At what stage I can't exactly tell you. They're experts in the field, they come along with their own vehicle. I know there's a group of trees along that side so they could rest people as well. Very*

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28 With Lawlers Road also known as Ditchmans Road.

29 Transcript 834.28.

much a consideration and also a consideration you don't want people driving right down a road to be told, "Turn around again." So it was very much a consideration in terms of safety, and as we progressed, in terms of the officers being able to rest and those types of things, but generally the location never changed, because when you start these things, you only have the situational awareness. I had what I saw on TV, that we all saw on the 10th. Again, on the 11th, as we spoke about, there was some activity happening at Oakey and those places that other police were coordinating some - well, it wouldn't be rescues, but support to people. And then you would get there and you see what's in front of you, and you make priorities, and our first priority is check every house to see in case there's someone living. Again, that road point at the beginning mightn't have been exactly there. Does that make sense? But once it was established, that's where it was, but it was in that general vicinity, and it was always west of the Quarry Access Road.

And it's a point picked: (a) outside of the search area so that you're keeping people out of the area where you're searching for their safety?---Yes. When I say "out of the search area", all that area got searched because once you have the fact that someone is located 101 kilometres, maybe not as the crow flies, but by the path of the creek, any assumptions you make about how far people can go or will go are out the window. So you need to search across all that area, which was done, so even behind across those fields would have been done as well. But as was demonstrated earlier, Grantham, there was 12 people. From memory, forgive me if I'm wrong, there's one person in Helidon unaccounted for, two at Postmans Ridge, two at Murphy's Creek, two at Spring Bluff, so that's where the search followed. And as we could locate people and we had searched it to make sure, because we found vehicles as well in the creek system, and we have to verify that those owners and drivers had been accounted for, and that was in that broader search area outside Grantham, Murphy's Creek, Spring Bluff. Again, you use points of interest to assist you. The vehicle from Helidon was located primarily mostly buried between Helidon and Grantham. You use those things to try and support your search. As we spoke about earlier, I think there was some discussion around how the child came to be on the grain bin. We don't know how the child gets on the grain bin at that stage, we've got no information, we just know the child is on the grain bin, so we - and this is what search coordinators do, they use what they know about the last point people are seen or if it's part of their clothing, or if it's part of the possessions, so - but in this search, we had to, on top of that, line people up side by side, search repeatedly.

You were using heavy machinery as part of some of this searching and also - - -?---Yes.

- - - to deal with safety issues?---Yes, there is significant safety issues, particularly, you know, there's power poles, power lines, other things, you know, in the environment. A town like Grantham ordinarily wouldn't have 40 army ADF machinery driving around the streets. You want to put every possible resource that you have in searching for people. We understood the importance of time for these people to try and get them back in the community. We had liaison officers at both the Grantham school and the Helidon centre from - I think it was the morning of about 15 January, we started on the 12th, so we could make sure that the right information flow with people, as you said, needed to get back into town to get items that they needed, medication. Some of that was facilitated before that, but that's important so you've got a nexus between the people who are on the ground doing the work and also what the community need, and what their feeling is, and so you can get information to them about people that are being

> *found, too. Because, remember, some of those people who are at evacuation centres probably last someone on a roof or in a car, they may have even reported those people, so getting that information back to them is important."*

73. Superintendent Kelly prepared a series of maps.[30] One of these is a map of the exclusion zone.

74. This evidence clearly articulates that the exclusion from Grantham was for reasons of safety to those persons who may be there. There were unsafe electrical wires, unsafe buildings and potential exposure to chemicals and asbestos. There existed risks including the use of heavy machinery that was being used in the search.[31] Further, exclusion minimised the risk of theft of items owned by flood victims. The exclusion allowed the search to be done systematically to ensure that a thorough search was completed for missing persons. Searches often needed to be repeated and to preserve the crime scene when remains were located.[32]

75. It is submitted that the exclusion from Grantham assisted the investigation. It enabled that search to be done thoroughly and unencumbered by managing a civilian population. It also was done out of a sense of protection of the Grantham community, so that they did not stumble upon human remains or encounter some dangerous debris.

76. It will be found that the search, which included the designation of the coordinates, including to the west at the Quarry Access Road, was sensible and prudent in the circumstances. It will be recalled that it was about the Quarry Access Road where the Lockyer Creek left its banks and from where the waters commenced their destructive journey towards Grantham. The evidence of those that resided in the vicinity of that street can bear testament to the ferocity of the waters and the damage that was done at that location.

77. Further, it ought be recalled that persons living outside Grantham, who had fallen victim to the floodwaters, were washed into the exclusion zone. Thus, any part where

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30 See Exhibits 134, 135 and 136.

31 Some property was damaged in the search which was the subject of successful claims under Section 119 of the *Disaster Management Act* 2003.

32 The last missing person located in the township of Grantham was on the morning of 17 January 2001 after the property had been searched at least four times by police, military and other searchers.

the water had left the creek was a potential site for the location of a deceased person.[33] Any suggestion that the police actions in the establishment and maintenance of the exclusion zone were heavy handed, cannot, in the light of the rational and compelling evidence of Superintendent Kelly, withstand scrutiny.

78. The Mayor also raises the issue as to the timing of when people were allowed to return. It appears the Mayor was distressed that he was not informed. This issue is dealt with by Assistant Commissioner Stephan William Gollschewski in his affidavit. The then Assistant Commissioner requested Superintendent Schafferius and Superintendent Kelly ensure that the community and the Lockyer Valley Regional Council and other stakeholders were consulted and advised prior to access to the township being allowed.

79. Representatives of the Lockyer Valley Regional Council and State government departments were included in the consultation process. Consultation regarding the potential repatriation of Grantham occurred with the Local Disaster Management Group on the 17th of January and continued into the 18th. The decision to repatriate was made formally on the evening of 17 January 2011.

80. On 18 January 2011, a meeting at the Grantham School Recovery Centre was held to update the community and advise the community of the repatriation process for the township. Senior police officers and Lockyer Valley Regional Council representatives attended the meeting. The Mayor was not present when the meeting commenced. Efforts had been made to contact him and resulted in his phone not being answered. No return calls had been received from the Mayor in response to attempts to contact him. Deputy Commissioner Gollschewski made the decision to commence the community meeting in the absence of Mayor Jones.

81. During the course of the meeting the Mayor arrived and was invited to address the community but he was irate, agitated and highly critical of police. The circumstances of the meeting are set out in paragraph 20 of the affidavit of Deputy Commissioner Gollschewski.

82. Prior to this meeting, meetings were held with the Lockyer Valley Disaster Management Group on 17 January 2011 or on the day before and were advised by

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[33] It will be recalled that the remains of Sylvia Baillie were located in Grantham, having last been seen at her premises at Postman's Ridge, some 15.5 kilometres from where she was last seen.

the Toowoomba District Disaster Coordinator, Superintendent Schafferius, the repatriation of the community may commence the following day. The general conditions of that repatriation were outlined at that time.

83. Analysis of the circumstances discloses that any concerns advanced by the Mayor are without foundation. The Queensland Police Service consulted with the Local Disaster Management Group and the Lockyer Valley Regional Council. If the Mayor was uninformed as to those processes, then any fault lay elsewhere other than with the police service.

84. The exclusion from Grantham was, as has been submitted, prudent. The repatriation cannot be validly criticised having regard to the efforts made to inform the stakeholders, as disclosed by Deputy Commissioner Gollschewski in his affidavit. All reasonable endeavours were made to repatriate the community at the earliest available opportunity once adequate steps had been taken to ensure the safety of the residents of that community. The Mayor's criticism in that regard is, it is submitted, without foundation.

Miscellaneous Matters

85. The statement of Mr Jones[34] raises a number of issues which were the subject of evidence at the Commission. It is proposed to make some brief submissions in relation to these issues.

Helicopters Over Grantham

86. Mr Jones, in his statement,[35] refers to comments that he heard that the Australian Defence Force (ADF) had made an offer to the State to send black hawk helicopters to assist in the evacuation of Grantham on the afternoon of the flood. This offer was refused by the District Disaster Management Group on the basis that the defence personnel were not white water trained. It was said that the call not to send in helicopters was made, *"at the highest level in the State Disaster Coordination Centre"*.

87. None of this is borne out by an examination of the evidence.

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34 See Exhibit 96.
35 See paragraph 8.

88. The evidence, with respect to this matter, is that at 4.10 on 10 January 2011, there was an urgent request for assistance for helicopter support which was to be made pursuant to the Defence Force Assistance for the Civilian Community Policy.[36] That request was made by the Toowoomba District Disaster Coordinator, Superintendent Schafferius to the State Disaster Coordination Centre.

89. It appears[37] that at 4.12pm on 10 January 2011 an email was received by the State Disaster Coordination Committee on behalf of the District Disaster Coordination Toowoomba attaching a request for assistance. Although it cannot be specifically recalled, it is likely that this was printed out and was walked to the Australian Defence Force liaison officer, who was in the State Disaster Coordination Centre at the time, Major Ian Dunn.

90. Further, evidence of telephone recordings disclose that a request was made by Major Ian Dunn to the ADF at 4.09pm on 10 January 2011 seeking air assets.

91. It appears from the affidavit of Air Vice Marshal Paule[38] that by 4 o'clock the Australian Defence Force was aware of the request. The ADF was unable to act upon it, due to inclement weather in and about Toowoomba.

92. By 4.51pm on the afternoon of 10 January 2011, an email had been received from Superintendent Dawson[39] to Superintendent Schafferius confirming, amongst other things, that fog in Toowoomba had prevented air support then being made available by the ADF.

93. The assertion recounted by the Mayor cannot withstand scrutiny. The action taken by officers of the State in making, by about 4.10pm on 10 January 2011, a request to the military for assistance acted expeditiously to secure the deployment of additional aerial assists. That request was unable to be actioned due to inclement weather in and around Toowoomba.

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36 See Exhibit 129.
37 See the affidavit of Steven Dunn sworn 14 August 2015.
38 See Exhibit 133.
39 The chair of the State Disaster Coordination Group.

94. Air support was made available by the ADF the following day and which assisted evacuations of other townships in the Lockyer Valley.

95. It was not as though there were no helicopters which were available. The evidence[40] clearly demonstrates that five helicopters operated by the State of Queensland were available and operating in the Lockyer Valley. Four of which[41] were effecting rescues in and about Grantham.

96. There is no suggestion, on the evidence, that no person who was able to be rescued was not rescued due to an inadequacy of aerial assets. The State deployed the maximum number of helicopters then available and those operating these helicopters acted with distinction in effecting rescues of the residents of Grantham.

97. Further, it ought be noted that the helicopters contained medical support.[42] These medics arranged for a triage centre to be established so that persons could be medically treated or, if necessary, removed to a more suitable location for further medical treatment.

98. In the context of the services that were available and provided, as a result of the actions of the State of Queensland, the interest in military helicopters is curious. It is clear that aerial assets were made available by the State and those assets effected rescues of all those who were able to be rescued.

99. It is submitted by the State of Queensland that there is no substance in this issue raised by the Mayor.

The Removal of Sergeant Wilce

100. The Mayor, in his statement, suggested that there was an impediment to communication by the removal of Sergeant Wilce, who was then a member of the Local Disaster Management Group. It is suggested that he was removed, shortly

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40 See statement of Lee Johnson dated 12 December 2011, statement of DW Parsons dated 14 February 2011, further statement DW Parsons dated 30 March 2011, second further statement of DW Parsons dated 25 March 2011, statement of B Sutherland dated 9 March 2011 (it ought be noted that the helicopter which this person was operating was being refuelled at Toowoomba when it received a tasking to proceed to Grantham which is consistent with the evidence of Mr McGuire – see T439.11 – which would suggest that what Mr McGuire was told during the course of the call made at para 4.14 was correct, that the helicopter was, at that stage, refuelling), statement of David Ian Turnbull dated 1 April 2011, statement of Stewart Wark made 5 March 2011, statement of Mark Kempton dated 17 February 2011.

41 One was a spotter aircraft.

42 See statements of Glenn Ryan made 31 March 2011 and Illya John Selmes made 1 April 2011.

after the flood event, for being, *"too close to Council"*.[43]

101. Perusal of the evidence of Mr Jones, given in respect of this issue at the public hearings,[44] is difficult to follow but he seems to suggest that the removal of Sergeant Wilce exacerbated difficulties in communication, although it is not clear how this arose.

102. Sergeant Wilce, who was, at the relevant time, the acting officer in charge of the Gatton Police Station, gave evidence that core policing work was still required to be done despite the disaster. That was Sergeant Wilce's principal duty. He was needed by the service to do this work rather than devote all his time to the Local Disaster Management Group.

103. The Queensland Police Service ensured that there was liaison between it and the Local Disaster Management Group by the appointment of another officer, being Acting Senior Sergeant Stahlhut, who relieved the then Sergeant Wilce from his role within the Local Disaster Management Group.

104. Sergeant Wilce continued in his operations as the Acting Officer In-Charge of the Gatton Police Station. His removal had nothing to do with being, *"too close to Council"* or anything like that.

105. It appears that the Mayor now understands why there was a change in personnel and accepts the reasons as outlined above.[45]

106. The miscellaneous matters raised by the Mayor ought be found to be without substance.

Conclusion

107. It is submitted that there is no basis for any adverse finding to be made against the State of Queensland in respect of any of the Terms of Reference in respect of which the State has been given leave to appear, or otherwise.

J. Rolls
Counsel for the State of Queensland

28 August 2015

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43 See Exhibit 96 at para 5 and para 15.
44 See Transcript page 919.10 and following.
45 See Transcript 924.10.