
**Findings of Coroner Simon Cooper following the
holding of an inquest under the *Coroners Act 1995*
into the deaths of:**

**Mary Kathleen Allford, Trevor Allan Foster and
Peter John Watson**

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Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Mary Kathleen Allford, Trevor Allan Foster and Peter John Watson with an inquest held at Hobart in Tasmania, make the following findings.

Hearing dates

22, 23 June 2022 and 1-3, 6-10 March 2023 in Hobart

Representation

S Nicholson – Counsel Assisting the Coroner (22 - 23 June 2022).

L Fox – Counsel Assisting the Coroner (1 - 10 March 2023).

R Munning, A Constance – Secretary, Department of Police Fire and Emergency Management.

J Sawyer, H Pill – Mr Wayne Richards.

Introduction

1. In early June 2016, large areas of Tasmania suffered significant flooding. Three people died in those floods. Mrs Allford died when her home at Latrobe, North West Tasmania was inundated by the rising Mersey River during the night of 5-6 June 2016. Mr Foster was swept away in flood waters at about 8.00am on 6 June 2016 as he tended to his sheep when the Ouse River broke its banks near his home at Ouse, in Central Tasmania. In the early hours of the following morning, 7 June 2016, Mr Watson died after driving his delivery van into waters overflowing from the South Esk River, near Evandale in the state's north.
2. Mrs Allford's body was recovered the day after her death. Mr Watson's body was found by a helicopter crew on 22 June 2016, downstream from where he was last

seen.¹ Mr Foster's remains were not found until 21 March 2018 on the bank of the Meadowbank Dam,² also a few kilometres downstream from where he went missing.

3. Each death was reported in accordance with the requirements of the *Coroners Act* 1995 (the "Act"). Each was the subject of an extensive investigation. Each was originally assigned to three different coroners for investigation.
4. On 23 December 2021 the Chief Coroner issued a direction to me under section 50 of the Act, requiring that all three deaths be investigated at the one inquest. Obedient to that direction, the inquests commenced in June 2022 and continued until March 2023. Unfortunately, a change of counsel assisting and then the unavailability of counsel (which was no-one's fault) caused a significant delay in the finalisation of the inquest.

Background

5. In early June 2016, a strong moisture laden weather system caused heavy rainfall and exceptional flooding throughout Tasmania. In the three days leading up to 9.00am on Tuesday 7 June 2016, several hundred millimetres of rain fell on the state. Numerous locations throughout Tasmania recorded the highest water levels in rivers ever measured.
6. The weather event was the subject of a number of flood watches for various river systems, in excess of 200 flood warnings and more than 20 severe weather alerts issued by the Bureau of Meteorology.
7. Between 50 and 100 millimetres of rain fell across Northern Tasmania in the 24 hours to 9.00am on Sunday 5 June 2016. The weather station at Pyengana, in North East Tasmania, recorded 129 millimetres of rain during that period, a record for the month of June.
8. Heavy rainfall on Sunday 5 June and Monday 6 June 2016, caused widespread major flooding to Tasmania's northern river basins including, relevantly in the context of this finding, the Mersey and South Esk Rivers.
9. The heaviest rainfall during this period was during the night of 5-6 June 2016. Many stations in the north of the state recorded falls in excess of 150 millimetres. In fact, 33 weather stations in Northern Tasmania recorded the highest amount of rain ever

¹ Exhibit C8, Affidavit Kriss Lawler (Police Officer – Rank not stated), sworn 29 August 2016.

² Exhibit F29, Statutory Declaration William Chapman, made 21 March 2018.

recorded for June during that period. The weather station at Fisher River, near Lake MacKenzie, recorded 278.6 millimetres of rain in the 24 hours leading up to 9.00am on Monday 6 June 2016.

10. The rain fall caused widespread flooding throughout the state, the worst of which was in the northern areas of Tasmania.

The functions of a coroner

11. Before considering the deaths in more detail, something should be said about the role of the coroner. A coroner conducting an inquest performs a role different to other judicial officers. The Australian legal system is, in the main, an adversarial one. In contrast, the role of a coroner is inquisitorial. An inquest might be described as a quest for the truth, rather than a contest between parties to either prove or disprove a case. The coroner's task is to try to find out what happened, to who and why and to identify, if possible, any lessons from the death or deaths being investigated.
12. The law requires a coroner to thoroughly investigate the death and answer the questions (if possible) that section 28(1) of the *Act* asks. These questions include who a deceased was, how they died, the cause of the person's death and where and when the person died. This process requires the making of various findings, but without apportioning legal or moral blame for the death.³ The task of the coroner is to make findings of fact about the death from which others may draw conclusions.
13. It is important to recognise that a coroner does not punish, or award compensation to, anyone. Punishment and compensation are for other proceedings in other courts, if appropriate. Nor does a coroner charge people with crimes or offences arising out of a death that is the subject of investigation. It should be made clear that I do not consider that anyone committed any offence in respect of Mrs Allford's, Mr Foster's or Mr Watson's deaths.
14. As was noted above, one matter that the *Act* requires, is a finding (if possible) as to how the death occurred.⁴ 'How' has been determined to mean "by what means and in what circumstances,"⁵ a phrase which involves the application of the ordinary concepts of legal causation.⁶ Any coronial inquest necessarily involves a consideration

³ *R v Tennent; Ex Parte Jager* [2000] TASSC 64.

⁴ Section 28(1)(b) of the *Coroners Act* 1995.

⁵ See *Atkinson v Morrow* [2005] QCA 353.

⁶ See *March v E. & M.H. Stramare Pty. Limited and Another* [1990 – 1991] 171 CLR 506.

of the circumstances surrounding the particular death so as to discharge the obligation imposed by section 28(1)(b) upon the coroner.

15. The standard of proof at an inquest is the civil standard. This means that where findings of fact are made, a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an inquest reaches a stage where findings being made may reflect adversely upon an individual, it is well-settled law that the standard applicable is that expressed in *Briginshaw v Briginshaw*, that is, the task of deciding whether a serious allegation against anyone has been established (or proved) should be approached with caution.⁷
16. A coroner is not bound by the rules of evidence when holding an inquest and may be informed and conduct an inquest in any manner the coroner reasonably thinks fit.⁸ To be properly received at an inquest, the evidence must be capable in some way of assisting the coroner to determine the matters under section 28(1) or, in appropriate circumstances, to assist in making a comment or recommendation. A coroner has significant latitude in receiving evidence, providing the evidence is something more than supposition, guess or intuitive hypothesis. The question of weight to be given to any evidence tendered at an inquest is a question for the coroner after receiving submissions from interested parties.
17. The final matter that should be highlighted is the fact that the coronial process, including an inquest, is subject to the requirement to afford procedural fairness. A coroner must ensure that any person (any person includes legal entities) who might be the subject of an adverse finding or comment is made aware of that possibility and given the opportunity to fully put their side of the story forward for consideration.⁹
18. One thing a coroner must always guard against is the clarity afforded by hindsight. When a coroner conducts an inquest, she or he knows exactly what occurred and, in many cases, why. That is information which decision-makers in the lead up to any death which is subsequently the subject of an inquest did not have.

Inquest and conduct of the inquest

19. Mr Watson died in the course of his employment as a delivery driver, Mr Foster died on his property and Mrs Allford died in her home. The circumstances of Mr Watson's

⁷ (1938) 60 CLR 336 (see in particular Dixon J at page 362).

⁸ Section 51 of the *Coroners Act 1995*.

⁹ See *Annetts v McCann* (1990) 170 CLR 596, *Attorney General v Copper Mines of Tasmania Pty Ltd* [2019] TASFC.

death meant it was mandatory to conduct an inquest (subject to an exception in the *Coroners Act 1995*, which was not relevant in this case).¹⁰ In the exercise of my discretion, I considered it was desirable to hold inquests in relation to the deaths of Mr Foster and Mrs Allford.

20. In advance of the inquest, a number of issues, in addition to those mandated by section 28(1) of the Act, were identified as being matters to be particularly considered at the hearing. A draft of the proposed scope was distributed to all interested parties and submissions made as to the proper extent of inquiry at inquest. In the event, I determined that the scope of the inquest would be:
- a) The response in relation to Mr Watson's 000 call;
 - b) The role of water release upstream from Mr Foster's property; and
 - c) In relation to Mrs Allford, the following matters were identified as being of especial interest and formed the scope of that aspect of the inquest:
 - i. *The adequacy of emergency service response to the circumstances surrounding the death of Mrs Allford at Latrobe on 6 June 2016 including (but not limited to):*
 - i. *The adequacy or otherwise of the relevant Municipal Emergency Management Plan (Mersey-Leven);*
 - ii. *Communication between emergency services in the North West (NW) Region for the period 5-7 June 2016 inclusive;*
 - iii. *Cooperation between emergency services in the NW Region for the period 5-7 June 2016 inclusive;*
 - iv. *The adequacy or otherwise of the State Emergency Service (SES) fatigue management policy (assuming one was in existence as at 6 June 2016); and*
 - v. *The actions of Mr Wayne Richards, NW Regional Manager SES.*
 - ii. *The adequacy of flood watch and warnings issued by the Bureau of Meteorology in the lead up to the Latrobe flood event.*
 - iii. *The adequacy or otherwise of SES personnel resources in the NW Region for the period 5-7 June 2016 inclusive.*
 - iv. *Arrangements in place by SES with respect to rostering of personnel in the NW Region for the period 5-7 June 2016 inclusive.*
 - v. *Tasmanian Emergency Service (Tasmania Police (TASPOL), Ambulance Tasmania, Tasmania Fire Service (TFS), SES) flood rescue capability as at 2016, and now.*

¹⁰ See Section S26A (3) of the *Coroners Act 1995*.

- vi. *Whether a flood evacuation plan or plans existed for the Mersey River at Latrobe as at June 2016 and if so:*
 - i. *The adequacy of that plan (or those plans);*
 - ii. *The familiarity of SES incident control personnel with those plans.*
- vii. *If no such flood evacuation plan or plans existed for the Mersey River at Latrobe, then why not?*
- viii. *The training provided in 2016, and now, to SES incident controllers and senior managers with respect to emergency management generally and flood response in particular.*

21. The evidence at the inquest necessarily focused on these issues. At the inquest, a number of witnesses were called to give evidence. The witnesses who gave evidence were:

- Ms Karen Cassidy (Watson);
- Sergeant Nathaniel Eldershaw (Watson);
- Former Senior Constable Samuel Lloyd (Watson);
- Constable Bradley Collins (Watson);
- Sergeant Damian Bidgood (Watson and Foster);
- Senior Sergeant Adrian Leary (Foster);
- Constable Mandy Ladson (Foster);
- Sergeant Paul Britten (Foster);
- Senior Constable Benjamin Cunningham (Foster);
- Mr Jack Penny – Hydro (Foster);
- Mr Mark Allford (Allford);
- Mrs Michelle Allford (Allford);
- Senior Sergeant Pendlebury (Allford);
- Detective Senior Sergeant David Chapman (Allford);
- Inspector Gregory (Shane) LeFevre (Allford);
- Senior Constable Melle Zwerver (Allford);
- Colonel Nicholas Wilson (Allford);
- Constable Dean Wotherspoon – TASPOL – Search and Rescue Controller – (Allford);
- Ms Mhairi Revie (Bradley) ESM – SES (Allford);
- Mr Anthony Dick ESM – North West Regional Officer, SES (Allford);
- Mr Dominic (Nick) Connolly – SES (Allford);

- Mr Gerald Van Rongen – Regional Training Officer – Norther Region SES (Allford);
 - Mr Jonathan Magor (Allford);
 - Mr Michael D’Alton – SES (Allford);
 - Mr Ian (Brian) Edmonds - former SES, Assistant Director of Operations and Resources (Allford);
 - Mr Shane Batt – Regional Chief (NW), AFSM TFS (Allford);
 - Mr Andrew Lea – ESM, former Director SES;
 - Mr Nigel Rist – Mapping/Engineering Latrobe Council;
 - Mr Christopher Irvine – SES;
 - Mr Wayne Richards – ex SES ;and
 - Mr Leon Smith ESM – Assistant Director of Operations and Resources (ADOR) SES.
22. In addition to the evidence from the witnesses outlined above, a considerable amount of documentary evidence was tendered at the inquest. That evidence included the affidavits of a number of witnesses who were not called to answer questions. That material is set out in the annexure attached to this finding.
23. Ranks and titles (and in one case names) have changed in some cases. I will use the rank, title or name of a witness at the time they gave evidence at the inquest.
24. I will now turn to consider the evidence in each case.

Background – Peter Watson

25. Peter John Watson was born on 19 September 1952. At the time of his death he lived at West Tamar Highway, Riverside in Launceston. He was father to Tanita, Natarsha, Corey, Matthew and Jessica.¹¹
26. His usual occupation was delivering newspapers and other periodicals in the area of Western Junction, Evandale, Longford, Perth, Cressy, Bracknell, Hadspen, Westbury, Exton and Deloraine. His employer was Mr Howard Calvert.
27. A non-smoker, Mr Watson was a good swimmer, having been a competitive swimmer as a younger man. He suffered diabetes and had undergone heart and shoulder surgery but was in reasonably good health for his age.

¹¹ Exhibit C10, Statutory Declaration Karen Cassidy, made 8 June 2016.

Circumstances of death – Peter Watson

28. The findings that follow are largely dependent upon the evidence of Mr Watson's partner, Ms Karen Cassidy, who was with Mr Watson on the night he died, and was lucky to escape with her life. The night before had been a bad one for Mr Watson because of flooding, and so Ms Cassidy managed to persuade him that she should accompany him on his delivery trip, taking the view that "*four eyes were better than two*". They left their home shortly before 1.00am. Mr Watson outlined to Ms Cassidy a route that he considered was the best to avoid the flooding. She thought that he had put quite a bit of thought into it, given the rough night he had the evening before.
29. During the initial part of the delivery run, the couple encountered a few puddles but nothing of real consequence. Ms Cassidy said it was raining lightly but the rain did not affect Mr Watson's manner of driving nor their ability to see the road.
30. The couple made a delivery at Launceston Airport and then made their way to Evandale, where they completed further deliveries. Upon leaving Evandale, they travelled north along High Street, before turning left (or west) onto Leighlands Road, in the general direction of the Midlands Highway and Perth.
31. Ms Cassidy said Mr Watson drove along Leighlands Road for a few minutes before the pair saw water flowing across the road. The water was from the South Esk River, which had 'broken its banks'. She said it was pitch black, and that the water was about halfway up the tyres. Ms Cassidy said that, initially at least, the water was easy to drive through and neither she nor Mr Watson had any concerns. She said there were no signs indicating the road was closed.
32. They drove a bit further along the road. Ms Cassidy said that she could feel the force of the water pushing the vehicle to the right (or north). She said that she told Mr Watson that they should go back, as the water was gushing and rising. Mr Watson tried to steer the van and keep it on the road moving forward. Water began entering the cabin. Ms Cassidy could feel it around her feet.
33. At 2.37am, Mr Watson rang an emergency line to tell them what was going on.¹² At 2.41am he rang his boss, Mr Calvert. Mr Calvert said that Mr Watson told him that he had driven into water. Mr Watson said he did not know where, but Mr Calvert thought it would have been roughly driving out of Evandale and across the bridge over

¹² Exhibit C25.

the South Esk River. Mr Calvert asked Mr Watson if he was alright. Mr Watson said he was but the water was coming up. Mr Watson told Mr Calvert he was frightened.¹³

34. Ms Cassidy said that she thought that they should ring family as she thought they would not be getting out of it. Mr Watson rang his daughter Tanita at around 2.45am. He told her he was stuck in flood waters which was now up to the window. Mr Watson asked Tanita to call her brothers and sisters and *'tell them he loved them'*.¹⁴
35. Mr Watson and Ms Cassidy then saw a police car approach from the Evandale end of Leighlands Road. The car stopped and Mr Watson received a phone call from Police Radio Despatch Services (RDS) to say the police approaching from the Evandale direction could not get through and that they would have to go around to the other end. Ms Cassidy said that Mr Watson estimated this would take about 15 minutes. After this, Ms Cassidy described seeing a large blue truck approach from the Midland Highway side. She remembered thinking they were going to use the truck to come around and get them, but the truck remained stationary. She then saw a police car again on the Evandale side and two more police cars on the Midland Highway side. The police car on the Evandale side appeared to fade out after a time and all she could see was a torch light.
36. Their van continued to slip off the road. Ms Cassidy said that by now the back end of the vehicle was sinking and the front end was tipping up and to the right. Mr Watson said to Ms Cassidy that he thought they should get out of the van. She climbed out the passenger window and on to the roof of the van.
37. Soon the water reached past the level of the spotlights on the front of the van. Ms Cassidy said the van *"moved again to the right as if it was being pulled down to be pushed forward"*.¹⁵
38. By now, both Mr Watson and Ms Cassidy were standing up on the roof of the van, holding hands.
39. The van moved again. The water was gushing a lot faster. There were a lot of logs and debris around.
40. Ms Cassidy said to Mr Watson, *"you know we're going to die don't you."* Mr Watson wanted to jump into the water as he thought the van would suck them down.

¹³ Exhibit C15, Affidavit of Howard Calvert, sworn 10 October 2017, page 3 of 6.

¹⁴ Exhibit C11, Affidavit of Tanita Thyne, sworn 29 June 2017.

¹⁵ Exhibit C10, page 3.

41. Suddenly another surge of water struck the van. Ms Cassidy described Mr Watson slipping, or being jolted, from the roof of the van and entering the water, face down. That was the last she saw of him.
42. The van continued to slip. Ms Cassidy stood on the bullbar and called out to police. She got her cigarette lighter out and started flicking the flame so that they could see where she was. She had two shirts on. She took one off and set it alight and waved it around until it went out.
43. The van slipped away completely with the stream of water. Ms Cassidy then launched herself off the bullbar. She tried to swim. She got hold of a log. After a while, she was able to climb up on to what was in effect a raft of river debris where she remained for a couple of hours. After a time, a member of the public, Mr Trent Biffin and now retired Senior Constable Samuel Lloyd located Ms Cassidy near 274 Mill Road. They established voice contact with her and guided the rescue helicopter (call sign Y9) to her location. Ms Cassidy was winched to safety, transferred to a nearby ambulance and taken to the Launceston General Hospital where she remained for treatment for bruising, lumps and bumps.
44. Another vehicle – a Mitsubishi Canter truck with two occupants – drove into the flood waters on Leighlands Road at about the same time as Mr Watson and Ms Cassidy. The truck entered from the opposite direction – that is heading from the west, away from Perth and the Midlands Highway, towards Evandale. The truck had to be abandoned and the occupants were lucky to survive the flood waters. Then Senior Constable Lloyd had driven that portion of the road only a short time before the Canter became trapped in flood waters. Its close shave illustrates the speed at which the waters rose.
45. Search and rescue efforts to attempt to locate and rescue Mr Watson commenced at 5.35am on 7 June 2016. A ground crew was mobilised for a ground search. The rescue helicopter continued to search the river focussing on each bank and snag points with floating debris within the river.
46. Search efforts were concluded in the afternoon with Mr Watson still missing. The following day, 8 June 2016, searching recommenced and continued throughout the day. During the day, searchers found the van 50 metres from the road and downstream.

47. A combination of ground, river and air searches continued on 9, 10, 11, 12, 13 and 14 June 2016. Personnel involved included police, SES and volunteer members of the public; the latter coordinated by Mr Watson's son, Corey.
48. Eventually, as river levels returned to normal Mr Watson's body was found on 22 June 2016 by the rescue helicopter. It was located some considerable distance downriver from where the van came to grief.

Investigation – Peter Watson

49. Mr Watson's body was recovered by Police Search and Rescue personnel and transported by mortuary ambulance to the Royal Hobart Hospital. At the Royal Hobart Hospital, experienced Forensic Pathologist, Dr Donald Ritchey, performed an autopsy. He identified that Mr Watson was suffering from advanced atherosclerotic coronary vascular disease, but that the cause of his death was drowning. I accept Dr Ritchey's opinion. It may be that his heart condition contributed to his death but the principle operative cause of his death was drowning.
50. It was necessary to use dental comparison to confirm Mr Watson's identity given the level of his body's decomposition. Forensic Odontologist, Dr Tom Pacza, provided a report in that regard and I accept his evidence.¹⁶
51. Subsequent analysis of samples taken at autopsy carried out at the laboratory of Forensic Science Service Tasmania did not identify any anomalies.

Conclusions – Peter Watson

52. I am satisfied on the evidence at the inquest that the response of emergency services and the efforts to rescue Mr Watson were appropriate.
53. I note the evidence that there were no warning signs indicating that the road was closed. The explanation for this is that the decision to close the road was not made by an officer of the Department of State Growth until 5.34am on 7 June 2016, after Mr Watson had driven into the flood waters. I do not consider that there is any reason to criticise the Department in this regard. It is simply unrealistic to expect that every single road in affected areas could be examined to determine whether they are safe or have been inundated by water.

¹⁶ Exhibit C5 – Forensic Odontology Report – Dr Tom Pacza, 27 June 2016.

54. Sadly, Mr Watson's death (and the near death of his partner) is another vivid example of the extreme danger of driving into flood waters.

Formal findings – Peter Watson

55. Pursuant to section 28(1) of the *Coroners Act 1995*, I make the following formal findings on the basis of the evidence at the inquest:
- a) The identity of the deceased is Peter John Watson;
 - b) Mr Watson died in the circumstances set out earlier in this finding;
 - c) The cause of Mr Watson's death was drowning; and
 - d) Mr Watson died on 7 June 2016, in the waters of the South Esk River near Evandale in Tasmania.

Background – Trevor Foster

56. Trevor Allan Foster was born in Latrobe, Tasmania on 26 November 1932, one of 10 children. He left school at the age of 13 and thereafter worked at a cement works, on farms and for Hydro Tasmania before retiring in the 1990s. Mr Foster married Helen in 1957 and the couple moved to Ouse in about 1960. They lived together at 1 Cluny Street, Ouse from then. Mr and Mrs Foster had two sons, Allan and Ronald. Mrs Foster has since died.
57. Mr Foster's health was reasonable for his age. He had a history of various ailments, none especially remarkable for a person of advanced years. Relevantly, I note the evidence that he suffered heart issues, hearing impairment and mesothelioma.
58. The property at 1 Cluny Street is roughly at street level. It includes a paddock of around 1.5 acres that extends along the Lyell Highway to the Ouse River. The paddock is about three metres lower than street level and is, in effect, on a river flat. Mr Foster ran sheep in the paddock. He also tended to his garden which was nearer the house.¹⁷

Circumstances of death – Trevor Foster

59. On Monday 6 June 2016, Mr Foster got up at about 7.15am, stoked the fire, dressed and went outside to feed his sheep. Mrs Foster got up about half an hour later. She

¹⁷ Exhibit F6, Affidavit Helen Foster, sworn 30 August 2016.

said in her affidavit tendered at the inquest that she remembered “*Trevor yelling out that some old trees that had been on the weir had moved*” but said nothing about the Ouse River being in flood.¹⁸

60. Mrs Foster watched the tragedy unfold from her kitchen. She saw her husband in the paddock feeding the sheep and watched as he walked from the residence to the paddock three times with feed for the sheep. Mr Foster walked next to a fence and a gate each time he walked to the paddock.
61. Suddenly, and without any warning, Mrs Foster saw the Ouse River break its banks and cross their paddock. She described the water as being about a foot deep and rolling over the dry ground quickly and with a rush. Mr Foster had his back to the approaching water. Mrs Foster could not yell a warning because he was hard of hearing. Mrs Foster went outside and watched as her husband, who by now was aware of the approaching flood waters, climbed onto part of the fence that was near the gate to attempt to escape the water. He stepped down and, as he reached the ground, his feet were swept from under him. Mrs Foster heard her husband yell out and saw him wash away. She did not see him again.
62. Mrs Foster immediately returned inside and called 000 for help.¹⁹
63. I am satisfied that the emergency service response was both timely and appropriate.
64. A wide-scale search was undertaken but Mr Foster’s body was not found for 2 years. On 21 March 2018, Mr William Chapman found skeletal remains on his property at Ouse.²⁰ They were later confirmed to be the remains of Mr Foster.

Investigation – Trevor Foster

65. The remains located by Mr Chapman were examined by specialist police officers and photographed *in situ*, before being removed and taken to the mortuary at the Royal Hobart Hospital. At the mortuary, highly experienced Forensic Anthropologist, Dr Anne-Marie Williams examined the remains. She confirmed that the remains were an almost intact human skeleton missing only the right lower ribs and most of the hand bones. Dr Williams expressed the opinion, which I accept, that the remains were those of an older aged male of most likely caucasian ancestry.²¹

¹⁸ *Supra.*

¹⁹ *Supra.*

²⁰ Exhibit F29, Affidavit William Chapman, sworn 21 March 2018.

²¹ Exhibit F5 – Report on Skeletal Remains from Ouse - Dr Anne-Marie Williams 25 March 2018.

66. Dr Ritchey then performed a post-mortem examination. He was unable to determine the cause of Mr Foster's death due to the extent of decomposition of the remains. He noted that there were fractures of the skull which were consistent both with post mortem weathering and trauma having occurred as he was swept away in flood waters.²² The circumstances in which Mr Foster disappeared suggest that the most likely cause of his death was drowning.
67. Samples taken at autopsy were forwarded to the laboratory of Forensic Science Service Tasmania. Following DNA comparison of those samples and with some taken from a hat that had belonged to Mr Foster, a report was provided by Dr Cory Griffiths, Forensic Scientist, in which he expressed the opinion that the profile taken from the skeleton is 100 billion times more likely to be obtained if the DNA originated from Trevor Allen Foster, rather than any other randomly chosen person within the population. This evidence satisfies me, absolutely, that the remains located by Mr Chapman on the bank of the Meadowbank Dam are those of Mr Foster.

Upstream water release

68. The principal issue examined in relation to Mr Foster's disappearance and subsequent death was the role, if any, of any release of water upstream of Cluny Street Ouse, which caused or contributed to the circumstances which led to Mr Foster's death.
69. An extensive investigation in that regard was carried out and evidence tendered to the inquest. In short, it is sufficient I think to say that I accept the evidence that no water was released from any storage facility in the catchment area upstream from where Mr Foster went missing on 6 June 2016, in the immediate lead up to that event.
70. Rather, I am quite satisfied that the catastrophic flood event was a naturally occurring phenomenon which impacted the whole state of Tasmania for several days and was the reason for not only Mr Foster's death, but the deaths of Mr Watson and Mrs Allford as well.

Formal findings – Trevor Foster

71. Pursuant to section 28(1) of the *Coroners Act 1995*, I make the following formal findings on the basis of the evidence at the inquest:
- a. The identity of the deceased is Trevor Allan Foster;

²² Exhibit F4 - *Post Mortem Report*, Dr Donald Ritchey.

- b. Mr Foster died in the circumstances set out earlier in this finding;
- c. The cause of Mr Foster's death was likely to have been drowning; and
- d. Mr Foster died in the waters of the Ouse River on or about 6 June 2016.

Background – Mary Allford

72. Mary Kathleen Allford was born on 12 February 1940 in Sheffield, Tasmania. She was educated in nearby Latrobe. In 1962, she married Mr Noel Allford²³ and together Mr and Mrs Allford had three sons – Mark, Gerard and Michael – and six grandchildren. She lived her entire life on the North West Coast of Tasmania. Mr and Mrs Allford moved into their home at 351 Shale Road, Latrobe in 1989. They were living there at the time of Mrs Allford's death and intended to live out their days there. Both Mr and Mrs Allford were independent and loved living where they did.
73. Mrs Allford was in poor health. She needed to use a walking frame to assist with her mobility and was unable to climb the stairs of the home. This meant she was restricted to the ground floor of the house.
74. Nonetheless, although incapacitated by her nerve damaged legs and feet, her son Mr Mark Allford said she was active around the house and in the garden, not letting "those bloody legs" stop her from doing most things. He described his parents' home as being "filled with pictures, ornaments and lifelong treasures and more furniture than she probably needed".²⁴ Mr Mark Allford said that the garden of the home of his parents was beautiful, and that his mother, despite her mobility issues, spent many hours outside on her hands and knees working in it.
75. Her physical incapacity necessitated the taking of medication including painkillers and anti-anxiety/depressant medication, some of which had sedative properties.²⁵ There is no evidence however that the medication Mrs Allford was taking in June 2016, caused or contributed in any way to her death.
76. Mr Allford also had some health issues having suffered a significant injury in 1988 when he fell from a roof. The fall saw him break 27 bones in his back and caused his retirement from employment.

²³ Sadly, Mr Allford died on 28 November 2021, before the hearing of the inquest.

²⁴ Transcript.

²⁵ Exhibit A 5 – Toxicological Report – Forensic Science Service Tasmania – pages 1 – 2.

77. Physical disabilities aside, it is evident that as at June 2016, Mr and Mrs Allford were content and living a comfortable and fulfilling life together.
78. Their house at Shale Road was an A frame home with a ground floor and a first floor. Naturally, given its A frame construction, the top floor was significantly smaller in area than the ground floor. The only method of access from the ground floor to the top floor was via a spiral staircase.²⁶ According to her family, Mrs Allford had not been up those stairs “in years” and both she and Mr Allford slept and lived on the ground floor. I think it is obvious that a spiral staircase would create difficult issues of access for any person suffering from mobility issues of the sort that plagued Mrs Allford.

Circumstances of death – Mary Allford

79. During 3–4 June 2016, the Bureau of Meteorology had issued a number of warnings that there would be severe weather statewide over the following days including strong winds, rain and flooding. The statements in the warnings initially concentrated on the North and North East, specifying the South Esk and the Eastern Coastal Areas as areas of concern.
80. The North West region of Tasmania was not mentioned specifically, apart to indicate that there was a possibility of higher total rainfall about elevated areas around the Western Tiers and heavy rainfall in the North West region and the potential for flash flooding across the northern half of Tasmania generally. All the evidence makes it very clear that the flood event in which Mrs Allford died was in fact the worst to impact Latrobe since the early 1900s. The river level measurements of a number of Tasmanian rivers, including the Mersey River, were the highest ever recorded and exceeded all predictions for the levels of floods at the time.
81. The cause of the rain event which caused the flooding is beyond the scope of this inquest. It is however sufficient to say that the evidence makes clear that it was a natural phenomenon; and not the result of human created circumstances such as cloud seeding, nor the result of dam management. Rather, the weather pattern which gave rise to the flooding originated from as far north as the central Coral Sea and was due, at least in part, to sea surface temperatures both in those waters, and in the Tasman Sea, being above average for that time of year. That in turn increased the amount of moisture available for evaporation into the atmosphere which moisture was driven on to Tasmania by a strong north easterly wind weather pattern. In basic

²⁶ Exhibit A 7 – Affidavit – Mark Allford, page 5.

terms, the floods were due to a significant amount of water in the atmosphere coupled with prevailing winds and topography of land which created something in the nature of a “perfect storm”.

Tasmanian emergency services generally

82. Before I consider further the circumstances of Mrs Allford’s death, it is necessary to look in some detail at the emergency services arrangements in place at the time. As at 2016, a number of agencies had responsibility for different types of emergencies. Those agencies included Tasmania Police, the Tasmanian Fire Service, Ambulance Tasmania and the State Emergency Service. The agency responsible for planning and responding to floods in Tasmania as at 2016 was the SES. The Tasmanian Emergency Management Plan [Issue 8.0],²⁷ which is the principal plan dealing with emergency response in this state, describes the SES as the RMA for both river and flash floods.²⁸
83. The acronym ‘RMA’ does not appear to be defined anywhere in the Tasmanian State Emergency Management Plan, but presumably means Response Management Authority (and contextually it is difficult to think what else it could mean). In any event, the plan provides that the RMA, the SES (and I did not understand it to be suggested otherwise) was the responsible agency insofar as decisions relating to the evacuation where members of the public are concerned.²⁹
84. The role of the SES in relation to floods included, *inter alia*, monitoring and interpreting flood watches and warnings issued by the Bureau of Meteorology, issuing media releases with safety advice for the public, organising the SES response and managing so-called “on ground” operations. The role included overseeing the coordination of the flood policy at a state level and plans at both municipal and state levels. It was the sole responsibility of the SES, as the RMA, in each region of the state to have detailed flood planning in place. I accept that, broadly speaking, as Counsel for the Department of Police, Fire and Emergency Management submitted, responses to floods were aligned with a suite of plans prepared under the the relevant legislation and that those plans were both scalable and flexible.
85. In 2016, the SES personnel consisted of some paid, career or full time staff, but mostly volunteers. In the North West Region, as at June 2016, there were 77 volunteer SES members.³⁰

²⁷ Exhibit A 44.

²⁸ *Supra*, Table 4, page 34.

²⁹ *Supra*, pages 43 and 77.

³⁰ Exhibit A 111, paragraph 90.

86. Tasmania Police obviously were involved in responding, particularly so far as search and rescue was concerned. I consider that the response of Tasmania Police to the flood incident was entirely appropriate and completely satisfactory. As a result, I do not consider it necessary to analyse that response in any particular detail, although I will return to aspects of the Tasmania Police on ground response, particularly in the context of the efforts to rescue Mr and Mrs Allford, which were at the direction of Tasmania Police, which was appropriate in terms of the then existing emergency management arrangements.
87. Other entities involved were the Bureau of Meteorology, local councils and in the case of the response to Mrs Allford's emergency, the Australian Defence Force. In the same way, I am satisfied that the response of the relevant local government authorities, and in particular the Latrobe City Council, including their employees Mr Jonathan Magor, Ms Michelle Dutton, Mr Peter Dawson, Mr Grant How, Mr Michael Lynd and Mayor Peter Freshney, was entirely appropriate. In particular, the efforts of Mr Grant How, the backhoe driver and Mr Michael Lynd the driver of a 16 tonne front-end loader, in an attempt to reach Mr and Mrs Allford's home are worthy of particular recognition.
88. It is worth noting that subsequent to the events of 2016, the SES has merged with the Tasmania Fire Service. Unquestionably this merger will have altered the nature of emergency response within Tasmania. That merger and what has flowed from it was the subject of extensive evidence from Mr Leon Smith, Assistant Director Operations and Resources of the SES, at the time of the inquest. I will return to that evidence later in these findings, but current arrangements are beyond the scope of this inquest.

The State Emergency Service - structure and organisation 2016

89. There have been changes in the structure and administrative arrangements of the SES since June 2016. Something needs to be said about the position as at that date, if for no other reason, than to understand the background against which the SES responded to the flood event. As of June 2016, the SES operated regionally, with a centrally located statewide director and support staff. The director performed management, administrative, development and policy functions, but had no operational (or tactical) functions. The director was located in Hobart and reported to the Secretary, Department of Police, Fire and Emergency Management. At the time, the substantive Director of the SES, Mr Andrew Lea, was absent from that role undertaking what was described as a project role.

90. Colonel Nicholas Wilson was acting in the director's role at all relevant times. His substantive position within the SES was Assistant Director of Operations and Resources.
91. The Assistant Director of Operations and Resources had responsibility for statewide operations. Each of the three Regional Managers reported directly to the Assistant Director of Operations and Resources. I observe that having people occupy positions on an acting basis, while sometimes necessary to cover absences, can be unsatisfactory. Those filling acting positions may lack sufficient corporate knowledge or they may feel that they lack the moral authority to make decisions. However, in this case there is no evidence of the fact that the two most senior positions in the SES were filled on acting bases impacted adversely upon the agency's ability to respond.
92. Not until Monday morning 6 June 2016, did Colonel Wilson have any role in the flood response. He only became involved when the State Flood Operations Centre was set up – after the floods had peaked and after Mr Foster and Mrs Allford had died. He did not play any role at an operational level so far as the flooding in the North West Region (or anywhere else) was concerned, at any time, although the evidence was he was in communication with some SES Personnel, principally in relation to concerns about Mr Wayne Richards, the SES North West Regional Manager, based in Burnie. I will return to Mr Richards later in this finding.
93. Supporting the Director was the role of acting Assistant Director of Operations and Resources was occupied by Mr Dominic (“Nick”) Connolly. Mr Connolly's substantive position within the SES was in Learning and Development.
94. In addition to Mr Richards, another permanent SES employee as at June 2016 in the North West Region, was Mr Anthony Dick, the Regional Officer and a Training Officer. Mr Dick was in effect, Mr Richards' deputy. In the course of an ordinary weekend either the Regional Manager or the Regional Officer would be rostered on as the on call regional duty officer. Initially, at least for the weekend 4 – 5 June 2016, Mr Dick was rostered on as duty officer and Mr Richards was neither on duty nor on-call. However, that changed on 3 June 2016 when, upon receipt of advice in relation to the likely pending weather event, Mr Richards and Mr Dick agreed between them that he, Mr Richards, would resume duty to manage the weather event and Mr Dick would continue managing the search and rescue operation that was already on foot.
95. The Regional Manager had responsibility for coordinating training, logistics and preparation in the region and providing support to enable volunteer units to function appropriately. Relevantly, in the event of an emergency, a Regional Manager became

the Incident Controller for that emergency, with responsibility to coordinate and manage the emergency incident planning and response on the ground. Once an emergency had commenced, the role of the Regional Manager as Incident Controller for an area involved making decisions regarding activating on-call and volunteer personnel and directing the ground response such as coordinating sandbagging, doorknocking to issue warnings, directing media responses and authorising and arranging evacuation as necessary.

96. There were two other SES Regional Managers at the relevant time – one for the Southern Region and one for the Northern Region. Ms Mhairi Revie was Regional Manager in the North. She was based in Launceston. The Southern Regional Manager was based in Hobart. The structure in each region was the same as the North West – in addition to the Regional Manager, there was also a Regional Officer and a Training Officer. Although the focus of the Training Officer was to coordinate training in the relevant areas of the SES, it is apparent from the evidence at the inquest that in an emergency situation, the role expanded somewhat and included involvement in the active management and directing of resources as an Incident Controller, if only to the extent necessary to relieve the Regional Manager/Incident Controller when required. The North West Regional Training Officer was at all relevant times on leave and the position remained unoccupied. I consider not filling the position was a reasonable decision in the context of the training aspects associated with the role. However, there is no compelling reason on the evidence why the position could not have been filled, perhaps by a volunteer or a staff member from another region to provide a third person capable of carrying out the function of an Incident Controller within the North West Region, during the flood emergency.
97. The Northern District Regional Officer was at all relevant times Mr Michael D’Alton. During the weekend of 4 – 5 June 2016, he was on-call to perform the role of Regional Manager but engaged in the search in the North West Region (Northern Region SES volunteers were involved in that search, along with volunteers from the North West Region). Mr D’Alton made a decision not to deploy Northern Region SES members to the search on Sunday 5 June 2016, on the basis that they might be required in the Northern Region to deal with the predicted weather event.³¹ For the same reason, Ms Revie returned to duty on 5 June 2016 as Regional Manager in the Northern Region. Mr D’Alton then resumed his duties as Regional Officer as assistant Incident Controller.

³¹ Exhibit A113, page 1.

98. The Northern Regional Training Officer was Mr Gerard Van Rongen. During the weekend of 4–5 June 2016, Mr Van Rongen was not on duty, but was on-call. On 5 June 2016, Mr Van Rongen presented at the Northern Regional Operation Centre, and was told to take on the role of Operations Officer in the Northern Region during the night shift (9.00pm to 9.00am) to enable Ms Revie and Mr D’Alton to rest. That Mr Van Rongen was able to carry out that role contrasts with the staffing situation in the North West Region.
99. In the event of an emergency incident, the procedure was for the region to set up a Regional Operations Centre for the management and coordination of the response to the incident. The decision to establish a Regional Operations Centre is for the Regional Manager to make. During the weekend of Saturday 4 – Sunday 5 June 2016, a Regional Operations Centre was set up in Launceston for the North. No Regional Operations Centre was established in the North West Region.

The emergency response

100. Before any proper consideration of the emergency service response to the statewide flood event, something needs to be said about what information was available about the weather event and when that information was received, and by whom.
101. The evidence was that the agency responsible for monitoring, predicting and reporting on weather conditions is the Bureau of Meteorology. Extensive evidence was before the inquest as to the data obtained by the Bureau of Meteorology in the lead up to, and during the occurrence of, the flood event. There was evidence as well, that apart from Tasmania Police and the SES having access online to reports and warnings, the Bureau of Meteorology gave briefings to the three SES regions and communicated on at least three occasions during Sunday 5 June 2016 directly with regional incident controllers.
102. It is important to recognise that the process for publication of Bureau of Meteorology warnings and predictions has changed significantly since 2016. My findings below expressly reflect that fact.
103. In the immediate lead up to the flood event, the Bureau of Meteorology issued alerts and warnings on both Friday 3 and Saturday 4 June 2016. The substance of those warnings was that there would be severe weather statewide in the following days which would include strong winds, heavy rain and widespread flooding. Initially at least, the warnings concentrated on the northern and north-eastern areas of the state, focusing in particular upon the South Esk River catchment and the Eastern Coastal

area as the principal areas of concern. A flood watch, issued at 11.57am on Friday 3 June 2016,³² was expressed to be for all northern and eastern river basins.

104. A flood watch in similar terms was issued the following day, Saturday 4 June 2016 at 10.01am. However, and significantly in the context of Mrs Allford's death, it expressly states: "*a trough over eastern Australia will approach Tasmania on Saturday, **extending over the northwest of the State on Sunday***" [emphasis added].
105. At 4.02pm the same day another Flood Watch was issued. Although the flood watch – described in evidence, as a "heads up" for possible future flooding – was entitled "*Flood Watch for Northern and Eastern River Basins*", it now expressly identified that a moderate flood warning was current for the Mersey catchment.³³ The distinction between flood watch alerts and flood warnings is, that a flood watch was broader in its scope (that is to say for the state) whereas warnings focused on specific river catchments. Flood watches did not cover all river catchments because the Bureau of Meteorology was not always able to provide a flood warning service for all of the catchments covered by the area of a flood watch.
106. Another flood watch, in essentially the same terms, was issued the following morning, Sunday, 5 June 2016 at 9.54am.³⁴
107. At 4.14pm that day, another flood watch was issued. This flood watch was entitled "*Flood Watch for all Tasmanian River Basins*". It indicated that a major flood warning was current for the Mersey River.³⁵ The flood warning remained in those terms for the rest of the time relevant so far as this inquest is concerned, being reissued at 10.18am and 4.01pm on Monday 6 June 2016 and 9.53am on Tuesday, 7 June 2016. It was the warning current during the night of 5–6 June 2016.
108. Thus, from at least 11.57am on Friday 3 June 2016, there was clear information publicly available, that a trough and rain would extend over the North West region of Tasmania during 5 June 2016. From at least 4.02pm on Saturday 4 June 2016, there was clear information that there was a formal moderate flood warning for the Mersey River basin. As at 4.14pm on Sunday 5 June 2016, there was a major flood warning for the Mersey River.

³² Exhibit A 41A.

³³ *Supra.*

³⁴ *Supra.*

³⁵ *Supra.*

109. Although for the lay reader, it might be the case that there was room for a degree of confusion by the distinction between a flood watch and a flood warning, I do not consider that any emergency service practitioner of even basic experience could have been confused. In my view, this is particularly so as far as accessing, comprehending and acting upon flood watch and warnings by those members with a response leadership role within the SES.
110. Returning to the subject of the available weather information, in addition to what were described as flood watch and warning “products”, the Bureau of Meteorology issued a series of severe weather warnings, relating to heavy rainfall over the days leading up to Mrs Allford’s death. The first severe weather warning, for heavy rainfall, was issued at 1.53pm on Saturday 4 June 2016. That warning, and all that followed, included a notation that heavy rain may lead to flash flooding. The warning issued at 1.53pm on 4 June 2016, expressly identified that it applied to the North West region (along with other areas in the north of Tasmania). The warning included advice to members of the public and it seems reasonable to conclude from a statement that appeared at the bottom, to the effect that the warning was available also through TV and radio broadcasts and referring to the Bureau’s website, that the intention was that it be made public. It is also important to note that the warning issued at 1.53pm on Saturday 4 June 2016, and the 12 subsequent severe weather warnings issued by the Bureau of Meteorology, indicated that for flood and storm emergency assistance contact should be made with the SES and gave a telephone number for such contact to be made. The severe weather warnings do not suggest contact be made with any other agency (such as Tasmania Police). The severe weather warnings do not appear to distinguish between seeking assistance and asking to be rescued. In fact, in a practical sense, from the perspective of an ordinary member of the community, it is difficult in my view, to say what that difference would be, if any.
111. The evidence was that there were several meetings and briefings leading up to Sunday 5 and Monday 6 June 2016, between personnel from the Bureau of Meteorology and the SES, to brief about the likely extent of the severe weather and particularly what flooding might be expected for various Tasmanian rivers.
112. Extensive evidence at the inquest concerned those meetings and briefings. Although there were some minor discrepancies as to when exactly (in terms of time of the day) the meetings occurred, and possibly who was specifically in attendance, the nature and frequency of those meetings, as well as the substance of the information discussed and conveyed was largely uncontroversial. Briefing occurred on Thursday 2 June, Friday 3 June, Saturday 4 June 2016 and Sunday 5 June 2016.

- I 13. At the risk of repetition, I am quite satisfied that more than adequate information was available to those SES personnel occupying positions responsible for coordinating and managing the response which was highly likely to be required to the emerging flood event. Unfortunately, it is apparent that little to no preparation was made by the SES in the North West region of Tasmania, despite those severe weather warnings for heavy rain, flash flooding and flood watches and warnings in the area.
- I 14. The evidence is that there were personnel from both the SES and the Latrobe City Council monitoring the water levels of the Mersey River, from as early approximately 6.00am on Sunday, 5 June 2016.
- I 15. No evacuation warnings were issued by the SES to media, in relation to the Latrobe area (or anywhere in the North West Coast region) until the morning of Monday 6 June 2016. By that time Mrs Allford was dead and it was too late to evacuate Latrobe.

The actions of Wayne Richards

- I 16. At all relevant times Mr Richards was the SES Incident Controller for the North West Region. However, rather than being in the North West Coast region, Mr Richards was in Launceston. The Manager on duty for the North West Region was the North West Regional Officer, Mr Anthony Dick, but he was co-ordinating a large search in the area of Bakers Beach/Asbestos Range.
- I 17. It is very clear to me that the SES response was hampered by the fact that Mr Richards was in Launceston. I accept that he was not rostered to work on the weekend 4–5 June 2016, and needed to be in Launceston for personal reasons (a brass band competition), but I consider that almost to be beside the point.
- I 18. His evidence at the inquest seems to suggest that it was intended that if there was a North West regional weather event that needed to be responded to by the SES he would attend the SES's Northern office to deal with the action in some type of liaison capacity.³⁶ I note that Ms Revie said in her evidence, which I accept, that not only did she not agree to Mr Richards working at the Youngtown facility (although it is not clear to me that her agreement was necessary), she did not even know about the "arrangement" until he actually arrived there.
- I 19. Moreover, even if there was some arrangement (and I am satisfied there was not in the sense that the only person who seemed to be aware of the "arrangement" was Mr

³⁶ Exhibit A27 – affidavit of Wayne John Richards, sworn 27 January 2017 page 1 of 3.

Richards) then it is clear that no consideration had been given as to who would do what and how Mr Richards would conduct his duties from Launceston. On his own evidence, he had no documents, policies or Standard Operating Procedures with him to guide his decision-making. There is no evidence that he had any plan in mind for the weekend other than he would use an office at Youngtown (although for what purpose, and when, remains unclear).

120. In any event, Mr Richards travelled from the North West to Youngtown during the morning of Saturday 4 June 2016. The evidence does not allow a certain conclusion to be reached as to what time he arrived, but I am satisfied that he was present for the telephone briefing with the Bureau of Meteorology that morning (although in his evidence at the inquest, Mr Richards said he could not remember that).
121. Mr Richards' evidence was he was involved throughout the rest of the day in a band competition at the Launceston College, following which he went to his hotel where he had dinner and where he "may" have had one or two alcoholic drinks, before retiring at about 10.00pm.³⁷ Self-evidently, he spent very little time at Youngtown during the day of Saturday 4 June 2016.
122. Mr Richards said in evidence that he rose at about 7.00am on Sunday 5 June 2016, when he began receiving calls on his mobile telephone relating to damage as a result of the severe weather event which the North West Region was by then experiencing. He said that they were "mainly" (but I note not exclusively) related to wind damage. He said that he then made a decision he needed to be "in work mode"³⁸ and thus after going to the Launceston College and advising other people associated with the band competition that he would be unavailable for the rest of the day, made his way to the SES office at Youngtown, arriving there at about 9.30am. He was unable to say who was there when he arrived but said that he went downstairs and "set himself up"³⁹ in a meeting room area. He was unable to recall if he had a laptop computer to use but said he used his mobile telephone to make and receive calls in relation to work-related issues. He said there were laptops he "could have used",⁴⁰ however, was unable to recall whether he used one or not. He could not recall whether he accessed the Bureau of Meteorology website at any time to check the status of flood watches, flood warnings or severe weather warnings for the North West. He was unable to explain why he did not do this, other than to seem to suggest that he was too busy taking,

³⁷ Transcript.

³⁸ Transcript.

³⁹ *Supra*.

⁴⁰ *Supra*.

and responding, to calls regarding weather damage throughout the North West Region.

123. It is notable in my view, that none of the witnesses were able to confirm what time Mr Richards arrived at Youngtown on Sunday 5 June 2016, although Ms Revie's evidence, which I accept, was that he was present for the Bureau of Meteorology briefing that occurred at about 11.00am that morning. She said she was surprised to see him.⁴¹ Ms Revie went on to say that she did not see Mr Richards again until the evening of that day. Mr D'Alton said in his evidence that he too also did not see Mr Richards at all that day at Youngtown until sometime after 5.00pm that evening. Mr Richards said that he was there all day. The evidence in relation to the office lay out of the headquarters facility at Youngtown, suggests strongly to me that if Mr Richards had been there, as he said, then Ms Revie and Mr D'Alton would have had to have seen him.
124. I am fortified in this conclusion because Ms Revie's evidence was that she was looking for him during the day but could not find him. She said she spoke to Colonel Wilson who was also trying to get hold of Mr Richards who was proving difficult to track down. Colonel Wilson confirmed this in his evidence. The final factor that leads me to conclude that Mr Richards was not at Youngtown, as he said he was during the day of 5 June 2016, is the evidence, that I accept, from Ms Revie to the effect that in a conversation with Mr Richards early in the evening he said words to the effect that he had no idea what was going on as he had been at the band competition during the day. I note in his evidence at the inquest Mr Richards denied saying this, but I reject his denial as unconvincing.
125. I am affirmatively satisfied Mr Richards was not at Youngtown for anywhere near as long as he said he was during the day of Sunday, 5 June 2016. The evidence does not allow me to determine where he was, but it is clear to me that he was not at the Youngtown complex from a time I cannot determine, but after the 11.00am briefing until a time after 5.00pm.⁴²
126. I am also affirmatively satisfied that after attending the Bureau of Meteorology briefing at about 11.00am,⁴³ that morning, and when he must have been aware that a flood warning was in place for the Mersey River, he did nothing. His inaction was compounded by the fact that as he said in his own evidence at the inquest, he took no

⁴¹ Exhibit A92 – affidavit Mhairi Revie, sworn 12 August 2022, page 7 of 16.

⁴² Exhibit A113 - affidavit Michael D'Alton, sworn 1 February 2023, page 2 of 4.

⁴³ Exhibit A92, *op. cit.*

action in relation to the various warnings because he had not looked at them and did not know about them. While I accept that he had not looked at any material from the Bureau of Meteorology, on its website or anywhere else (and he should have), I do not accept that he was unaware of the flood warning for the Mersey River. As I have said, I am quite satisfied Mr Richards had been at the briefing at about 11.00am at which, amongst other things, that flood warning had been discussed.

127. I am also satisfied that Mr Richards received a personal briefing from a forecaster at the Bureau of Meteorology at about 3.30pm on Sunday 5 June 2016.⁴⁴
128. The evidence is that while things were relatively quiet in the Northern Region, Ms Revie left Youngtown at about 4.00pm to go home and rest. She left Mr D'Alton in charge.⁴⁵ While she was away the volume of calls to the Radio Dispatch Service (RDS) requesting assistance in the North West Region began to increase. RDS were apparently unable to contact Mr Richards and therefore began directing calls to the Northern Region. Similarly, the response forecaster at the Bureau of Meteorology was also unable to contact Mr Richards.⁴⁶
129. The fact that Northern Region personnel had to assume responsibility for what should have been Mr Richards' calls meant that their workload quickly became untenable.⁴⁷
130. Mr D'Alton briefed Mr Richards after he arrived at Youngtown that evening. Mr D'Alton told him that over 30 requests for assistance had been received by RDS relating to issues such as trees and powerlines being down and water inundation due to blocked drains. Mr D'Alton said, and I accept, that Mr Richards appeared '*clearly overwhelmed*' and that he '*didn't really know what to do*'.⁴⁸ Mr D'Alton said that Mr Richards began to task SES units in the North West Region directly without advising him (noting Northern Region were receiving and dealing with the calls). He did this without reference to RDS – something which would be likely to cause, and in fact did cause, confusion.
131. Mr D'Alton gave, Mr Gerald Van Rongen, responsibility for handling North West Region requests for assistance, while he concentrated on the Northern Region.

⁴⁴ Exhibit A95D.

⁴⁵ *Supra*.

⁴⁶ *Supra*.

⁴⁷ Exhibit A60, After Action Review M D'Alton.

⁴⁸ Exhibit A113, *op. cit.*

132. Ms Revie returned to Youngtown and received a comprehensive briefing from Mr D'Alton about what was happening in the North West. She spoke to Colonel Wilson to apprise him of the situation that was unfolding there. She rang the Meander Valley Municipal Co-ordinator and requested that the Deloraine Evacuation Centre be made ready. She discussed the situation in Latrobe with the Bureau of Meteorology.
133. Ms Revie then briefed Mr Richards on what was happening and what she had done to respond to the rapidly developing emergency in his region. She said and I accept that she told him in very clear terms that Latrobe was going to 'go under', and at least twice that Latrobe needed to be evacuated as a priority to which Mr Richards replied '*she'll be right*' or '*it'll be alright*' or words to that effect.⁴⁹ In his evidence at the inquest Mr Richards acknowledged that Ms Revie had given him that advice. Of her advice he said in evidence:
- "I took it very much as just a reactive – not not flippant in any way but just a – just a comment ah ah not not a um not a decision or statement made from any form of analysis that I was aware of".⁵⁰*
134. I am not sure that I understand what Mr Richards was attempting to convey by this answer. Whatever he meant, as he himself acknowledged, he did not order an evacuation of Latrobe, contrary to Ms Revie's firm advice. In my view Mr Richards' failure to heed her advice and order an evacuation was a bad mistake. I say that acknowledging the significant advantage a coroner enjoys when assessing incidents with the benefit of hindsight. Even allowing for that, it remains the case that Mr Richards had made no assessment of what was in fact going on himself. He had no plan in place for Latrobe, or anywhere. He had not established an Incident Management Centre, had no crews on standby, had no one on the ground monitoring developments and had not even briefed the Tasmania Police Commander for the relevant region. On his own evidence, he was unaware of the Bureau of Meteorology warnings (despite having been at two briefings that weekend about that precise issue) and did not even look at any weather warnings. To have rejected Ms Revie's advice in such circumstances of what was essentially complete ignorance was, in my respectful view, very poor decision making.
135. Mr Richards was, on Sunday 5 June 2016, as he said in his evidence at the inquest, the Incident Controller in respect of the flood event unfolding in his region. He was

⁴⁹ Exhibit A92, *op. cit.* page 8 of 16.

⁵⁰ Transcript.

responsible for coordinating the SES response. His job was receiving, interpreting and using information from the Bureau of Meteorology to inform the SES response. It was his job to provide information to the public and issue warnings as appropriate. He did none of those things.

136. In his evidence at the inquest, he claimed that resources were not available to assist him from both Tasmania Police and Tasmania Fire Service. That is simply not correct, as the response by Tasmania Police attempting to rescue Mr and Mrs Allford demonstrates. So does the fact that at least on two occasions during the Sunday 5 June 2016, Mr Richards approached TFS Volunteer brigade officers on an *ad hoc* basis for help – and received it. It is also inconsistent with the evidence of the TFS establishing and running an Incident Command Centre in Burnie during the morning of Monday 6 June 2016, which was established by the Regional Chief (TFS) Mr Shane Batt as a result of a request made of the Tasmania Fire Service by Colonel Wilson in the late afternoon or early evening of Sunday, 5 June 2016.⁵¹
137. Mr Anthony Dick, Regional Officer, North West Region, SES gave evidence at the inquest. He was, I considered an impressive witness indeed. In substance his evidence in relation to Mr Richards was that he, Mr Richards, did nothing to address the unfolding emergency and was essentially uncontactable. I note Mr Dick's evidence is consistent with the evidence from Colonel Wilson, Ms Revie and Mr D'Alton, and I accept it. Mr Dick described Mr Richards as appearing overwhelmed by the situation and said that he was '*blabbering*',⁵² that is, not making any sense. Mr Dick said, and I accept, that he kept emphasising to Mr Richards the need for a plan – any plan – but that Mr Richards did not have one. He described himself becoming extremely annoyed with Mr Richards.
138. Ultimately, Mr Richards left duty without telling Mr Dick – a significant failure of communication in my assessment. It is I consider a basic tenant of leadership and management that an Incident Controller does not abandon his or her post without advising those that are reporting to him or her of that fact. In addition, Mr Richards did not advise anyone to whom he reported at the SES headquarters in Hobart that he had left Launceston, and returned to the North West Coast. This meant that during the morning of Monday 6 June 2016, volunteer members of the SES from the North West Region were actually sent to Launceston to support him because SES

⁵¹ Exhibit A109 - affidavit Shane Batt, sworn 10 January 2023.

⁵² Transcript.

personnel involved in the management of human resources were unaware that he was no longer there.

139. In contrast, I consider that Mr Dick's response to the unfolding flood emergency was both concrete and useful, and continued to be so even though he was very tired. I note that it is apparent that Mr Richards had made no arrangements to ensure his subordinate had received adequate, or indeed any, rest.
140. It is of significance also in my view that the search in the region of the Asbestos Ranges (which was being coordinated and controlled by the SES North West Region) was abandoned because of adverse weather at around lunchtime on 5 June 2016. This should have been, but evidently was not, another indication to Mr Richards that significantly adverse developments were occurring in his region. It should have been, but evidently was not, a clear indication to Mr Richards that plans to respond to that weather event needed to be reviewed and, if appropriate, actioned. This did not occur either.
141. It is evident that there was wide spread concern about Mr Richards within the SES at the time. Having considered all of the evidence very carefully, I think that concern was warranted. It is clear to me that Mr Richards had no plan, at all, for the SES response to the emerging flood emergency in the North West Region of Tasmania. He was not in his area, but all the evidence (and common sense) says he should have been. He was not even where he said he was on Sunday 5 June 2016. To the extent that he did anything, what he did was unstructured and ineffective.
142. Lest it be thought that blame is being laid at the feet of Mr Richards, and Mr Richards alone, for the obviously poor response in the North West Region of Tasmania, I am firmly of the view that the SES must bear ultimate responsibility for that response. Mr Richards' limitations were seemingly well known within the agency, but not addressed in any meaningful way in my assessment of the evidence. It was left to his subordinate Mr Dick and the personnel from the Northern Region to attempt to deal with the consequences of his inaction.
143. Another factor in my view which impacted upon the SES's poor response was insufficient personnel. The evidence makes very clear that there simply were not enough staff available to respond to the floods and allow for sufficient rest of those staff actually tasked with co-ordinating the response. While it may be true volunteers were available from other regions, and potentially from the Tasmanian Fire Service, no request was made by Mr Richards for additional personnel resources.

144. I must emphasise that the purpose of this inquest, and any other, is not to apportion blame. Nonetheless, having heard all the evidence in relation to the matter and considered it very carefully, it is impossible to escape the conclusion that Mr Richards did nothing to respond to the unfolding flood event and it was his responsibility to make those preparations for the North West Region. His inaction is to be contrasted with the response and arrangements in place in Launceston for the Northern Region. To the extent that he did anything, it involved a series of unstructured, *ad hoc*, personal approaches in the absence of a plan.

Tasmania Police

145. I have already said that I am satisfied on the evidence that the planning and preparation on the part of Tasmania Police was satisfactory. During the night of 5-6 June 2016, the officer with overall responsibility was Acting Inspector David Chapman. He was the weekend duty supervisor, on a rostered day off, but at home in Ulverstone that night. At about 12.37am on Monday 6 June 2016, he received a telephone call advising that a police car had been inundated with flood water on Railton Road (not far from Latrobe), he became aware that residents at an address on Railton Road were trapped by rising floodwaters and that the Mersey River had breached its banks. He made contact with the uniform supervisor in Devonport and then was involved in monitoring evacuations, and monitoring developments in various other areas throughout the North West. He went to the Devonport police station arriving there at 2.05am, but before that he had received a number of calls with search and rescue personnel including Constable Wotherspoon.

146. Acting Inspector Chapman had a variety of issues to deal with all of which he managed appropriately in my assessment.

147. The Police command and control arrangements in place were more, in my assessment than adequate, were informed by relevant information as to the likely impact of the weather event and obviously functioned effectively, as the response to the calls for help from 351 Shale Road demonstrate.

148. Tasmania Police were not advised that evacuation of Latrobe (or its surrounds) was necessary on 5 June 2016 and thus took no action to warn any residents to evacuate.

Efforts to rescue Mr and Mrs Allford

149. Mr and Mrs Allford's home was on the outskirts of Latrobe in a generally rural location. It was located to the east of, and uphill from, the Mersey River, roughly 50 or

so metres from the ordinary bank of the river. It was necessary to demolish the house after the flood event, it having been too badly damaged to be restored. Another home now stands in its place.

150. During the evening of Sunday 5 June 2016, Mr and Mrs Allford were at home together. They watched television news and then a game of AFL football⁵³ before both going to bed at about 10.30pm.
151. Mr Noel Allford said that the couple watched the television news every night and that he “*did not remember seeing anything about the weather for Tasmania which caused [him] concern*”.⁵⁴ It is fair to conclude that they watched the news that night.
152. Neither had any cause for concern when they retired for the evening. Specifically, they had no idea that the Mersey River would shortly break its banks and engulf their home. Neither had they received any direct advice from any emergency service or other organisation that their home was at risk of flooding.
153. Just after midnight, Mr Noel Allford was awoken by his wife calling out. He got up and found there was water in his room. Mrs Allford was out of bed and sitting in a chair in her room. Mr Allford rang their son Mark, who lived a 10-12 minute drive away in Stony Rise, before helping his wife back into bed.⁵⁵
154. Mr Mark Allford left straight away and drove in his 2-wheel drive Ford Ranger, to Shale Road. He reached an area roughly adjacent Perkins Dairy, north of his parents’ home before he noticed water on the road, which he said in his evidence at the inquest was at least a metre deep, preventing him from travelling any further.
155. The water continued to rise, quickly reaching 30–45 centimetres deep, so Mr Noel Allford rang 000 asking for help. The call was logged at 12.42am by Tasmania Police Radio Despatch Service. The water continued to rise inside the house. Mr Noel Allford continued to ring 000 for assistance. In his affidavit tendered at the inquest, Mr Noel Allford described looking outside the house, through a window, and seeing that the water had reached the level of the window but was not that deep inside the house. He rang Mark again for assistance.⁵⁶

⁵³ Although there was no evidence about which game they watched, I note St Kilda were comprehensively defeated by the Adelaide Crows at Adelaide Oval that evening.

⁵⁴ Exhibit A6, affidavit of Noel Allford, sworn 17 July 2016, page 2 of 5.

⁵⁵ *Supra*, page 2 and 3 of 5.

⁵⁶ *Supra*.

156. The evidence was Mr Mark Allford's wife Mrs Michelle Allford called the SES for assistance while Mr Mark Allford tried to get to his parents' place in his vehicle. Mrs Michelle Allford's unchallenged evidence, was that she was told by an unidentified person at the SES headquarters that "*they didn't do rescue and they should go and evacuate her in-laws themselves*". Mrs Michelle Allford advised that person that was what her husband was doing. Mr Mark Allford then called his wife to say that the road was blocked with water and he could not get in. Mrs Michelle Allford called the SES again and was again told they couldn't or didn't (or perhaps wouldn't) do rescues and she should call the police (which she did).
157. I do not think it is unfair to say that the response of the Tasmania Police was rather different to the SES. At 1.26am, Mr Noel Allford called 000 and spoke to police. He told the RDS operator that both he and his wife were trapped by rising floodwaters and that his wife is incapacitated and bedridden. The RDS operator, Senior Constable Petra Schnierier, to whom Mr Noel Allford spoke, immediately made multiple transmissions to a number of police units and tasked them to assist.
158. First Class Constable Dean Wotherspoon, a very experienced search and rescue operative, was recalled to duty at approximately 1.00am on Monday 6 June 2016. He was advised that an elderly couple were trapped in a house by rising floodwaters at 351 Shale Road, Latrobe.
159. He was tasked along with Constable Johnson and Constable Filler to respond to that incident.
160. After going first to the Search and Rescue Store at the Devonport Police Station to prepare and equip themselves to respond, they arrived in the area within a matter of minutes of being tasked. Upon arrival, Constable Wotherspoon was advised that the water within 351 Shale Road was at the level of the bed and that furniture was floating inside the house. Constable Wotherspoon described seeing the flood waters rising, with the water flowing quickly and standing waves evident in some areas. He said that the depth of the water was such that fences had disappeared under the surface. He saw debris in the water.⁵⁷
161. Constable Wotherspoon, Constable Johnson and Constable Filler launched an inflatable rescue boat and manoeuvred it into the water. However, it quickly became apparent that the flow was such that the inflatable rescue boat would not be able to

⁵⁷ Exhibit A18, affidavit of Dean Wotherspoon, the sworn 9 August 2016, page 3 of 9.

reach 351 Shale Road. Efforts were made to reach Mr and Mrs Allford's address on foot. Those efforts, carried out at significant personal risk to the police officers involved, proved unsuccessful.

162. Constable Wotherspoon telephoned Sergeant Steane at Southern Search and Rescue to assess the feasibility of deploying the rescue helicopter (he was aware that the helicopter had experienced significant safety issues flying the previous day during daylight hours). However, adverse weather conditions meant that a helicopter could not be dispatched until first light. I accept that the decision not to dispatch the helicopter until first light so that it arrived at Shale Road at about 8.50 am was reasonable. Moreover, it seems doubtful that even if it had been able to fly immediately that it would have reached Latrobe in sufficient time in any event to have enabled Mrs Allford to have been rescued alive.
163. Police then attempted to use a backhoe driven by Mr Grant How from the Latrobe City Council to get to Mr and Mrs Allford. Mr How was provided by the police with a PFD and then drove into the water with Constable Wotherspoon standing on the steps on the left-hand side and Constables Johnson and Filler on the right. After moving about 50 metres water began flowing sideways through the cab and the force of the water was such that the machine itself began to move sideways. Accordingly, that effort to rescue Mr and Mrs Allford had to be abandoned at about 3.15am.
164. Constable Wotherspoon made contact with the Duty Officer for Surf Life Saving Tasmania to see if any jet skis were available in the North West Region. He was told that the only jet skis were in Hobart. Constable Wotherspoon asked for them to be relocated to the North West, expecting they might be required later that day, before continuing with the task of attempting to rescue Mr and Mrs Allford from their home.
165. A large articulated front-end loader weighing 16 tonnes from the nearby Devonport City Council, operated by Mr Michael Lynd arrived at the scene. Mr Lynd was provided with a PFD by the police. Constable Wotherspoon stood on the steps on the right-hand side of the machine to communicate with Mr Lynd, while Constables Johnson and Filler stood on the engine cover on the rear of the front-end loader. The front-end loader entered the water. After travelling approximately 100 metres into the flood waters, the loader began to be moved sideways by the water. Again, the rescue effort had to be aborted.
166. The last attempt to reach Mr and Mrs Allford was made by Constables Wotherspoon, Johnson and Filler trying to make their way by skirting the flood waters and attempting to reach the house by wading or swimming. Constables Wotherspoon and

Filler entered the water in front of a building known as the old paint factory, which is situated immediately behind 351 Shale Road approximately 50 metres east of the property. After only a short distance from dry land, the water quickly became chest deep and the officers began to lose their footing and float. The effort had to be abandoned. It was by now about 5.00am.⁵⁸

167. While all these rescue efforts were occurring, the water continued to rise in 351 Shale Road. It was pitch dark. A refrigerator, and various pieces of furniture, were floating in the water in the house. Mr Noel Allford tried to keep his wife's head above water by moving her to a mattress that he found floating in the house. He went upstairs to get a doona to try and keep his wife warm. When Mr Noel Allford returned downstairs the door to the bedroom in which he had left his wife was blocked by a refrigerator. He tried to remove it from the doorway but could not do so. He kept talking to his wife telling her to stay on the mattress. She told him she was cold (Mr Noel Allford said she was only wearing a pair of silk pyjamas).
168. Soon, Mr Noel Allford could not hear his wife. He was very tired, but could not remember feeling cold.⁵⁹ He moved to the stairs and then went upstairs. Mrs Michelle Allford said she last spoke to her father-in-law at approximately 4.00am, after which the phone went 'dead'. Police RDS were also unable to contact Mr Noel Allford after about 5.00am.
169. Mr Noel Allford was finally rescued from the roof of his home later that morning by the crew of the rescue helicopter. The next day, Constable Wotherspoon found Mrs Allford's body in the main bedroom of the home pinned between the bed and the walls in the north-west corner of the bedroom. Her body was covered by a large amount of sediment.⁶⁰
170. Mrs Allford's body was examined and photographed where it was found⁶¹ before being placed in a body bag, onto a stretcher and carried to a waiting Army Unimog truck. After formal identification,⁶² her body was transported to the Latrobe Police Station, before being taken to the Royal Hobart Hospital by mortuary ambulance.

⁵⁸ *Supra*, pages 4 – 6 generally.

⁵⁹ *Supra*.

⁶⁰ *Supra*.

⁶¹ Exhibit A26, affidavit of Melle Zwerver, sworn 29 July 2016 (and scene photographs).

⁶² Exhibit A3, affidavit of Peter Dabney, sworn 7 June 2016.

Investigation

171. At the Royal Hobart Hospital, Dr Donald Ritchey, Forensic Pathologist, performed an autopsy. Following the autopsy, Dr Ritchey provided a report which was tendered in evidence at the inquest.⁶³ In that report, Dr Ritchey expressed the opinion, which I accept, that the cause of Mrs Allford's death was drowning. He noted contributing factors were her obesity (BMI 30.3) and disabling idiopathic peripheral neuropathy.
172. Toxicological analysis of samples taken at autopsy proved unremarkable. Only therapeutic levels of prescription drugs were found to have been present in Mrs Allford's body at the time of her death.⁶⁴ I am satisfied that those drugs did not cause or contribute in anyway to Mrs Allford's death.
173. The comprehensive investigation initially centred around Mr and Mrs Allford's home at Shale Road, which was photographed and carefully examined. Those photographs were in evidence at the inquest. The house was a complete wreck. Ultimately it had to be demolished. The house itself, aside from being the place where Mrs Allford died really had nothing to do with this investigation. The real focus of the investigation was the response of emergency services, and particularly the SES, to the flood as it developed.
174. In carrying out this assessment it needs to be firmly born in mind that the weather event was creating dangerous conditions throughout the state (as in fact the deaths of Mr Foster, Mr Watson and Mrs Allford in the South, North and North Western regions respectively illustrate very well). The search for the missing person in the Asbestos Range area was evidently human resource intensive, directly involved members of the Western Search and Rescue squad and had left the majority fatigued by their involvement.⁶⁵ Police and emergency services were also involved in responding to multiple other incidents associated with the severe weather throughout Tasmania. Self-evidently, any emergency service anywhere has finite resources and a necessarily limited capacity to respond to incidents as they occur. Planning and the judicious allocation of resources is the only appropriate response. Even then, not every emergency incident will always be able to be responded to immediately in times of pressure and high demand.

⁶³ Exhibit A4, affidavit of Donald Ritchey, sworn 14 September 2016

⁶⁴ Exhibit A5, affidavit of Miriam Connor, Forensic Scientist, sworn 22 August 2016.

⁶⁵ Exhibit A17, affidavit of Simon Conroy, sworn 17 May 2017.

The helicopter deployment

175. I have already touched upon this issue earlier in this finding. However, it is important to say some more about the decisions associated with deploying the rescue helicopter. In his affidavit, Senior Constable Peach said that he received a phone call at home, where he was off duty, at about 2.45am on Monday 6 June 2016, from Constable Wotherspoon asking for assistance. Senior Constable Peach said that Constable Wotherspoon told him that a house at 351 Shale Road, Latrobe, had been inundated by floodwaters and that two people were believed to be trapped inside. Senior Constable Peach immediately telephoned the Rotolift helicopter base and spoke with the duty pilot. The duty pilot advised Senior Constable Peach that the weather conditions were such that the helicopter could neither safely nor legally fly to Latrobe due to very low cloud and extremely high winds. Senior Constable Peach relayed that information to Constable Wotherspoon.⁶⁶
176. At 5.50am Constable Wotherspoon rang Senior Constable Peach again. He explained that all efforts to get to 351 Shale Road had been unsuccessful. Senior Constable Peach rang the duty pilot again who advised that an attempt to fly could be made at daylight. Senior Constable Peach went straight to the Rotolift base at Cambridge. The helicopter took off at 7.40am with two rescue crewmen (Senior Constable Peach and Sergeant Steane) and a flight paramedic on board. The helicopter arrived on the scene at 8.50am and the crew rescued Mr Allford by winch and flew him to the nearby Devonport airport where he was transferred to an ambulance and taken to hospital.
177. I consider that the helicopter was deployed as soon as was both practical and safe. The point is if there had been any proper warnings, or a timely decision made to evacuate Latrobe, or areas under threat, then the deployment of the rescue helicopter would not have been necessary.

Swift water rescue

178. Various efforts, set out above, were made to get to Mr and Mrs Allford. Those efforts exposed a deficiency in relation to swift water rescue capability in Tasmania.⁶⁷ I am satisfied that those deficiencies having been identified, have been or are being addressed. But again, as with the helicopter and jet skis, the point is that had timely (or indeed any) warnings to evacuate the areas of Latrobe, including 351 Shale Road

⁶⁶ Exhibit A22, affidavit of Joshua Peach, sworn 28 June 2016, generally.

⁶⁷ Exhibit A18, *Op. Cit.*

impacted by the flood, been issued then the issue of swift water rescue capability would not have arisen.

Municipal authority response

179. Shale Road is within the municipal area of the Latrobe City Council. There is, on the evidence, in my view, no reason to criticise the response of the Council to the emergency which impacted the town of Latrobe during the night of 5–6 June 2016.
180. The evidence suggests that the first warning to the Council of the potential for problems came at about 6.30pm on Sunday 5 June 2016, when Mr Richards rang Mr Jonathan Magor, Latrobe City Council's Emergency Management Coordinator⁶⁸ to advise him that significant floods were expected in the Mersey River.⁶⁹ Thereafter, Mr Magor returned to work, briefed the mayor and commenced checking river heights and flood warnings. He was involved in discussions and further on ground monitoring as the evening progressed and this flooding became worse. He contacted Mr Peter Dawson, who was in charge of the building maintenance team for the Latrobe City Council, at about 8.00pm that evening and asked him to return to work to organise sandbags and sandbagging. Mr Magor did his job and did it well.
181. Another Latrobe City Council employee, the Community Development Officer Ms Michelle Dutton was also actively involved in the flood response during the night 5–6 June 2016. She returned to work shortly after 10.00pm that night. She spoke to Mr McGraw and Mr Dick and noted that the height of the river was rising. She said two other personnel from the SES arrived who were then directed by Mr Dick to make observations on the ground in around the Latrobe area. She was involved in a discussion about the possibility of some evacuations occurring. At about 11.15pm, having returned home, she received a telephone call from the Regional Recovery Coordinator warning her that it would probably be necessary to open up an evacuation centre. This progressed quickly; at about 11.30pm Ms Dutton was advised, again by the Regional Recovery Coordinator, an evacuation centre would be established in East Devonport. She went to the newly established evacuation centre which opened at midnight.
182. Ms Dutton became aware at about 7.00am of evacuations and rescues that were occurring in Latrobe involving the local fire brigade and also the Australian Army. She

⁶⁸ Mr Magor was also the Emergency Management Coordinator for the neighbouring Kentish Council.

⁶⁹ Exhibit A 32, Affidavit – Jonathan Magor, sworn 20 April 2017.

in fact made contact with army personnel in Devonport to arrange for vehicles to assist in rescue efforts. Like Mr Magor, Ms Dutton, in my view, did her job well.

183. The Mayor, Mr Peter Freshney also, in my estimation, performed well. He made practical contributions and performed a liaison role between emergency services, the council and the media. He knew that he had no responsibility for making decisions in relation to the actual utilisation of council assets nor any responsibility for decisions in relation to the rescue of affected persons and did not interfere in the decision making associated with those issues. In my view, this is a very commendable approach by an elected official, from which other elected representatives in future situations could learn a considerable amount.
184. In addition, the evidence at the inquest satisfies me that the Latrobe City Council's level of preparation, including discharging its obligations with respect to advance planning, maintenance of appropriate plans and the like was satisfactory.

Formal findings – Mary Kathleen Allford

185. Pursuant to section 28(1) of the *Coroners Act 1995*, I make the following formal findings on the basis of the evidence at the inquest:
- a) The identity of the deceased is Mary Kathleen Allford;
 - b) Mrs Allford died in the circumstances set out earlier in this finding;
 - c) The cause of Mrs Allford's death was drowning; and
 - d) Mrs Allford died, aged 76 years, on 6 June 2016, at 351 Shale Road, Latrobe in Tasmania.

Summary – specific findings having regard to the scope

186. Set out below are a summary of what I consider to be the responses or answers to the scope of the inquest.
187. *The adequacy of emergency service response to the circumstances surrounding the death of Mrs Allford at Latrobe on 6 June 2016 including (but not limited to):*
- a) *The adequacy or otherwise of the relevant Municipal Emergency Management Plan (Mersey-Leven);*
The plan was adequate.

- b) *Communication between emergency services in the NW Region for the period 5-7 June 2016 inclusive;*
I consider that such communication was adequate, despite the North West SES Incident Controller being absent and/or failing to communicate with other agencies adequately or at all.
- c) *Co-operation between emergency services in the NW Region for the period 5-7 June 2016 inclusive;*
I consider that such co-operation was *adequate*, despite the North West SES Incident Controller being absent and/or failing to facilitate any co-operation with other agencies adequately or at all.
- d) *The adequacy or otherwise of the SES fatigue management policy (assuming one was in existence as at 6 June 2016);*
There is no evidence that there was in fact a fatigue management policy in existence as at 6 June 2016.
- e) *The actions of Mr Wayne Richards, NW Regional Manager SES;*
These have been dealt with above.
- f) *The adequacy of flood watch and warnings issued by the Bureau of Meteorology in the lead up to the Latrobe flood event.;*
Noting that there have been significant changes in relation to how information is disseminated by the Bureau of Meteorology, I consider the flood watch and warnings issued were adequate.
- g) *The adequacy or otherwise of SES personnel resources in the NW Region for the period 5-7 June 2016 inclusive;*
The SES personnel resources available in the North West Region were inadequate.
- h) *Arrangements in place by SES with respect to rostering of personnel in the NW Region for the period 5-7 June 2016 inclusive;*
The evidence at the inquest was that there were no such arrangements in place.
- i) *Tasmanian Emergency service (TASPOL, Ambulance Tasmania, TFS, SES) flood rescue capability as at 2016, and now;*
The capability of the SES as the lead flood agency in 2016 was poor. However, I am satisfied that significant improvement has been made in

building that capability. There is no evidence to suggest that the flood rescue capability of the other emergency agencies was lacking in 2016 or now.

- j) *Whether a flood evacuation plan or plans existed for the Mersey River at Latrobe as at June 2016 and if so:*
- i. *The adequacy of that plan (or those plans);*
There is no evidence to suggest that flood evacuation plan or plans were inadequate. The problem was that no plan was in fact actioned.
 - ii. *The familiarity of SES incident control personnel with those plans;*
In contrast to Ms Revie and Northern Region personnel, the North West Region Incident Controller Mr Richards was completely unfamiliar with the principal tactical response document which, if consulted, would have given clear practical assistance in assessing risk and formulating a plan to respond to that risk.
- k) *If no such flood evacuation plan or plans existed for the Mersey River at Latrobe, then why not?*
Not applicable.
- l) *The training provided in 2016, and now, to SES incident controllers and senior managers with respect to emergency management generally and flood response in particular;*
It is obvious that Mr Richards lacked any real training or qualifications in relation to flood response at all. He said in his evidence that it was his intention to become more familiar with flood response but seemingly did not do that. The evidence is he was offered assistance by Ms Revie, her knowledge was broad and impressive but he did not apparently take her up on that offer either. He initially asserted that time constraints precluded his becoming more familiar with, and receiving appropriate training in relation to, flood response but in his evidence at the inquest he admitted he found the task too daunting and did not know where to start.⁷⁰ I am satisfied on the basis of Mr Smith's evidence this area has been significantly improved.

⁷⁰ Transcript.

Conclusion

188. I **comment** that in my view the rescue efforts by Constables Wotherspoon, Johnson and Filler are worthy of particular recognition. They made a number of attempts to rescue Mr and Mrs Allford in the dark, in deep swiftly flowing flood waters at considerable personal risk. I consider that they acted with bravery in very hazardous circumstances. I **recommend** that their bravery be formally recognised.
189. Arguably the most important function of the coronial system is to learn lessons from deaths and from those lessons prevent avoidable deaths in the future. Where deaths have occurred in a natural disaster (such as these floods undoubtedly were) a coroner has an important role to independently review the preparedness and response of those government agencies whose job it is to keep the community safe.
190. Having carefully reviewed and considered the voluminous evidence amassed during the investigation into the deaths of Mrs Allford, Mr Foster and Mr Watson, I do not consider any other comments or recommendations pursuant to section 28 of the *Coroners Act 1995* are warranted or necessary. As I said at the beginning of these findings the emergency service landscape has changed substantially since the floods in 2016. The response to the floods in Tasmania in 2022, in which no one died, emergency warnings were issued in a timely way and the incident managed effectively in my assessment, all point to significant improvements since 2016.
191. These finding were sent in draft to the Department of Police, Fire and Emergency Management and to Mr Richards' lawyers. Mr Richards, through his lawyers, indicated he did not wish to make any submissions about the draft finding. I therefore proceeded on the basis that he did not dispute any of the factual findings in relation to his actions.
192. The Department of Police, Fire and Emergency Management delivered written submissions to which I had regarded in concluding the matter.
193. In conclusion, I wish to express my sincere and respectful condolences to the families and loved ones of Mrs Allford, Mr Foster and Mr Watson.

Dated: 21 February 2025 at Hobart, in the State of Tasmania.

Simon Cooper
Coroner

Annexure

Peter John Watson Exhibits

No.	TYPE OF EXHIBIT	NAME OF WITNESS
C1	REPORT OF DEATH	I/Cst Leigh BAILEY
C2	LIFE EXTINGUISHED AFFIDAVIT	Dr Rod FRANKS
C3	AFFIDAVIT OF IDENTIFICATION	Michael LAHERTY
C4	DIRECTION OF FULL AUTOPSY	Coroner Olivia McTAGGART
C5	FORENSIC ODONTOLOGY REPORT	Dr Tamas PACZA
C6	FORENSIC PATHOLOGIST REPORT/S	Dr Donald RITCHEY
C7	TOXICOLOGY REPORT	Miriam CONNOR
C8	AFFIDAVIT	Cst Kriss LAWLER
C9	AFFIDAVIT & MAPS	Sgt Damien BIDGOOD
C10	STATUTORY DECLARATION	Karen CASSIDY
C11	AFFIDAVIT	Tanita THYNNE
C12	AFFIDAVIT	Justin O'NEILL
C13	AFFIDAVIT	Mark BRADSHAW
C14	AFFIDAVIT	David RICHARDSON
C15	AFFIDAVIT	Howard CALVERT
C16	AFFIDAVIT	Sgt Anthony ROUGHAN
C17	AFFIDAVIT	I/Cst Leigh BAILEY
C18	AFFIDAVIT	S/Cst Nat ELDERSHAW
C18A	ADDITIONAL PHOTOS & VIDEO	S/Cst Nat ELDERSHAW
C19	AFFIDAVIT	S/Cst Samuel LLOYD
C20	AFFIDAVIT	I/Cst Bradley COLLINS
C21	AFFIDAVIT & PHOTOGRAPHS & VIDEO FOOTAGE	S/Cst Peter McCARRON
C22	AFFIDAVIT & PHOTOGRAPHS	I/Cst Brett TYSON
C23	AFFIDAVIT & PHOTOGRAPHS	I/Cst Marcus WILLIAMS
C24	AFFIDAVIT	Mhairi BRADLEY (SES)
C25	PHONE RECORDS	TELSTRA
C26	IDM REPORT	Tasmanian Police
C27	BRIEFING NOTE	Sgt Philip SUMMERS
C28	TASMANIA POLICE COMMAND & CONTROL SYSTEM JOB L04511-16 & 000 CALL MADE BY PETER WATSON	Tasmania Police
C29	STATE GROWTH WEEKLY REPORT	Dave RICHARDSON
C30	INCIDENT REPORT	Stornoway
C31	MAJOR FLOOD WARNING FOR THE NORTH ESK RIVER	Bureau of Meteorology
C32	ROADWORKS SPECIFICATION R101 EMERGENCY MANAGEMENT- NOVEMBER 2010	Department of Infrastructure, Energy and Resources
C33	STATE ROAD AND BRIDGE EMERGENCY MANAGEMENT PLAN- DECEMBER 2008	State Growth Transport Infrastructures Division

Trevor Allan Foster

No.	TYPE OF EXHIBIT	NAME OF WITNESS
F1	REPORT OF DEATH- Foster	I/Cst Dion MENZIE
F1A	REPORT OF DEATH- Bones	S/Cst Peter GIBSON
F2	AFFIDAVIT OF IDENTIFICATION	Anthony CORDWELL
F3	FSST DNA IDENTIFICATION	Dr Corey GRIFFITHS
F4	POST MORTEM AFFIDAVIT	Dr Donald RITCHEY
F5	ANTHROPOLOGY REPORT	Anne-Marie WILLIAMS
F6	AFFIDAVIT	Helen FOSTER
F7	AFFIDAVIT	Mark DANCE
F8	AFFIDAVIT	Graham ROGERS
F9	AFFIDAVIT	I/Cst Dion MENZIE
F10	AFFIDAVIT	Sgt Adrian LEARY
F11	AFFIDAVIT	S/Cst Paul BRITTEN
F11A	PHOTO	S/Cst Paul BRITTEN
F11B	PHOTO	S/Cst Paul BRITTEN
F12	AFFIDAVIT	S/Cst Bradley COULSON
F13	AFFIDAVIT (28.07.2016)	Cst Mandy LADSON
F13A	PHOTOGRAPHS	Cst Mandy LADSON
F13B	Affidavit (27.06.2022)	Cst Mandy LADSON
F14	AFFIDAVIT	Cst Ingrid PAJAK
F15	AFFIDAVIT	Cst Benjamin CUNNINGHAM
F16	AFFIDAVIT	Cst Andrew OAKDEN
F17	AFFIDAVIT	S/Cst Christopher WILLIAMS
F18	AFFIDAVIT & MAPS	Sgt Damien BIDGOOD
F19	AFFIDAVIT	Cst Ashley KENT
F20	AFFIDAVIT	S/Cst Scott WILLIAMS
F21	AFFIDAVIT	Sgt Karl KRELLE
F22	AFFIDAVIT	Cst Daniel ADAMS
F23	AFFIDAVIT	Cst Simon DARKE
F24	AFFIDAVIT	Cst David PROVAN
F25	AFFIDAVIT	Cst Rodney STACEY
F26	AFFIDAVIT	Cst Craig KEOGH
F27	AFFIDAVIT	Cst Amanda PHAIR
F28	AFFIDAVIT & PHOTOGRAPHS	Cst Dean WALKER
F29	STATUTORY DECLARATION	William CHAPMAN
F30	MAPS	
F31	WEB-EOC – FLOOD INCIDENT	
F32	HYDRO TASMANIA REPORT FOR TREVOR FOSTER UNDRAFTED	Hydro Tasmania
F32A	HYDRO TASMANIA REPORT FOR TREVOR FOSTER DRAFT	Hydro Tasmania
F33	HYDRO TASMANIA CLOUD SEEDING	Hydro Tasmania
F34	OPERATING RULES FOR LAKE AUGUSTA, LITTLE PINE LAGOON, PENSTOCK LAGOON, SHANNON LAGOON	Hydro Tasmania
F35	REPORT OF THE INDEPENDENT REVIEW INTO THE TASMANIAN FLOODS OF JUNE & JULY 2026	Mike BLAKE

No.	TYPE OF EXHIBIT	NAME OF WITNESS
A1	COVERING REPORT	S/Sgt Darren PENDLEBURY
A2	REPORT OF DEATH	Cst Peter DABNER
A3	AFFIDAVIT OF IDENTIFICATION	Cst Peter DABNER
A4	POST MORTEM AFFIDAVIT	Dr Donald RITCHEY
A5	TOXICOLOGY REPORT	Miriam CONNOR
A6	AFFIDAVIT – 17/7/16	Noel ALLFORD
A7	AFFIDAVIT – 17/7/16	Mark ALLFORD
A7A	LETTER TO COMMISSIONER OF POLICE	Mark ALLFORD
A8	AFFIDAVIT – 17/7/16	Michelle ALLFORD
A9	AFFIDAVIT – 31/5/17	Gerard ALLFORD
A10	AFFIDAVIT – 7/4/17	S/Sgt David CHAPMAN
A11	AFFIDAVIT – 17/5/17	Insp Shane LeFEVRE
A11A	ANNEXURE 1 – 1-6 June 2016 - Le FEVRE'S SCRIBE'S NOTES	Insp Shane LeFEVRE
A11B	ANNEXURE 2 – 7 JUNE 2016 - Le FEVRE'S SCRIBE'S MEETING NOTES	Insp Shane LeFEVRE
A12	AFFIDAVIT – 31/5/17	S/Sgt Darren PENDLEBURY
A12A	FLOOD DE-BRIEF – 17/8/16	S/Sgt Darren PENDLEBURY
A12B	INCIDENT REPORT – 6/6/16	S/Cst Ben ELLIOTT
A13	AFFIDAVIT – 30/5/17	Cst Michael HOLLINGSWORTH
A14	AFFIDAVIT – 30/5/17	Sgt Luke BISHOP
A15	AFFIDAVIT – 10/5/17	S/Cst Benjamin ELLIOTT
A16	AFFIDAVIT – 7/1/16	Cst Peter DABNER
A17	AFFIDAVIT – 17/5/17	S/Sgt Simon CONROY
A18	AFFIDAVIT – 9/8/16	Cst Dean WOTHERSPOON
A19	AFFIDAVIT- 15/6/16	Cst Adam FILLER
A20	AFFIDAVIT – 12/8/16	I/Cst Mark JOHNSTON
A21	AFFIDAVIT – 23/6/16	Sgt Paul STEANE
A22	AFFIDAVIT & HELMET CAM FOOTAGE & PHOTOGRAPHS ON DISC – 26/6/16	S/Cst Joshua PEACH
A23	AFFIDAVIT- 15/6/16	S/Cst Petra SCHNIERER
A24	AFFIDAVIT – 15/6/16	Cst Hannah MACLEOD
A25	AFFIDAVIT – 16/6/16	Cst Glenn READING
A26	AFFIDAVIT & PHOTOGRAPHS – 29/7/16	S/Cst Melle ZWERVER
A27	AFFIDAVIT – 27/1/17	Wayne RICHARDS
A27A	AFFIDAVIT – 11/10/17 & SES MEDIA RELEASES	Wayne RICHARDS
A28	AFFIDAVIT – 26/8/16	Anthony DICK
A28A	SES FLOOD OPERATIONAL REPORT FOR LATROBE	Anthony DICK
A29	AFFIDAVIT – 9/2/17	Gerald VAN RONGEN
A30	AFFIDAVIT – 9/2/17	Mhairi BRADLEY
A31	AFFIDAVIT – 5/6/17	Dominic CONNELLY
A32	AFFIDAVIT – 20/4/17	Jonathon MAGOR
A33	AFFIDAVIT – 28/4/17	Robert EDDY
A34	AFFIDAVIT – 25/1/17 WITH MAPS	Nigel RIST
A34A	AFFIDAVIT – 26/5/17	Nigel RIST
A35	AFFIDAVIT – 23/5/17	Christopher AUTY
A36	AFFIDAVIT – 21/3/17	Peter FRESHNEY
A37	AFFIDAVIT – 20/4/17	Michelle DUTTON
A38	AFFIDAVIT – 20/4/17	Peter DAWSON

A39	AFFIDAVIT (unsigned)	Michael LYND
A40	AFFIDAVIT – 29/4/17	Grant HOW
A41A	FLOOD WARNING PRODUCTS FOR JUNE 2016 FLOODING EVENT 25/11/16	Bureau of Meteorology
A41B	FLOOD WARNING PRODUCTS FOR JUNE 2016 FLOODING EVENT 9/8/17	Bureau of Meteorology
A41C	FLOOD WARNING PRODUCTS FOR JUNE 2016 FLOODING EVENT (REVISED) 3/3/16	Bureau of Meteorology
A41D	TASMANIAN RECORD MAJOR FLOODING EVENT - JUNE 2016 – 25/11/16	Bureau of Meteorology
A41E	MAJOR FLOODING IN HUONVILLE JULY 2016 -25/11/16	Bureau of Meteorology
A42	INTERNAL SES EMAILS RE WATER LEVEL AT LATROBE BRIDGE	Bureau of Meteorology
A43	TASMANIAN EMERGENCY MANAGEMENT ARRANGEMENTS ISSUE 1 2019	Tasmanian Government
A44	TASMANIAN EMERGENCY MANAGEMENT PLAN ISSUE 8	Tasmanian Government
A45	TASMANIAN MUNICIPAL EMERGENCY MANAGEMENT PLAN	Mersey Leven
A46	MERSEY RIVER FLOOD SURVEY	Entura of Hydro Tasmania
A47	HELICOPTER CREW OPERATIONS REPORT	Insp Lee RENSHAW
A48	FILES OF MAPS ON DISC	Tasmanian Police
A49	MERSEY RIVER MAPS & ROWALLAN DAM MAPS	
A50	STATEMENT & INCIDENT MANAGEMENT LOG	Mhairi BRADLEY
A51	STATEMENT & COMMUNICATIONS LOG	Gerald VAN RONGEN
A52	TasIMS OPERATIONS LOG	Tasmania State Emergency Service
A53	TASMANIA POLICE COMMAND & CONTROL SYSTEM JOB K03720-16	Tasmania Police
A54	SES LOG BOOK	Chris IRVINE
A55	EXPERT OPINION REPORT	Craig LAPSLEY
A56	FATIGUE MANAGEMENT GUIDELINES	SES
A57	STORM & WATER DAMAGE RESPONSE LEARNER GUIDE	SES
A58	TEAM LEADER LEARNER GUIDE	SES
A59	AFTER ACTION REVIEW – 30/6/16	Mhairi REVIE
A60	AFTER ACTION REVIEW – 1/7/16	Michael D'ALTON
A61	AFTER ACTION REVIEW – 1/7/16	Nick CONNOLLY
A62	AFTER ACTION REVIEW – 4/7/16	Nick WILSON
A63	AFTER ACTION REVIEW – 20/7/16	Shane BATT
A64	AFTER ACTION REVIEW – 11/7/16	Tim DOOLEY
A65	AFTER ACTION REVIEW – 11/7/16	Wayne RICHARDS
A66	AFTER ACTION REVIEW – 18/7/16	Gerald VAN RONGEN
A67	AFTER ACTION REVIEW – 3/8/16	Colleen RIDGE
A68	AFTER ACTION REVIEW – 6/7/16	Anthony DICK
A69	AFTER ACTION REVIEW – 29/7/16	Chris IRVINE
A70	AFTER ACTION REVIEW – 1/8/16	Cheryl AMES
A71	POLICE FLOOD DEBRIEF – 6/7/16	Tasmania Police
A72	AFTER ACTION REVIEW	SES

A73	SES 2016 ONLINE DEBRIEF SURVEY	SES
A74	SES REVIEW OF THE 2016 FLOODS: SURVEY FINDINGS	SES
A75	SES INFORMATION REVIEW	SES
A76	REQUEST OF ASSISTANCE OF THE AFAC	SES
A77	STATEWIDE FLOODING SITUATION UPDATE AND OUTLOOK	SES
A78	RAPID IMPACT ASESMENT	SES
A79	STATE WIDE FLOODING MEDIA TALKING POINTS	SES
A80	INCIDENT ACTION PLAN SUMMARY	SES
A81	SES SITUATION REPORT	SES
A82	MEDIA RELEASES	SES
A83	STATE PREPAREDNESS STRATEGY	SES
A84	TFS STAND DOWN NOTIFCATION & DAILY PLANNING SCHEDULE	TFS
A85	PROJECT INFORMATION SHEET FOR TAS SES SURVEY	UTAS
A86	CORRESPONDENCE	SES
A87	AFFIDAVIT – 16/6/16	Cst Hayden WILLIAMS
A88	RESPONSE SUPPORT ARRANGEMENTS FLOOD/SWIFT WATER	DPFEM & Surf Life Saving Tasmania Inc
A89	TASMANIAN SEARCH AND RESCUE PLAN ISSUE 3, 2015	DPEM
A90	TASMANIAN SEARCH AND RESCUE PLAN ISSUE 5, 2020	DPFEM
A91	REPORT OF THE INDEPENDENT REVIEW INTO THE TASMANIAN FLOODS OF JUNE & JULY 2016 (F35 in Trevor Foster Exhibits)	Mike BLAKE
A92	AFFIDAVIT – 23/8/22	Mhairi REVIE
A93	MEDIA RELEASE and DISC x1	ABC News and WinNews
A94	AFFIDAVIT – 6/9/22	Asst Comr Adrian BODNAR
A95A	TAS SEVERE WEATHER LOGBOOK	Bureau of Meteorology
A95B	CALL LOG ANALYSIS	Bureau of Meteorology
A95C	HO FLOOD DESK LOGBOOK	Bureau of Meteorology
A95D	TAS FLOOD DESK LOGBOOK	Bureau of Meteorology
A96	FLOOD WARNING SERVICES POLICY 1999	Bureau of Meteorology
A97	MEDIA RELEASES	Bureau of Meteorology
A98	SERVICE LEVEL SPECIFICATION FOR FLOOD FORECASTING AND WARNING SERVICES FOR TASMANIA	Bureau of Meteorology
A99	TAS WINTER 2016 WARNING AND WATCHES	Bureau of Meteorology
A100	AFFIDAVIT – 27/9/22	Anthony VAN DEN ENDEN, SLST
A100A	ATTACHMENT – REVIEW OF RESPONSE SUPPORT ARRANGEMENTS FLOOD/SWIFT WATER BETWEEN DPFEM AND SLST – Dec 012	Anthony VAN DEN ENDEN, SLST
A100B	ATTACHMENT – AFAC FIRST RESPONDERS ATTENDING A SWIFT WATER RESCUE PROCEDURAL GUIDELINES	Anthony VAN DEN ENDEN, SLST

A100C	ATTACHMENT – TASMANIAN SEARCH AND RESCUE PLAN ISSUE 5, 2020 PAGE 29	Anthony VAN DEN ENDEN, SLST
A100D	ATTACHMENT – NSW STATE RESCUE POLICY V4.1 5.07.2021 PAGE 83	Anthony VAN DEN ENDEN, SLST
A100E	ATTACHMENT – ARTICLE FROM THE INTERNATIONAL JOURNAL OF DISASTER RISK REDUCTION 76(2022)103013	Anthony VAN DEN ENDEN, SLST
A101	AFFIDAVIT – 27/9/22 AND PHOTOS	I/C CST Dean WOTHERSPOON
A102	PERSONNEL FLOOD RELATED DUTIES SUMMARY	
A103	NW REGION FLOOD EVENT DEBRIEF 14/6/16	Ulverstone Fire Station
A104A	NEWS ARTICLE – LIVE BLOG – 5/6/2016	The Advocate