
TRANSCRIPT OF PROCEEDINGS

THE MEDICO-LEGAL SOCIETY OF VICTORIA

THE MELBOURNE CLUB

MELBOURNE

FRIDAY 4 MARCH 2011

"ASBESTOS AND FIRE"

PRESENTED BY: MR JOHN T. (Jack) RUSH RFD QC

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1 "Asbestos and Fire"

2 DR FRENCH: I would just like on behalf of the committee to
3 welcome everyone here tonight and, in particular, to
4 welcome Mr Jack Rush RFD QC and his wife Mrs Sandi Rush.
5 We are very honoured and thrilled to have Mr Rush talking
6 here tonight.

7 Mr Rush has been in practice at the Victorian Bar
8 for a long time and during that period was at one point
9 chairman of the Victorian Bar Council. He has a very
10 impressive list of things that he has done over his time
11 at the Bar. His practice is primarily in trial and
12 appellate advocacy, predominantly in common law cases,
13 product liability, insurance law, personal injury,
14 criminal law and trade practices and with many highlights
15 and I am just picking out a few, some of which are
16 relevant to what he is going to be talking about tonight.

17 Representing miners and residents who contracted
18 asbestos disease as a consequence of working and living at
19 the Wittenoom mine in Western Australia; counsel in a
20 number of significant class action cases including breast
21 implant litigation both in Australia and the US; also
22 relating to issues of persons acquiring HIV and hepatitis
23 C as a consequence of use of contaminated blood product.

24 He was counsel for Lorna Cubillo and Peter Gunner in
25 the stolen generation's case and also counsel for Rolah
26 McCabe in the case against British American Tobacco;
27 counsel for the unions and victims group in the Commission
28 of Inquiry of New South Wales into funding by James Hardie
29 of compensation for Australian victims of asbestos
30 exposure; counsel assisting the Coal Inquiry into the loss
31 of the HMAS Sydney 2 and most recently, as I'm sure people

1 have seen on television in Victoria, counsel assisting the
2 Royal Commission into the Victorian bushfires of 2009.
3 Has also done some interesting and different things like
4 being Chairman of the AFL Grievance Tribunal involved in
5 deciding disputes between players and umpires and clubs
6 and he's a captain in the Royal Australian Naval Reserves,
7 so a very interesting career and background.

8 It is with great pleasure that I would like to
9 introduce Mr Rush to talk on the topic tonight "Asbestos
10 and Fire".

11 MR RUSH: Ladies and gentlemen, I received some advice earlier
12 in the week from one of your legal members and he
13 indicated my debut speech at the Medico-Legal Society
14 should be amusing; people relaxed on a Friday night and
15 they would laugh at anything. I had to advise him that
16 that could be very difficult, I was talking about some
17 reasonably serious issues.

18 But the word "debut" did strike a chord and it
19 brought to mind the great football commentator Jack Dyer,
20 talking long ago about the Melbourne footballer Les
21 Bamblett. "Bamblett made a great debut last week and an
22 even better one today". This was said by Dyer in
23 describing a game of football, Fitzroy v. Melbourne, where
24 he summarised the game "Fitzroy has copulated to
25 Melbourne".

26 I was rummaging through some old papers over January
27 to tidy up my Chambers. There was a lot of rain in
28 January. It's extraordinary the artefacts and mementos
29 that are stored away. There was a lot of old transcript.
30 I can give you a couple of examples of why I kept it.
31 Daryl Wraith the barrister cross-examined a victim in

1 custody over his prior convictions. Wraith: "What was the
2 nature of the aggravated burglary and riotous behaviour,
3 that's all I'm asking". Accused: "I stole some purses".
4 Wraith: "Assaulted some nurses?" Accused: "What I said
5 was 'stole some purses', you idiot, get it right".
6 Wraith: "Already, all right, you stole some purses".
7 Magistrate: "If you're not careful you could well be
8 charged with contempt of court if you carry on". Accused:
9 "I'm already locked up, what else could go wrong?"

10 Old speeches - I'm at the Green Enviro in January -
11 I should tell you about two. Welcome speech for Justice
12 Stuart Morris when he was appointed to the Supreme Court,
13 a position that he has since retired from and come back to
14 the Bar, and it related to a period of time when Stuart
15 Morris was President of the Planning Appeals Board. He
16 was hearing an application by Bob Jane for a permit to
17 extend the Calder Park Speedway known as the Thunderdome.

18 The critical issue was the noise made by a
19 particularly fast and noisy type of dragster known as "the
20 top fueller". The discussion turned as to how this
21 vehicle might be described in a permit condition so as to
22 impose restrictions on its use. Morris asked Bob Jane how
23 top fuellers might be described. Bob Jane thought for a
24 while then replied "I'd call them nitro-fuelled jet cars.
25 I mean even if your wife would understand that". Stuart
26 Morris responded proudly, "My wife's got a PhD". Jane
27 again thought for a while and then offered the observation
28 "Well, tell her to go and put some nitro in it and then it
29 will really go".

30 There was of course little place for humour in the
31 bushfires Royal Commission. It's eight months since I

1 finished at the Royal Commission; it's eight months or 16
2 months after the most intense and difficult times,
3 distressing work encountered in my time as a barrister. I
4 think for many of us the way we operate is to shut out the
5 emotional and stressful part of our work but the shutting
6 out process is sometimes difficult, it is essential to
7 enable the meeting of timelines and proper procedure.
8 Nevertheless, it always comes at some cost.

9 It has been an unusual time in that it was not until
10 the conclusion of all the evidence that the real impact of
11 the fires on people began to sink in. It was a terrible
12 day and I cannot get out my head how much that devastation
13 could have and perhaps should have been avoided.

14 Before going on to consider some of the detail, it
15 is necessary to acknowledge some real positives because at
16 one level the Royal Commission spent through necessity a
17 considerable time in negative territory as we investigated
18 and then criticised key aspects of some sections of
19 emergency services on the day.

20 An overwhelming impression for me is the response of
21 the Victorian community: generous, caring for each other;
22 acts of extraordinary bravery and sacrifice; a great
23 generosity of spirit. People in those early days
24 exemplifying the enthusiasm and the initiative and the
25 commonsense that is such an important part of our national
26 character. The state asked much of its volunteers - time
27 and continuing commitment.

28 These bushfires surely tested that resolve and
29 loyalty. Some of the evidence was graphic. CFA personnel
30 having to identify bodies of people they went to school
31 with; volunteers having to check the charred remains of

1 people in cars - whole families, sometimes neighbours
2 discovered dead, often huddled together in a last
3 desperate attempt to find shelter.

4 Evidence at the Royal Commission convinced me that
5 the CFA as an organisation is of the utmost importance to
6 this state. To many local communities the CFA is a
7 unifying and powerful force of community cohesiveness and
8 cooperation. The idea of service exemplified by the CFA
9 is an attribute that should never be lost. I do not think
10 in 155 days of hearings one volunteer was the subject of
11 criticism for actions on 7 February. This was not an
12 oversight or some deliberate tactic.

13 The fact is that without exception across the state
14 the volunteer effort was quite remarkable. Despite the
15 lack of criticism one matter I think we underestimated was
16 the stress for those who fought the fires and held
17 positions of responsibility on 7 February in giving
18 evidence and being cross-examined at the Royal Commission.

19 I listened to an address given by the captain of the
20 Kilmore Volunteer Brigade just a couple of weeks ago. He
21 graphically described the preparation of his statement for
22 the Royal Commission over days; his preparation with
23 lawyers for giving evidence then facing the Royal
24 Commission at that time in the County Court sitting in the
25 witness box of a criminal court: cameras, the media, the
26 intense scrutiny. He was an excellent witness and a true
27 leader yet he confided at this event just weeks ago that
28 this was the first time he had been able to speak of all
29 of the events without breaking down.

30 The experience of examining 173 deaths had a great
31 and continuing impact on the lawyers and counsel assisting

1 at the Royal Commission. Let me give you one example.
2 Rob and Natasha Davey with two daughters, Georgia aged
3 three and Alexis eight months lived at Bald Spur Road,
4 Kinglake. I read from the final report of the Royal
5 Commission: "At about 6.15 p.m. Ralph Cosh, Sandra's
6 husband, called the Daveys. Natasha answered and yelled
7 'Going fire' before hanging up. At 6.20 p.m. Natasha used
8 Rob's mobile to call 112, the Emergency Services number.
9 She spoke to the operator, describing fire in the roof and
10 computer room of the house and could be heard moving
11 children into the bathroom. The operator lost voice
12 contact with Natasha but the line remained open for about
13 six or seven minutes. On 9 February Rob, Natasha, Georgia
14 and Alexis were found lying close together in what had
15 probably been the bathroom, their house completely
16 destroyed".

17 A phone call to Emergency Services is as distressing
18 a recording that you could imagine. Here was a family
19 that had done everything to comply with the stay or defend
20 policy, overwhelmed by fire, their remains found huddled
21 together. The contents of the call were not played
22 publicly but of course we heard the recording and it is
23 very hard sometimes to put that in context let alone put
24 it out of your mind. The Royal Commission had a big
25 impact on many.

26 I am often asked where I was on 7 February. My
27 answer is explained by this photograph. My then work, I
28 was involved in another inquiry, an inquiry that had been
29 established through the Department of Defence into the
30 loss of HMAS Sydney 2 with counsel assisting Terrence
31 Cole. This photograph depicts the ship's company in a

1 triumphal march on 11 February 1941 through the streets of
2 Sydney. The ship had returned after an outstanding
3 campaign in the Mediterranean where it sank the Italian
4 battlecruiser Bartolomeo Colleoni. Just nine months later
5 nearly every person dressed in white in that photograph
6 would be dead.

7 To give some context to that, on 19 November 1941
8 Sydney was lost in an engagement with a German raider off
9 the Western Australian coast. When I say "lost", the ship
10 and her entire crew of 645 in effect disappeared. Over
11 200 of the German crew of the raider Kormoran survived.
12 Australia was then a country of just over seven million
13 people. It was Australia's largest wartime loss in the
14 sense of its greatest loss in a single war engagement.
15 The impact on the nation in 1941, as would understand, was
16 profound. Thus, from Australian's greatest wartime
17 tragedy to Australia's greatest peacetime tragedy.

18 Many Victorians, those not directly impacted, the
19 scale and ferocity of the fires on 7 February was not
20 appreciated. I listened to Jon Faine on 774 at around
21 6.00 p.m. on the day. Really, it has to be said there was
22 no hint of the magnitude of what was happening at that
23 very time in Kinglake, Marysville, Beechworth, Calignee.

24 Bernie Teague was determined to make the Royal
25 Commission as open and as accessible as possible.
26 Internet streaming of proceedings was an innovative but
27 highly effective way of ensuring that anyone could observe
28 the proceedings without the necessity of being in
29 Melbourne and the openness of the Royal Commission was
30 unparalleled and I think an unparalleled success.

31 Counsel assisting's point of view, our first work,

1 was to read and familiarise ourselves with the reports
2 that had been written into previous bushfires in Victoria.
3 If I read to you a description of the drought and heat of
4 the fire of 1851 you would say that could be 2009. If I
5 read from the Stretton report of the fires of 1939 you
6 would say that could be 2009. If I read from the report
7 of the Ash Wednesday fires of 1983 that could be 2009.

8 We quote "The year had been one of exceptional heat
9 and drought. Pastures had withered, creeks had become
10 fissured clay pans, waterholes had disappeared, the very
11 leaves upon the trees crackled and appeared to be as
12 inflammable as tinder. The air which blew from the north
13 resembled the breath of a furnace, a fierce wind arose,
14 gathered strength and velocity from hour to hour until
15 about noon it blew with the violence of a tornado. For
16 some explicable means you wrap the whole country in a
17 sheet of flame. Men, women and children, sheep, cattle
18 birds and snakes fled before the fire in common panic.
19 The air was darkened by volumes of smoke, relieved by
20 showers of sparks, forests were ablaze and on the ranges
21 the conflagration transformed their wooden slopes into
22 appalling masses of incandescent columns and arches".

23 This was a description of the fire in Victoria in
24 1851. It most certainly could have been 2009. That a
25 major bushfire is inevitable in this state is a lesson of
26 history. The other constant theme through report after
27 report is the emphasis upon timely and useful information
28 regarding prediction of the spread of fire. This will
29 enable potentially affected persons to make informed
30 decisions. Was it too much on 7 February 2009 that our
31 citizens would be provided with a predicted course of

1 fires that spread into predicted locations so that
2 informed decisions could be made.

3 Warnings were of particular significance on 7
4 February. It was appreciated that if fire broke out on 7
5 February in the absence of successful, initial attack such
6 a fire would quickly burn out of control and in the
7 anticipated conditions would be incapable of being
8 contained, incapable of being fought.

9 This graph gives some idea of what we are talking
10 about. At the bottom of the graph 1,000 kilowatts of
11 intensity per metre and so we go up to 10, which is the
12 current limit to suppression for direct attack, that is
13 aircraft machines and personnel. I'm sorry, that's at 4.
14 At 10 you get an act of ground fire which is fire in the
15 tops of the trees.

16 As you see, on Black Saturday right at the top of
17 the page, "Black Saturday 7 February 2009 burned at a
18 velocity of approximately 80,000 kilowatts per metre". It
19 was an incredible fire, much worse than Ash Wednesday 1983
20 and, as you would see, much worse than Black Friday of 13
21 January 1939. So direct attack by conventional means of
22 firefighting was out of the question and known to be out
23 of the question if fire was to break out.

24 Flame height on this day was observed to leap 100
25 metres or more into the air. Radiation from flame makes
26 survival within a distance of three to four times flame
27 height difficult. Flame temperatures were between 900 and
28 1200 degrees centigrade. To try and understand what went
29 on on the day we initially concentrated on the Kilmore
30 fire. This fire killed 121 people, destroyed 1244 homes.
31 It started at 11.50 a.m. as a consequence of the failure

1 of a single electricity conductor spanning a gully a
2 kilometre wide and the electrical arcing started the fire.

3 The north-easterly wind velocities across the fire-
4 affected regions were in excess of 100 kilometres per
5 hour. The FDI that you see there exceeded 100 and it is
6 said that once under way the fire could not be stopped.
7 An incident control centre was meant to be established at
8 Kilmore as established in other areas around the state.
9 It was meant to be ready for what was called "a hot
10 start", experienced people would be in place and ready.

11 The establishment of an incident management team is
12 seen as critical for proper management of fire. Despite
13 assertions of proper preparedness, the level 3 control
14 centre being in place ready for a fire, there was in fact
15 nothing in place at Kilmore. The captain of the Kilmore
16 brigade was on duty with his brigade members. He
17 despatched the Kilmore tankers to the fire. He was
18 telephoned at approximately twelve o'clock by the regional
19 officer for CFA who informed him that he was to be the
20 incident controller for the fire. As I said, nothing in
21 place.

22 The local captain thereupon set about pulling his
23 members off the trucks, quite literally undertrained
24 people and experienced people who had never worked
25 together to try and fulfil his incident management team.
26 Over the course of the afternoon, others came to Kilmore.
27 The incident controller captain was not level 3 qualified.
28 Those put into critical IMT positions were not level 3
29 qualified and these people were completely unaware of each
30 other's skills and qualifications. They had not been
31 properly trained individually or as a group to cope with

1 the stress or the pressure that was to come.

2 In short, that lack of preparation meant the
3 communications between the fire ground, aircraft and the
4 incident control centre were deficient to very little.
5 The incident control centre was not provided with proper
6 and important information in what is terms the IECC, the
7 state control centre in Melbourne. Warnings to the
8 communities in the path of the fire were deficient, late
9 and in some cases non-existent.

10 Just a couple of examples: We see here is a line
11 scan that was taken over the fire at 12.48 just close to
12 one hour after the fire started and this is taken from an
13 aircraft flying over the fire with infrared equipment and
14 the photographic image is sent straight back to the state
15 control centre based in Melbourne. The aircraft did a
16 return run over the fire at 12.55, 12.58.

17 What the experts were able to tell us just in that
18 time, looking at those line scans, was that it
19 demonstrated an increase in the size of the head of the
20 fire and the fire body itself in just ten minutes and it
21 was an incredibly intense fire and that the fire was
22 spotting, creating other fires, ahead of itself.

23 Between the two line scans the experts were able to
24 tell us that the plume of smoke had in fact drawn the fire
25 together. The effect of the smoke plume on fire to me was
26 a stunning piece of information. Heat and combustion
27 products rise in the smoke plume, as the hot air rises it
28 must be replaced. This can create great wind velocities
29 at the base of the fire. Indeed, in some areas the wind
30 was of such force that the trunks of trees snapped.

31 Rapidly rising air creates pyro cumulus cloud and on 7

1 February smoke, plume and cloud of the Kilmore fire
2 reached a height of 8,500 metres. The instability of the
3 smoke plume created what was a fire-induced understorm
4 with the lightening creating further fires in catchment
5 areas after six o'clock that night.

6 The upper winds were more westerly than the winds on
7 the ground but the upper winds drove the smoke plume such
8 that the fire was dragged in a more easterly direction by
9 the upper winds - an extraordinary effect. These line
10 scans, as I said, were sent direct to Melbourne. They
11 never arrived at the incident control centre at Kilmore
12 nor was the incident controller ever informed of the
13 nature of the information that they contained. They
14 provided important information in relation to fire
15 prediction.

16 Behaviour experts were working in the state control
17 centre in Melbourne. They produced a prediction map of
18 the fire at 3.15. The prediction map shows that towns
19 such as Strathewen, Kinglake West, Kinglake, Steels Creek,
20 Dixons Creek, as far out as Flowerdale could be
21 potentially impacted by this fire. The map was never
22 provided to the incident control centre at Kilmore.

23 Indeed, at the state control centre the three
24 leaders of the fire and emergency service organisations
25 had a good knowledge and understanding of where this fire
26 would potentially run. It is demonstrated by the
27 following evidence: "As soon as we saw the Kilmore East
28 fire, in a very short time we knew we had a real problem.
29 It was turning towards populated areas. You could run a
30 ruler towards where it would run; you knew straight away,
31 as the evidence revealed, the ruler headed to Kinglake".

1 Warnings are loaded to CFA websites and broadcast on
2 774 emergency radio. The issuing of warnings is the
3 responsibility of the information officer working at the
4 incident control centre. At the outbreak of the Kilmore
5 fire there was no information officer. An information
6 officer did not arrive until late afternoon. Warnings
7 were issued through the Seymour office of CFA. The person
8 responsible for the warnings had no contact with those on
9 the fire ground, little contact with those at the Kilmore
10 incident control centre and he was distracted performing
11 the duties that had previously been allotted to him. The
12 warnings concerning the Kilmore fire reflected what was in
13 place.

14 Between 12.40 and 2.25 there were no warnings
15 provided concerning the Kilmore fire. At 2.25 a warning
16 was provided indicating that the fire was not currently
17 posing a threat to communities: this, despite what was
18 reported by ground crew who gave evidence at the Royal
19 Commission of this being the most intense wild fire they
20 had ever encountered and at 2.25 the fire was in fact
21 tracking into the Kinglake mountain and the whole of that
22 area was at risk.

23 At 4.10 an urgent threat message was issued by the
24 Kilmore incident control centre to warn the communities of
25 Mt Disappointment, Kinglake, Strath Creek, Reedy Creek,
26 Humevale that they be directly impacted by the fire.
27 This, it stated, was an urgent threat message. Although
28 issued at 4.10 it did not reach state control centre until
29 4.35. The message was never loaded to the CFA website.
30 At 5.41 an urgent threat message was issued by Kilmore ICC
31 to communities from Kinglake to Flowerdale and, as you

1 see, an enormous area, an appreciation of the enormity of
2 the event almost six hours after it started. The message
3 was posted to the CFA website at 5.55 p.m. and by then it
4 was all too late. Strathewen, Kinglake, West Dixons
5 Creek, Humevale, all those towns with the names of which
6 we are now so familiar had been struck by the fire.

7 Not one warning from Kilmore or from the state
8 control centre was given to Victoria concerning the
9 anticipated south-westerly wind change. Those who live in
10 the city the change is a relief, for firefighters it is a
11 totally different matter. Typically, in a bushfire, 80
12 per cent of the area burned occurs with the wind change.
13 Ash Wednesday 1983 and the 1977 fires in the Western
14 District, indeed the experience of the fires that burned
15 in the Western District on 7 February when the change came
16 early to the Western District demonstrated the impact of
17 this wind change.

18 Here we see a graph demonstrating the common fire
19 behaviour. In the black, a normal course of the fire then
20 with the south-westerly wind change fire spreading out
21 from the course with which it had run. That impact is
22 perhaps demonstrated here by what occurred in the Kilmore
23 East fire. This depiction with the red arrow shows a fire
24 burning under the effects of the north-easterly wind, so
25 there is a fairly narrow band. Ahead of the fire was
26 estimated - the part of the fire that leads was estimated
27 to be four kilometres wide. Here we see the effect of the
28 south-westerly wind change and the enormity of the damage
29 from a fire front of approximately four kilometres. This
30 fire turned into a fire on its western front of
31 approximately 35 kilometres. It was an enormous fire.

1 Not one warning in relation to the south-westerly wind
2 change.

3 From time to time, of course as counsel assisting,
4 we questioned our approach. 20/20 vision of hindsight is
5 of course all very easy but I think the evidence
6 demonstrated a complete breakdown, a failure at the
7 control centre in Melbourne and a failure to properly run
8 and properly manage warnings to the community not only of
9 the Kilmore fire.

10 Council assisting were accused of headhunting and
11 going after scalps. It was put that it was unnecessary to
12 focus on the tall poppies and it was said there was no
13 advantage in relation to the Commission and the inquiry or
14 the future by doing so. I can only say the command and
15 control that is exercised on 7 February was, in my view,
16 unacceptable.

17 The job of the Royal Commission under the terms of
18 reference would not have been complete if this had not
19 been properly investigated, exposed and hopefully remedied
20 by recommendations. I think there is much that has come
21 out of the Royal Commission that will be of great benefit
22 to the community, yet I detect two years after February
23 2009 that bushfires and the community, it is already
24 starting to be forgotten. The effluxion of time has eased
25 the pain, the loss and deadened the lessons learned. The
26 message of preparation for bushfire does not carry with
27 it, in my opinion, the practical lessons that were learned
28 as a consequence of the Royal Commission, which is
29 probably the title of another paper.

30 I was asked to speak on asbestos and, as you would
31 appreciate, the residue of asbestos as a consequence of

1 the damage to buildings in these fires was an issue in the
2 cleanup in 2009. It is now appreciated that just a slight
3 exposure to asbestos fibre can many years later cause
4 lethal disease. Asbestos litigation I think has always
5 had its controversies. Costs to insurers over the years
6 has been enormous.

7 In 2002 Equitas, the reinsurance vehicle, which
8 assumed Lloyds of London's enormous liabilities stated
9 "asbestos claims were the greatest single threat to Lloyds
10 of London's existence". Asbestos claims involve a
11 retrospective assessment of the standards of many years
12 ago. The process always involves controversy but it is a
13 common process in most litigation.

14 Dr Julian Lee, a respiratory physician addressed the
15 Medico-Legal Society of New South Wales in 1993, its title
16 "Yesterday makes today mean". The point that Dr Lee
17 sought to make was "We should not fall into the trap of
18 judging yesterday by today's standards". He went on, "Of
19 course we always do and we do it in areas of life,
20 particularly in litigation".

21 Dr Lee was speaking in the context of asbestos
22 litigation in particular and I have no doubt that Dr Lee
23 was particularly addressing what was then, after long
24 trials in both Victoria and Western Australian Supreme
25 Courts of then recent verdicts where the owners of the
26 Wittenoom Mine were found to have failed to meet standards
27 of a reasonable employer in the way they exposed their
28 workers to asbestos. Dr Lee had given evidence on behalf
29 of the mine in the Western Australian case.

30 One of those cases, the Victorian case of Rabenault,
31 the jury in fact awarded not only compensatory damages but

1 exemplary damages against Australian Blue Asbestos Pty Ltd
2 (a subsidiary of CSR that ran the mine) because that
3 company had demonstrated a contumelious disregard for the
4 health and welfare of the plaintiff.

5 Thus Rabenault, a German migrant, later a successful
6 businessman in Melbourne, who in 1960 was required to
7 stuff raw asbestos fibre into hessian bags by hand with no
8 mask or protective equipment. He wore a pair of football
9 shoes. The jury's finding was that this was unacceptable.

10 Let me provide a couple of examples of the evidence
11 that perhaps may have supported the jury's verdict. In
12 1898 the inspector of factories in the United Kingdom
13 reported as follows: "The evil effects of asbestos dust
14 have also attracted my attention. Microscopic examination
15 of this mineral dust which was made by Her Majesty's
16 medical inspector, clearly revealed the sharp, vastlike
17 jagged nature of the particles and where they are allowed
18 to rise and remain suspended in the air of a room in any
19 quantity the effects have been found to be injurious as
20 might have been expected".

21 In 1930 a significant report on the effects of
22 asbestos dust on the lungs was issued by the medical and
23 engineering inspectors of factories in Great Britain. A
24 description of asbestosis, a fibrotic condition of the
25 lung caused by inhalation of asbestos, provided a strong
26 message as to the dangers of the substance. Asbestosis
27 was described as "The slow growth of scar tissue between
28 the air cells of the lungs wherever the inhaled dust comes
29 to rest. While new fibrous tissue is being laid down like
30 a spider's web that deposited earlier gradually contracts.
31 This fibrous tissue is not only useless as a substitute

1 for the air cells but with continued inhalation of the
2 causative dust by its invasion of new territory and
3 consolidation of that already occupied it gradually and
4 literally strangles the essential tissues of the lungs".

5 By the 1930s and 1940s asbestos was associated with
6 the development of lung cancer. In 1942 medical text
7 "Occupational Tumours and Allied Diseases" by Hueper
8 elected the growing number of reports associating
9 carcinoma of the lung with asbestos exposure. Dr Douglas
10 Shiels in the late 1930s through to the 1950s was the
11 medical director of industrial hygiene with the Victorian
12 Department of Health. He was a pioneer in his field. He
13 said he was responsible for the harmful gases, vapours,
14 fumes, mist, smokes and dust regulations of 1945.
15 Regulations were applicable to Victorian factories and
16 workplaces.

17 As a consequence of the regulations, by law it was
18 an offence to expose workers to a concentration of dust
19 including asbestos dust that exceeded five million
20 particles per cubic foot. As was stated in 1942, that
21 concentration of five million particles per cubic foot of
22 air is a very small concentration, so small in fact that
23 the condition may look good even to a critical eye and
24 still present an exposure greater than this low limit.
25 The only safe procedure is to have recourse to actual dust
26 determinations. This is especially important when the
27 injurious condition is not immediately evident; it
28 requires years to develop.

29 Professor Eric Saint was the foundation professor of
30 medicine at the Royal Perth Hospital and later Vice-
31 Chancellor of the University of Queensland. He was a

1 compelling witness in the Wittenoom trials. He was able
2 to give an exact contemporary picture. After service in
3 the RAF he migrated to Australia and joined the Royal
4 Flying Doctor Service in Western Australia. He flew to
5 Wittenoom on a number of occasions in 1948. He wrote to
6 his superior in Perth in 1948 stating that the mine and
7 mill at Wittenoom - "It would produce the most lethal crop
8 of asbestosis in the world's literature".

9 He was literally shocked by the conditions of
10 exposure at Blue Asbestos that he saw. He personally
11 warned the mine manager of the dangers, indicated his
12 warning had little impact, describing the mine manager in
13 his correspondence to his superior as "the local El Duce".
14 Reports in Scientific America, Encyclopaedia Britannica
15 and the Medical Journal of Australia in the 1950s
16 discussed asbestos as a carcinogen.

17 Wagner, a pathologist of South Africa, co-authors -
18 highlighted the disease of mesothelioma in the British
19 Journal of Industrial Medicine in 1960. 33 cases of
20 mesothelioma were analysed. Histories of a number of
21 these people indicated a brief exposure to asbestos in the
22 North-West Cape Province that produced mesothelioma:
23 Storekeeper, an accountant, persons with just transient
24 exposure were diagnosed with mesothelioma. Not long after
25 Dr James McNulty, a medical inspector of mines in Western
26 Australia, another critic of the Wittenoom mine, reported
27 in the Australian Medical Journal of the first case of
28 mesothelioma in that mine.

29 In the British Medical Journal in 1965,
30 epidemiologist Neuhausen reported on a series of 83
31 patients from London hospitals who had been diagnosed with

1 mesothelioma. These cases included persons who lived in
2 the same house as an asbestos worker, others who lived
3 with in half a mile of an asbestos factory. The reports I
4 think highlighted minimal exposure was necessary for the
5 contraction of this fatal disease, yet it might be said
6 all this seemed to wash over James Hardie.

7 Internal document tendered in numerous cases dated
8 16 February 1966 and the personnel manager of James Hardie
9 commented on a newspaper article that had been referred to
10 him by the managing director of the company: "The article
11 is not new, it is merely one of many reports on world
12 studies which have been conducted since 1935 when the
13 association between exposure to dust, carcinoma of the
14 lung and, later, mesothelioma of the pleura and even
15 tumour of the bladder and uterus were first recognised.
16 The nucleus is dust particles. The only preventative
17 action is to eliminate the presence of dust. The best
18 advise you can give", he wrote "ignore the publicity, dust
19 is a fact, denials merely stir up more publicity".

20 A year later in 1967 a further internal document
21 commented "On the other hand, there appears to be
22 developing an increase in tendency to question the safety
23 of the finished product, asbestos cement. It is unlikely
24 the cutting of a few lengths of asbestos sheeting for
25 domestic purposes would be dangerous. Nevertheless, it is
26 inadvisable to saw asbestos sheeting in a confined space.
27 There is the case of a woman who for some six weeks
28 intermittently held asbestos sheets which her husband cut
29 to build a rabbit hutch and who 25 years later died of
30 mesothelioma".

31 At the time of that correspondence production of

1 asbestos cement materials by this company was at record
2 levels. So it continued almost to the 1980s. Throughout
3 the country people were sawing, cutting, scraping the many
4 asbestos products in many different types of industry and
5 in their homes without any form of warning. No warning
6 appeared on James Hardie product until at least October
7 1978. Australia now claims the highest rate of
8 mesothelioma in the world.

9 In 2001 James Hardie sought to disassociate itself
10 from what board papers described as "the legacy issues of
11 its asbestos manufacturing history". There was some
12 degree of urgency in the decision. A new accountancy
13 disclosure regulation were likely to be promulgated later
14 that year which would require disclosure of the provision
15 of future asbestos liability in the company accounts.
16 Investment and expansion of the company, particularly in
17 the USA, such disclosure was seen as anathema. The
18 company was desperate to cut itself loose of its asbestos
19 liabilities and it had tried to do this and failed prior
20 to 2001.

21 In preparation for the day that it could cut itself
22 loose, the assets of James Hardie & Coy, a subsidiary
23 company that manufactured and supplied asbestos in
24 Australia had been sold off. In 1998 this company which
25 had been the main operating arm of James Hardie in
26 Australia had been the main operating arm for most of the
27 20th Century. Thus, in 2001 the Medical Research and
28 Compensation Fund was established by James Hardie as a
29 trust to be responsible for claims for asbestos injury
30 that formally would have been made against the now non-
31 operating James Hardie & Coy.

1 The company incorporated in the Netherlands was to
2 become the principal company of the James Hardie Group.
3 Removal from Australia upon court sanction of the proposed
4 restructure is close to complete. What is noteworthy
5 about the material and the board papers, at a meeting in
6 February of 2001, was that the board assented to this
7 course of conduct when there was no real recognition of
8 what funding was needed to compensate in the years ahead.

9 What was appreciated was the principal challenge to
10 the implementation of the proposed scheme would come if
11 there was a public perception that the money being made
12 available to the foundation was insufficient to meet
13 future claims. Elaborate steps were proposed to avoid
14 such perceptions being adopted yet nothing in the board
15 papers - nothing - provided any satisfactory basis for
16 identifying what the liabilities might be.

17 James Hardie in 1996 and 1998, 2000 and February
18 2001 had commissioned actuarial assessments of its
19 asbestos liabilities. Extraordinarily, no member of the
20 board had seen or read prior to the separation a copy of
21 these reports which remained in draft. Any actuarial
22 report is as good as the information provided. Lack of
23 information provided by James Hardie and the performance
24 of the actuaries was the subject of considerable criticism
25 by the Commissioner after the inquiry established by the
26 New South Wales government in 2005 to examine the
27 establishment of the foundation.

28 In the 2000 Trowbridge report the asbestos liability
29 placed the actuarial assessment at between \$300 and \$350
30 million dollars. This compared with the 1998 estimate of
31 \$234 million. The legal officer for James Hardie was

1 appalled that the number was so high. He instructed the
2 claims officer for the company to stay close to Trowbridge
3 and the actuary responsible and test the figures of this
4 draft report.

5 The concern was to keep the numbers as low as
6 possible to advance the prospect of restructure.
7 Consistent with the pressure applied, the actuary
8 subsequently informed Hardies that the figure would be
9 reduced and liabilities were in the range of \$300 to \$310
10 million. Evidence at the inquiry revealed that the claims
11 manager for James Hardie knew that the information being
12 provided to the actuaries was inaccurate and understated
13 the continuing cost of compensation. In fact, the legal
14 officer for James Hardie asserted that he informed the
15 incoming directors of the foundation in 2001 that there
16 could be no guarantee in relation to funding and it may
17 not be enough to cover all liabilities over the long haul.

18 Despite this, on 16 February 2001, following the
19 board meeting authorising the separation, a press release
20 was issued by James Hardie quoting its CEO Mr Peter
21 McDonald as follows: "Establishment of the medical
22 research compensation foundation provides certainty for
23 people with legitimate claims against the former company.
24 It will fund all future claims for compensation and
25 support medical research. Effective today, the
26 consolidated profit and loss statement of the James Hardie
27 Group will not include costs associated with asbestos.
28 From today, those costs will be borne by the new
29 foundation".

30 The Court of Appeal in New South Wales confirmed the
31 decision of the trial judge in the recent ASIC prosecution

1 against James Hardie who found that these statements were
2 misleading and well they might have. The actual sum
3 necessary to fund liabilities was closer to \$1.5 billion,
4 a big difference to the \$293 million provided to the
5 foundation. Thus, without going any further, one of the
6 aspects I was going to speak to tonight was the manner in
7 which the application proceeded by Justice Santo in the
8 Supreme Court of New South Wales which regrettably I think
9 does not do a great deal to put the legal profession in a
10 good light.

11 That said, I have been extremely fortunate in my
12 career to have a part in such interesting and fascinating
13 cases and I must say it was a pleasure to be able to bring
14 some of that together tonight.

15 DR FRENCH: Mr Rush has indicated that he is happy to take some
16 questions, if anyone has a question Mike has got the
17 microphone.

18 MS JOCKEL: Nothing like sticking my neck out. Maria Jockel
19 from Russell Kennedy. Mr Rush, I was very challenged by
20 what you had to say because insofar as the asbestos
21 situation is concerned my take on that is basically
22 individual and corporate negligence and a failure to heed
23 the warnings of something that was clearly unsafe and
24 could have been managed better if there had been a mind to
25 do so.

26 That is a very different situation to the former
27 situation that you spoke about which was the fires where
28 yes, you've touched upon a whole range of factors which
29 came together to compound the tragedy but ultimately - and
30 there was a failure in terms of leadership but what came
31 through to me was the fact that nature can be so

1 unpredictable and so fierce that regardless of our
2 capacity to lead and communicate we can be caught unawares
3 and that has been so prevalent in terms of the natural
4 disasters that we have experienced more recently.

5 I am just wondering, given that you've had this
6 perspective from this very diverse range of experiences,
7 what are the lessons that you would think that we can best
8 learn from, moving forward, and I am in particular
9 interested in regard to the unpredictability of natural
10 disasters.

11 MR RUSH: I accept what you say but I would say that flood and
12 fire are different to earthquake and here on the Wednesday
13 before 7 February the preparations in place, what was
14 being distributed to firefighters in relation to the
15 nature of the fire that they could expect, clearly
16 indicated what was shown on this graph that this was a
17 fire that could not be fought. The only thing that could
18 be done was to ensure proper warning and we have - when we
19 put our mind to it - fantastic ability to warn.

20 I think another element of some importance was that
21 in the mid 1990s there was a change in the manner of
22 thinking in relation to government that people should be
23 more responsible for their own welfare in relation to the
24 way they engaged with a day like 7 February and, thus,
25 people may remember that in most communities, after the
26 Ash Wednesday fire, what was established were refuges and
27 there used to be signs on country roads where refuges were
28 pointed to people who could at least go to a place of
29 comparative safety and we know that at Gallipoli Park in
30 Marysville many many people went to this place as a former
31 refuge and survived the fire.

1 So, I think by that example what I am saying is that
2 we need to be much better prepared and what I indirectly
3 referred to was I think the warnings that we get and the
4 warnings over the summer period are fairly ineffectual.
5 If you go to the back of Rosebud and Rye and Sorrento or
6 to Lorne where people live surrounded by trees there is no
7 escape from fire.

8 Yet if we lived in California, people who lived in
9 those areas or holidayed in those areas would once a year,
10 they would practise a response to fire so they would know
11 where to go; they would know the roads to take so that the
12 roads aren't clogged up. Each individual community is
13 given a lesson in geography: if they don't leave - which
14 is of course the best way to go - but we know from
15 research that over 70 per cent of people will not leave
16 their homes on a Code Red day.

17 So, I think the response to fire has to be what do
18 we do in answer to that? We tell people that we can't
19 protect them but your best method of approach in the face
20 of a fire like that is here - a refuge, a safer place, a
21 Lorne main street, that's what we should be doing and
22 until we get into a pattern of recognising natural
23 disaster like this - and if you believe in climate change,
24 those people tell us that it is going to be more frequent
25 - then we need to understand that this is the approach
26 that has to be taken.

27 It is against human nature just to leave for no
28 reason. People will not leave until they know there is a
29 potential threat and then if we practise and we're aware
30 we can do so in a fashion that will minimise the sort of
31 loss that we suffered on 7 February.

1 DR FRENCH: I might just ask you about the stay or go policy
2 and what you think about it.

3 MR RUSH: I think, as the Commission report indicates, that the
4 stay option and the impact of trying to fight a fire for
5 individuals is enormous, not only the people that
6 successfully defended their homes and they have a perfect
7 right to, and some of those people who survived showed
8 scars of their attempt the defence of their homes. Some
9 people left after their homes had been burned down but as
10 an option I think the stay option, as the promotions
11 indicate, the stay option should be the last option on a
12 day like 7 February.

13 But, as I said, the research since 7 February 2009
14 clearly indicates that over 70 per cent of people in high
15 risk bushfire areas will not leave their home unless they
16 get information of direct risk and I think that is human
17 nature. So we have to understand that people will not
18 leave until they are given notice.

19 We called an expert in disaster management from
20 Harvard University who described the stay or go policy as
21 not a policy. It is, in effect, someone's belief as to
22 what would happen, it was not a policy and I think that's
23 exactly what it is: we have to adopt policies that are
24 practical and fit in with the way in which the community
25 react. It was a sustained education campaign for ten
26 years to try and get people to leave before fire broke out
27 - the night before 7 February or the morning of 7 February
28 before fire, it doesn't work, and I think we understand
29 why.

30 DR FRENCH: I just wanted to invite Andrew Clements, legal
31 member of our community to give the vote of thanks.

1 MR CLEMENTS: On behalf of the Committee of the Society, I
2 would like to thank Mr Rush for a most informative and
3 engaging presentation on fire and asbestos and as a token
4 of the Committee's appreciation I would like to present Mr
5 Rush with some wine.

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