IN THE MATTER OF
The Hazelwood Coal Mine Fire Inquiry

STATEMENT OF PROFESSOR CHRIS BROOK PSM

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I, Chris Brook, of 50 Lonsdale Street, Victoria, Chief Advisor on Innovation, Safety and Quality in the Department of Health, can say as follows:

A. Introduction

1. My full name is Dr Christopher William Brook.

2. I am the Chief Advisor on Innovation, Safety and Quality at the Department of Health (**DH**).

3. Prior to taking up my current position, I was the Deputy Secretary of the Wellbeing, Integrated Care and Ageing Division in DH. That Division was responsible for planning, policy development, funding, performance monitoring and regulation in relation to: health protection, health prevention, integrated care, aged care, aboriginal health and workforce policy and planning in the health and aged care sector. I held that position from August 2009 until April 2014. Prior to that, between 1988 and August 2009, I held positions at the Deputy Secretary level in DH, in the Department of Human Services (**DHS**) and in predecessor departments, at all times working in the health portfolio. My roles have included both operational and policy responsibilities at this level.

4. I have postgraduate qualifications as a specialist physician as well as qualifications in public health medicine and emergency management, including Certificate 4 in Major Incident Management Incident Control. A copy of my Curriculum Vitae is attached (Attachment 1) **[DOH .0006.004.0001]** .

5. In addition to my role within the organisational structure of DH, I am the State Health and Medical Commander, a position established under the State Health

Emergency Response Plan (**SHERP**). I held that position during the Hazelwood Mine Fire.

6. This Statement has been prepared pursuant to the request made by the Hazelwood Coal Mine Fire Board of Inquiry at a meeting on 6 May 2014 and by letter of 7 May 2014 (the **Letter**).

7. I note that the Letter requests that this witness statement cover the following topics:

(a) The relationship between my role and that of the Chief Health Officer (**CHO**);

(b) Any understanding or arrangement between DH and the Environment Protection Authority (**EPA**) in relation to responding to and informing the community about environmental health issues;

(c) The role of the State Health and Medical Commander within SHERP and in relation to the Hazelwood Mine Fire specifically;

(d) Sources of information used by DH to monitor the health impacts of the Mine Fire, including all data gathered by DH from 9 February 2014 onwards concerning the numbers of people presenting at health services with complaints possibly related to smoke and ash from the Hazelwood Mine Fire and equivalent figures from the same period in 2012 and 2013;

(e) The establishment and operation of the Community Health Assessment Centre, including the considerations that lead to its being opened, details of the checks and advice made available and data collected in relation to the number and nature of presentations to the Assessment Centre;

(f) DH's strategy in relation to the physical and mental health impact of the Hazelwood Mine Fire and how that strategy was implemented (including community advice, programs and activities undertaken by the CHO);

(g) How DH assessed the effectiveness of the strategy, and any changes made in light of the assessment; and

(h) My views on what worked well, what did not work well, and what could have been done better by DH in responding to the physical and mental health impact of the Hazelwood Mine Fire.

8. This Statement seeks to address each of those matters.

9. This Statement comprises information from my personal experience and knowledge, or contained in records of DH.

B. The role of the Department of Health generally

10. DH is the government department responsible for funding and oversight of health services, mental health services, ageing and aged care services, health protection programs and preventative health programs in Victoria.

11. DH is responsible for planning, policy development, funding, performance monitoring and regulation of health service providers and activities that promote and protect Victorians' health, including:

(a) health care services provided through the public hospital system, community health services, ambulance services, dental services, public mental health, and drug and alcohol services;

(b) residential and community care for older people, support and assistance to enable people to function independently in their own homes, positive ageing programs, healthy and active living and seniors card;

(c) health promotion and protection through protection against health risk (in food, water, radiation, communicable diseases or environmental contamination), preventative services, education and regulation; and

(d) emergency preparedness and coordination, including incident control of major public health emergencies.

12. DH does not deliver clinical services directly to the public.

C. The role of the Department of Health in emergency management

13. The role of the DH in emergency management is set out in the Emergency Management Manual Victoria (EMMV). A copy of the relevant section of EMMV is set out in Att achment 2 **[DOH.0005.004.0004]** .

14. In the Victorian emergency management framework, in the response to an emergency incident, a single agency has control responsibility. Control is the overall direction of the response to an incident. Other agencies may provide essential resources or personnel, and are described as being support agencies.

15. Pursuant to the EMMV, the role of DH is:

(a) prevention, mitigation and risk reduction, through:

(i) developing prevention, preparedness, response and recovery capability across the hospital, primary health and aged care sectors for an emergency with major health consequences;

(ii) providing leadership and direction in planning and preparing for emergencies with major health consequences;

(iii) implementing regulatory measures to minimise public health risk from infectious diseases, contaminated food, contaminated water supplies, radiation and chemicals.

(b) responding to emergencies, by:

(i) acting as control agency for specified human disease/epidemics, food/drinking water contamination and incidents involving radiological substances and intentional biological releases;

(ii) coordinating the provision of onsite pre-hospital care by Ambulance Victoria and by other health professionals if and as required;

(iii) directing the strategic health response during an emergency with major health consequences;

(iv) coordinating and directing the deployment of additional resources across the health sector in response to the emergency as required;

(c) contributing to relief and recovery through:

(i) supporting DHS in coordination of relief and recovery planning and management at State and regional levels;

(ii) providing advice, information and assistance to affected individuals, communities, funded agencies and councils.

16. In response to emergencies such as fire and flood, DH acts as a support agency. DH only assumes incident control of emergencies involving human disease, epidemics, food and drinking water contamination and incidents involving radiological and biological materials.

17. DH's relief and recovery activities (outlined in paragraph 14(c) above) are performed by Health and Human Services Emergency Management (HHSEM). HHSEM is a shared service for DH and DHS. Activities undertaken by HHSEM are performed for and on behalf of DH.

D. The role of the State Health and Medical Commander and arrangements under the State Health Emergency Response Plan

18. SHERP is a sub-plan of the State Emergency Response Plan, which is set out in Part 3 of the EMMV issued under the *Emergency Management Act 1986*. SHERP outlines the arrangements for coordinating the health response to emergency incidents that go beyond day-to-day business arrangements. A copy of SHERP is provided in Attachment 3 **[DOH.0002.001.0130]**.

19. The aims of SHERP are to reduce preventable death and permanent disability and to improve patient outcomes (that is, ensure that patients achieve the maximum possible level of recovery, health and wellbeing following any illness or injury) by matching the needs of injured patients to an appropriate level of treatment in a safe and timely manner.

20. SHERP sets out the command and coordination arrangements, and roles and responsibilities for a health emergency response that involves pre-hospital and hospital care, patient transport, receiving hospitals and other healthcare facilities.

21. Under SHERP, DH is responsible for monitoring the demand on health resources that arise from an emergency incident, and coordinates and directs the deployment of health resources as required.

22. SHERP is designed to escalate when an incident occurs that is likely to impact the health system, or a particular agency. In the case of a health service, an escalation of

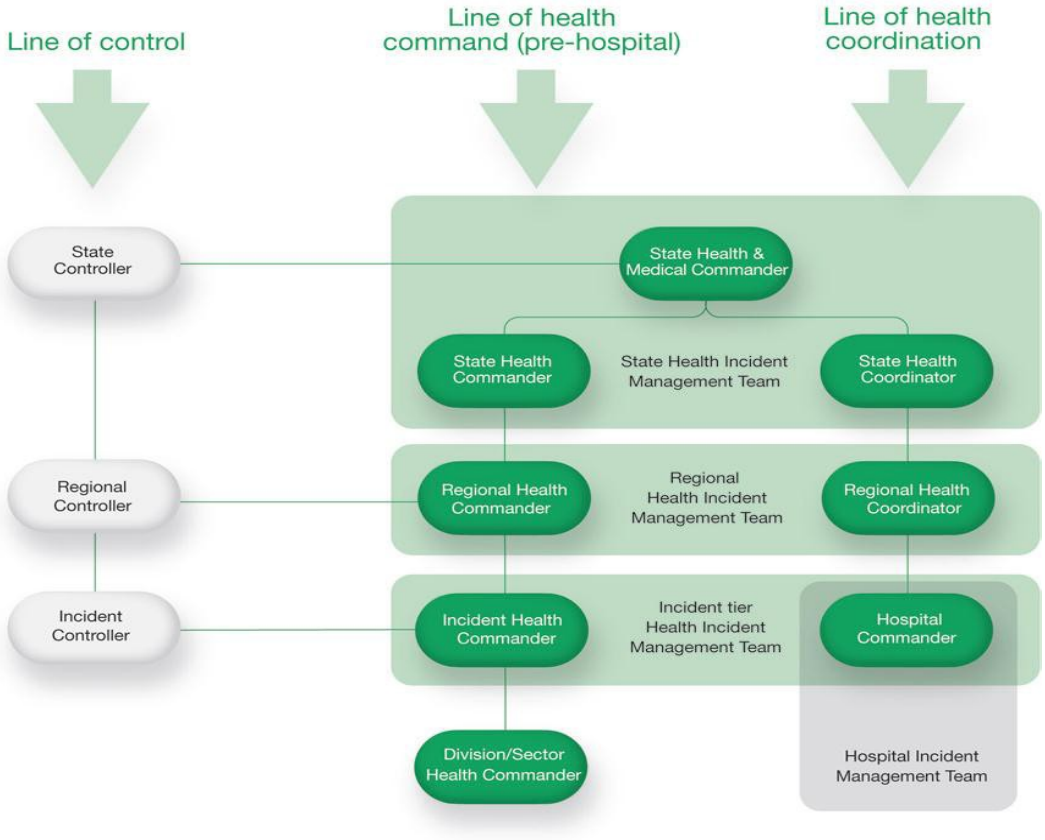
SHERP may activate a "Code Brown" Plan. A Code Brown Plan sets out the process for a health service to reduce non-critical services in order to manage an unexpected influx of patients.

23. DH monitors the impact of emergencies on health resources and directs or facilitates the deployment of additional health resources if required. This is undertaken through the State Health and Medical Commander, the State Health Commander and the State Health Coordinator.

24. DH's response to an emergency depends on the impact on the health system and whether control of the emergency is exercised at the incident, local or state level. The Health Commander (or Health Coordinator where necessary) will decide whether to escalate the incident based on its complexity, taking into account the size of the incident, resources required to respond to the incident and any other risks.

25. At each level of response, an Emergency Management Team is responsible for developing an incident strategy which addresses the risks and consequences of the incident. The Health Commander and Health Coordinator work with the Emergency Management Team to ensure that the incident is managed in a way that minimises the impact on health resources.

26. The reporting lines within health command and health coordination are set out in the following diagram.



27. The State Health and Medical Commander is responsible for strategic oversight of health coordination. The role of the State Health and Medical Commander is to direct health and medical resources. This includes the authority and responsibility to use departmental and other resources to prepare for and respond to the health impacts of emergencies.

28. The State Health Coordinator is appointed by the State Health and Medical Commander and is responsible for coordinating DH emergency activities at the state tier.

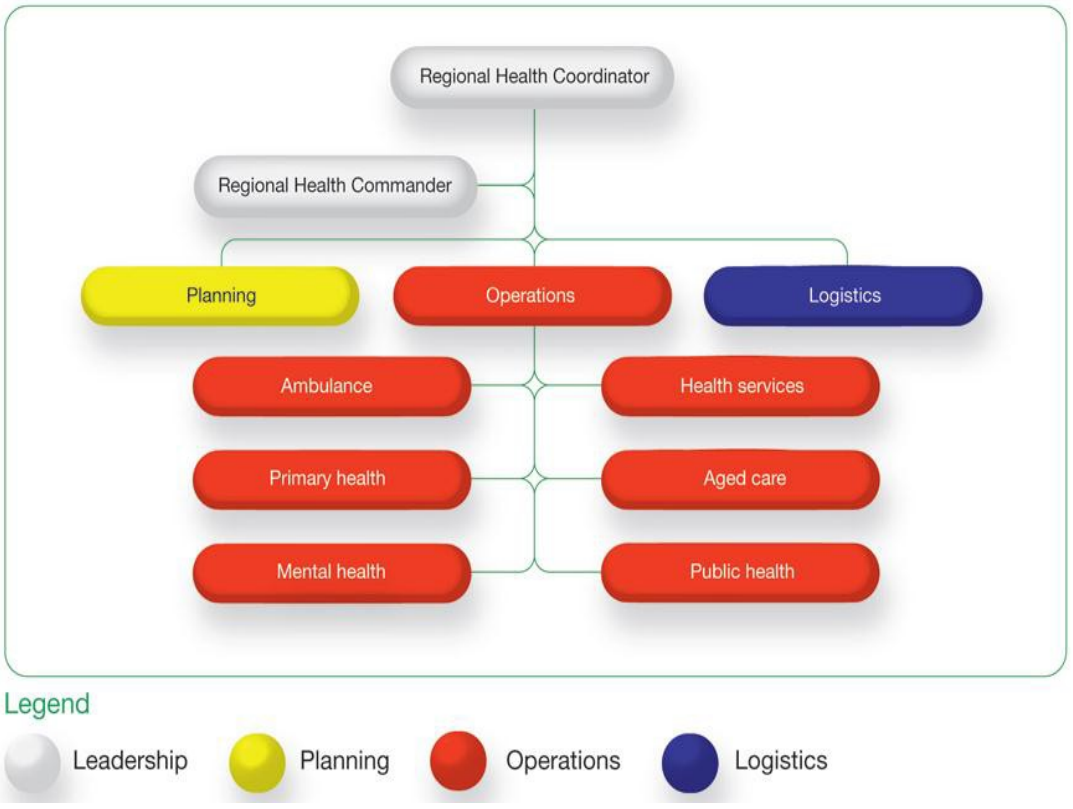
29. The State Health Commander is the appointed ambulance emergency manager and is responsible for directing the pre-hospital response to an emergency at the state tier. The State Health Commander reports to the State Health and Medical Commander.

30. The State Health and Medical Commander may form a State Health Incident Management Team (S-HIMT) to coordinate a whole-of-health response to an emergency at a strategic level. The S-HIMT is comprised of the State Health and Medical Commander, the State Health Coordinator and the State Health Commander. It may include others, such as the CHO, as required in this instance. The State Health and Medical Commander or delegate represents the S-HIMT on the State Emergency Management Team. The CHO is also a member of the State Emergency Management Team.

31. SHERP also provides for a Regional Health Coordinator who is responsible for coordinating the activities of DH in response to an emergency at a regional level. The Regional Health Coordinator reports to the State Health Coordinator.

32. The Regional Health Commander is a rostered ambulance manager and is responsible for directing the pre-hospital response to an emergency at the regional tier. The Regional Health Commander reports to the State Health Commander.

33. The Regional Health Coordinator may form a Regional Health Incident Management Team (R-HIMT). The R-HIMT is comprised of the Regional Health Commander (Ambulance Victoria) and the Regional Health Coordinator (DH). The R-HIMT includes an operations function. This function coordinates regional health services as required. The structure of R-HIMT is set out in the following diagram.



34. The R-HIMT engages directly with local health services and other agencies to obtain information about demand for health or related services, and requirements for community engagement on health issues. For this incident, the R-HIMT included representatives from the Latrobe Regional Hospital, the Gippsland Medicare Local (the peak body for General Practitioners), Latrobe Community Health Service and the Latrobe City Council.

E. The relationship between the roles of State Health and Medical Commander and Chief Health Officer

35. The State Health and Medical Commander does not direct the CHO in relation to the exercise of any of her statutory functions, nor any assessment of risk to public health or decision about protective measures or warnings the CHO may recommend.

36. Where DH acts as control agency (for an emergency involving human disease, epidemics, food and drinking water contamination and incidents involving radiological and biological materials) the CHO (or CHO's delegate) will act as Incident Controller. The CHO in that capacity liaises with the State Health and Medical Commander in accordance with the SHERP arrangements described above (see in particular the diagram at paragraph 26).

37. The CHO is a statutory position established under section 20 of the *Public Health and Wellbeing Act 2009*. That legislation sets out powers and functions for the CHO, which include developing and implementing strategies to promote and protect public health and wellbeing, and providing advice to the Minister or the Secretary on matters relating to public health and wellbeing. The CHO also has other specific

powers set out in the Act. The CHO acts as the Government's media spokesperson on matters relating to public health.

38. Where DH acts as a support agency in responding to an emergency, the CHO provides advice and support to the responsible control agencies in relation to public health consequences arising from the incident. The CHO also continues to act as the Government's media spokesperson on matters relating to public health.

39. During the Hazelwood Mine Fire, the CHO also liaised closely with me in my capacity as State Health and Medical Commander. This ensured coordination of information, resourcing and activity that impacted on the health sector or on public health. In particular, it ensured that the CHO was provided with information relating to health sector demand, which could be indicative of health impacts arising from the incident and thereby assist her in the assessments she was required to make regarding risk to public health arising from the incident. Both the State Health and Medical Commander (or delegate) and the CHO were part of the State Emergency Control Team, which ensured liaison with the State Controller.

F. The role of DH and State Health and Medical Commander in relation to the Hazelwood Mine Fire

40. The role of DH in relation to the Hazelwood Mine Fire was:

(a) prior to the incident, developing emergency preparedness and coordination across the health sector;

(b) prior to the incident, planning, policy development and funding of health services;

(c) during the incident, monitoring of demand for health services and coordinating and directing the deployment of health system resources, as required for the response to the incident and as necessary for community engagement and recovery activities; and

(d) during the incident, providing support to responding agencies, and providing information to the public about health issues arising from the fire – principally, information authorised or issued by the CHO regarding the potential health risks arising from smoke and air quality.

41. Consistent with SHERP, the State Health and Medical Commander, or delegate, was responsible for overseeing the performance of DH's monitoring, coordination and support roles (described at subparagraphs (c) and (d) above). The CHO was responsible for developing and issuing any advice to the public about potential risk to public health.

G. Health coordination arrangements for the Hazelwood Mine Fire

42. On Saturday 8 February 2014 the State Emergency Management Centre (SEMC) was staffed by departmental staff in preparation for anticipated heatwave conditions and a severe fire danger rating forecast to impact the entire State.

43. On Sunday 9 February the State Health Commander and State Health Coordinator attended the SEMC to monitor the impact of the heatwave conditions and bushfires on the health sector. The State Health Coordinator on that day was the Deputy State Health and Medical Commander.

44. There was significant bushfire activity across the State, including the Mickleham-Kilmore fire. In order to coordinate the health response to this bushfire activity, I established a S-HIMT, according to SHERP. On that same day, I was advised that fire was burning in the Hazelwood Open Cut Mine.

45. From Thursday 13 February 2014 a Health and Human Services Emergency Management Liaison Officer (EMLO) attended the Hazelwood Incident Control Centre (ICC). The role of the EMLO is to represent DH and DHS at the ICC and provide advice in relation to impacts and consequence management.

46. Between 9 February 2014 and 14 February 2014 there was significant focus on two fires designated by fire services as the 'Mickleham/Kilmore' and 'Hernes Oak' fires. On Saturday 15 February 2014 I was informed that weather conditions had increased fire activity in the Hazelwood Open Cut Mine. On Sunday 16 February 2014 I received further information about further escalation of the fire in the mine, and it became clear that the scale and complexity of the event were increasing.

47. A S-HIMT was in operation for the duration of the Hazelwood Mine Fire incident and a R-HIMT was in operation from 17 February 2014.

H. Strategies for monitoring and satisfying health system demand that arose from the Hazelwood Mine Fire

48. The SHERP arrangements outlined above provide the framework within which DH monitors health system demand and coordinates and deploys necessary resources in an emergency. In addition, to obtain necessary information about demand arising from an emergency, DH utilises the relationships it has with health services at a state, regional and local level as a result of its general roles and functions. Those relationships also provide the networks and mechanisms by which DH is able to effectively deploy resources as required.

49. In particular, during the Hazelwood Mine Fire, I received regular updates about the impact of the Hazelwood Mine Fire on health services as follows.

50. From 15 February 2014, the R-HIMT requested information and updates from the Latrobe Regional Hospital about any increase in emergency department presentations related to the smoke and ash. This information was provided to me, through the R-HIMT, on a daily basis from 19 February 2014. The reports set out the total number of presentations to the emergency department, the number of respiratory cases, and the number of presentations from Morwell residents.

51. From 16 February 2014, I received daily activity reports from Ambulance Victoria. These reports set out the number of calls that Ambulance Victoria attended in the Gippsland region, and how many (if any) related to shortness of breath or chest pain.

52. From 17 February 2014, I received a daily report from Nurse-On-Call. Nurse-On-Call is a free, 24-hour telephone advice line, funded by DH and staffed by nurses. The reports set out the number of calls to Nurse-On-Call that originated from the Latrobe City Local Government Area and required triage guidelines for respiratory issues.

53. On 19 February 2014, Medical Officers from DH's Health Protection Branch contacted 18 General Practices in Morwell and surrounding towns. The Medical Officers sought information about the level of demand experienced by the General Practitioners, and the type of conditions being treated.

54. From 19 February 2014, I was provided with reports from Gippsland Medicare Local twice a week setting out the impact of the Hazelwood Mine Fire on General Practices in the Latrobe Valley. These reports were based on information received by the Gippsland Medicare Local from the General Practices.

55. From 21 February 2014 I was provided with twice daily reports by Ambulance Victoria (at 12pm and 8pm) about: the total number of clients who presented to the Community Health Assessment Centre in the relevant reporting period; the total number of those who were referred to either hospital or a general practitioner; and the total number of clients who were transported by Ambulance Victoria.

56. The information described in paragraphs 50-55 above, together with the fact that no health service considered it necessary to activate its Code Brown Plan, demonstrated that the demand for health services arising from the Hazelwood Mine Fire was able to be managed adequately without the need for additional resources.

57. Data collected during an emergency incident to monitor demand on health services, and to ascertain whether additional resources are required, is not directly comparable to the data that is routinely collected and held by DH for the purposes of health service planning, funding and performance monitoring. Data collected during an incident consists of the immediately available figures regarding numbers of people requesting services, and qualitative anecdotal advice from service providers as to whether they are able to meet the demand for services. In contrast, data collected and held for planning, funding and performance monitoring is submitted by service providers to DH retrospectively on a periodic basis. It is collated and aggregated to suit those purposes, rather than being intended to inform an immediate operational assessment of whether services are sufficient to meet demand in the short-term. Furthermore, in an emergency DH collects information from sources, such as Medicare Locals, from which DH does not routinely collect data.

58. DH has produced a report that analyses the data that was collected during the Hazelwood Mine Fire Incident, as described above, in the context of available figures for the operation of the relevant services during the same period in 2013. The report, entitled *Hazelwood Mine Fire February – March 2014: Assessment of Short Term Health Impacts in Morwell and the Latrobe Valley – Interim Report May 2014*, is at Attachment 4 **[DOH.0005.004.0005]**. If it would assist the Inquiry DH can produce further analysis that takes into account the data that is available in relation to the operation of the relevant services during the same period in 2012.

Residential aged care services and Home and Community Care services

59. From 20 February 2014, DH liaised with the Commonwealth Department of Social Services (**DSS** - responsible for the funding and regulation of residential aged care facilities). DH advised DSS of fact sheets produced by DH and the advice issued by the CHO. DH and DSS maintained contact throughout the incident to facilitate and monitor actions being taken locally to provide support to older people.

60. On 21 February 2014 DH communicated with all health services, residential aged care facilities and home and community care (HACC) service providers, the majority of which are provided by Latrobe City Council, about the risks arising from the fire and to discuss actions being taken to monitor clients.

61. HACC service providers and Community Care providers were asked to monitor their clients' wellbeing, provide information to clients and refer clients to DHS to seek advice and make arrangements for temporary relocation where this was required. DH remained informed about the actions taken by service providers in this regard, for example through meetings between regional DH staff and HACC service providers on several occasions throughout the incident. Following the advice from the CHO on 28 February 2014 that people aged over 65 should consider temporary relocation from the southern area of Morwell, the St Hilary's Community Aged Care Facility decided to relocate its residents. Prior to the advice from the CHO, DH and AV maintained regular contact with St Hilary's Community Aged Care Facility, given its proximity to the mine, to ensure adequate contingency planning was in place and to monitor any impacts from the Hazelwood Mine Fire on the operation of the facility. Following the CHO's recommendation, and the decision by St Hilary's Community Aged Care Facility to relocate its residents, AV provided on site logistics support and transport to assist with the relocation of residents.

62. As the State Health and Medical Commander, I was advised that the R-HIMT was regularly in contact with St Hilary's Community Aged Care Facility about the progress of the relocation.

Community Health Assessment Centre

63. Despite the information that I received about the health system being able to respond adequately to the impact of the Hazelwood Mine Fire, there was widespread community concern about the possible health risks from the ongoing exposure to the smoke.

64. In order to address this concern, on Wednesday 19 February 2014 I directed that a Community Health Assessment Centre (CHAC) should be established in Morwell.

65. The CHAC opened on Friday 21 February 2014, and operated seven days a week from 8am until 8pm. It was located in Morwell, close to public transport.

66. The CHAC was staffed by Ambulance Victoria paramedics and nursing staff from Latrobe Regional Hospital, Latrobe Community Health Service, West Gippsland Healthcare Group and Central Gippsland Health Services.

67. The purpose of the CHAC was to:

(a) provide information, assessment, reassurance and referral services to residents and visitors who had health-related concerns arising from smoke and ash from the Hazelwood Mine Fire;

(b) perform basic health checks;

(c) provide carbon monoxide monitoring; and

(d) deliver medical care as needed, and referral to a local General Practitioner or Emergency Department as required.

68. In total, 2072 people attended the CHAC before it closed on Sunday 30 March 2014.

Assessment of strategy

69. DH was able to assess on an ongoing basis whether there was a need to deploy additional health resources in response to the incident, through its systematic collection and analysis of information about demand for health services in the affected area (see paragraphs 50-55 above). Demand was met by existing services, so it was not necessary to deploy any additional resources.

J. Strategies for communications, community engagement and recovery in relation to the Hazelwood Mine Fire

70. DH's primary role in recovery from the Hazelwood Mine Fire was the provision of advice, information and assistance to the Morwell community from the outset of the incident.

71. The CHO, and other publications produced by DH, provided regular information to the Morwell community about avoiding the risk of smoke exposure and other self-protection advice.

72. DH also participated in extensive community engagement activities, including:

(a) provision of information and basic health checks at the CHAC;

(b) attendance by DH and Ambulance Victoria personnel at community meetings;

(c) participation by DH and Ambulance Victoria staff in the CFA Information Bus;

(d) participation by Ambulance Victoria staff in the CFA Communication Team;

(e) attendance of Ambulance Victoria staff at the Moe Respite Centre and the Community Information and Recovery Centre;

(f) attendance at public meetings convened by the Morwell Neighbourhood House;

(g) distribution of fact sheets by local health services;

(h) conduct of "welfare checks" of community members, through the Latrobe Community Health Centre and Latrobe City Council;

(i) involvement of the Acting Chief Executive of Latrobe Regional Hospital in press conferences and community meetings; and

(j) regular press conferences.

73. Further details of the community engagement activities are set out in Attachment 5 **[DOH .0006.005.0001]**

Assessment of strategy

74. Contemporaneous assessment of whether communication, community engagement and recovery activities are effective is often difficult. In the case of the Hazelwood Mine Fire the key question was whether the health information that was produced and distributed by DH was being received and understood by the community.

75. As a result of its community engagement activities (see paragraphs 70-72 above) DH received community feedback and information about ongoing community concerns regarding the potential health impacts of the smoke and ash from the fire.

76. My decision open the CHAC, to provide a further avenue for community members to obtain information and reassurance, was a response to these community concerns.

77. In addition, DH actively sought to disseminate health information broadly and present it in a manner that was accessible and comprehensible.

78. The communication of health information to the community always presents a challenge in any emergency situation. There is a need to convey complex medical and scientific information in an accurate, easily understandable format. Furthermore, in an emergency context community confusion and anxiety can arise, and a range of information is often circulating from disparate sources. These factors can make it even more difficult for health information to be clearly and authoritatively delivered and readily understood.

79. In relation to the Hazelwood Mine Fire, the initial focus for communicating public health messages was through mass media, in order to achieve the fastest and broadest reach for the messages. As the incident continued, and more was understood about the demographic profile of the Morwell community, a more targeted approach could be adopted. In particular, the following strategies were employed:

(a) information was made available at the Community Respite Centre in Moe (which opened on 19 February 2014) and at the Community Information and Recovery Centre (which opened on 28 February 2014) – at both facilities, printed materials prepared by DH were distributed and Ambulance Victoria personnel were present to respond to questions;

(b) DH worked with the Chair of the Community Advisory Committee at the Latrobe Regional Hospital to tailor the health messaging to the Morwell community. Updated fact sheets that reflected the feedback received from that Committee were in circulation by 25 February 2014;

(c) in keeping with its usual practices, DH worked closely with other government agencies to ensure that accurate and consistent health messages could be provided to the community in all government communications. Relevant agencies included those engaging directly with the community (such as the CFA and Ambulance Victoria) and those responsible for broader messaging (such as EPA, which issued media releases reporting on air quality, and the Department of Premier and Cabinet, which coordinated paid and unpaid media advertising across government);

(d) in keeping with its usual practice, DH provided information to health service providers to assist them to address issues or concerns patients may have. Since DH does not provide clinical services directly, nor does it provide advice on treatment, this approach facilitates the provision and explanation of appropriate and personalised advice at the patient level. In particular, the CHO released Health Alerts and Health Advisories.[1] These are published on the CHO page of the DH website, and are distributed through networks and peak bodies, such as: Networking Health Victoria (which distributes to Medicare Locals, peak bodies for General Practitioners); the Royal Australian College of General Practitioners; Directors of Emergency Departments and Intensive Care Units in hospitals; Municipal Association of Victoria (a peak body for local government); and Nurse-On-Call, as well as by email to health service providers. In relation to the Hazelwood Mine Fire:

(i) on 13 February 2014 the CHO issued a Health Alert, directed to local health service providers, which outlined the potential health issues arising from the Hazelwood Mine Fire and provided guidance on how they could be addressed with patients. That Alert was updated on 17 February 2014 and 21 February 2014; and

(ii) provision of information to local service providers continued on 4 March 2014, when the CHO issued a Health Advisory. That Advisory was updated on 17 March 2014 and 20 March 2014; and

(e) DH regarded all of its community engagement activities (discussed in paragraphs 71-73 above) as avenues by which health information could be provided in a direct and interactive manner, to ensure it was being received and understood.

80. I note that Dr Rosemary Lester, CHO, has been asked to provide a witness statement to the Inquiry and I understand that her statement will include detailed information about the Alerts, Advisories and other communications issued by the CHO throughout the incident.

L. Arrangements between DH and the EPA

81. DH interacts with the EPA principally in the course of performing its health protection role, referred to in paragraph 11(c) above. Where a public health risk may arise from environmental factors, DH may require information from the EPA about

[1] A Health Alert advises the Victorian community of an issue that is urgent, poses an immediate threat to public health and requires an immediate response. A Health Advisory is less urgent than an Alert and provides advice that is of importance to the Victorian public and may require action.

the relevant environmental conditions, in order to assess what public health risk may arise and address that risk. In relation to public health risk arising from air quality, DH relies on air quality assessments made by the EPA, which are based on the EPA's analysis of EPA monitoring data and on forecasts made by EPA (in turn based on weather information from the Bureau of Meteorology).

82. In particular, and relevant to this Inquiry, DH and EPA have developed a *Bushfire Smoke, Air Quality and Health Protocol* (**Protocol**). The Protocol was developed to ensure that when EPA issues a media release to inform the public about poor air quality, an appropriate message from the CHO is included in the media release about the potential risk to health that may arise from the poor air quality that is described. The Protocol establishes the circumstances when EPA will issue a 'low' or 'high' level smoke advisory (on the basis of the concentration of fine particles in the air and the level of visibility). The Protocol sets out quotes from the CHO for each level of advisory, for inclusion in those media releases. The quotes outline the potential health risk arising from the relevant level of air quality and recommend steps for mitigating or reducing risk to health. A copy of the Protocol is included as Attachment 6 to this statement **[DOH .0005.001.0115]**.

83. I note that Dr Rosemary Lester, CHO, has been asked to provide a witness statement to the Inquiry. I understand that her statement will include further detail about Protocol, about arrangements with the EPA generally, and about the respective roles and actions of DH and EPA during and in response to the Hazelwood Mine Fire.

M. What worked well, what did not work well and what could have been done better?

84. A key achievement for DH in response to the Hazelwood Mine Fire was the establishment of the CHAC at a time when the fire had clearly escalated. The CHAC allowed the community to easily access health assessments, providing additional reassurance about the health impacts of the smoke. The success of the CHAC has been recognised nationally, having received a Public Safety Award from the Association of Public-Safety Communications Officials Australia.

85. Consistent with every major emergency management incident with which I have been involved, over many years, there are always important learnings to be taken. DH is open to any improvements or changes which arise from the Inquiry.

86. As noted above in paragraph 78, effective communication of health information to a community in an emergency situation is challenging. I consider it would be useful to explore how a tailored approach to communication of health information to the community, such as I have described at paragraph 79(b) above, could have been adopted earlier in the incident, to ensure the public health messages were understood by the community and effectively addressed community concerns.

Dated

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CHRISTOPHER WILLIAM BROOK