IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 000834

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the ***Coroners Act 2008***

Findings of:	Coroner Simon McGregor
Deceased:	Claudette Marie Daw
Date of birth:	10 January 1946
Date of death:	11 February 2023
Cause of death:	1(a) Effects of fire
Place of death:	43 Vermont Street, Glen Waverley, Victoria, 3150
Key words:	House fire; smoke alarms

INTRODUCTION

1. On 11 February 2023, Claudette Marie Daw was 77 years old when she died in a fire at her home. At the time of her death, Claudette lived at 43 Vermont Street, Glen Waverley, Victoria with her brother, William Daw.

2. Claudette was born in Alexandria, Egypt, the youngest of three siblings to Edmond and Pisani Daou. When Claudette was approximately two years old, her father passed away. Soon after this event, the family moved to Australia and changed their surname to Daw, settling in Preston, Victoria. When Claudette was approximately 12 years old, her mother remarried.[1]

3. Claudette began experiencing delusions and hearing aggressive voices when she was 16 years of age, which she found frightening. She was diagnosed with schizophrenia and in the years that followed and spent extended periods in hospitals and supported group homes undergoing various treatments with mixed success.[2] William recalls that Claudette became ineligible for supported housing in the early 1980s and returned to living with her family at 43 Vermont Street, Glen Waverley.[3]

4. Claudette's mental health became relatively stable and, aside from occasional episodes when she would become distressed and scream at the voices, she was able to live a happy life with her family. Claudette’s mental health was supported by medication which she was known to diligently take as directed.[4]

5. Following the death of their mother in 2007 and stepfather in 2009, Claudette and William cared for each other, though Claudette’s condition appeared to William to deteriorate somewhat. William states she was very independent and capable of feeding and caring for herself, but relied on William to support her in activities outside the house as she rarely went out.[5]

6. Claudette’s medical care was managed predominantly by her long-standing general practitioner, Dr Ashraf Ebrahim, with whom she had a good relationship.[6] Dr Ebrahim describes Claudette’s condition at their last in-person consultation in April 2020 as medically stable, frail but lucid and engaging. He was satisfied that she was engaging in self-care

[1] Coronial Brief, statement of William Daw dated 16 February 2023.
[2] Ibid.
[3] Ibid.
[4] Ibid.
[5] Ibid.
[6] Ibid; statement of Dr Ashraf Ebrahim dated 17 February 2023.

activities, was compliant with her medications and had not had a relapse in the 20-plus years he had been treating her.[7]

7. In later years, Claudette was diagnosed as suffering from aortic sclerosis, stage 2 renal disease and Parkinsonism due to anti-psychotic use. Claudette had also begun to have falls on occasion, the most serious of which resulted in her being admitted to the intensive care unit at Mulgrave Private Hospital in August 2021.[8]

8. As William aged, his own health declined and required him to undergo a number of inpatient stays at hospital, usually for one or two days, and on one occasion for a period of three weeks. During these admissions, Claudette preferred to stay at home as she was more comfortable there and it enabled her to stay with her cats, who she loved very much and enjoyed spending time with. William states that Claudette always managed well on these occasions.[9]

9. Claudette was a heavy smoker and tended to smoke in her bedroom so that the smoke did not aggravate William's health condition. She kept her ashtray beside her bed and would generally smoke two pouches of tobacco per week, rolling her own cigarettes.[10]

10. Claudette was not known to express any kind of suicidal thoughts or ideation and was not known to have any particular interest with or fixation on fire or fire-setting behaviours. To the contrary, Claudette was safety conscious and expressed appropriate concerns to William about having appliances serviced regularly to ensure they were safe.[11]

THE CORONIAL INVESTIGATION

11. Claudette's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

12. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The

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[7] Coronial Brief, statement of Dr Ashraf Ebrahim dated 17 February 2023.
[8] Ibid.
[9] Coronial Brief, statement of William Daw dated 16 February 2023.
[10] Ibid.
[11] Ibid.

purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

13. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

14. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Claudette's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

15. This finding draws on the totality of the coronial investigation into the death of Claudette Marie Daw including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[12]

16. In considering the issues associated with this finding, I have been mindful of Claudette's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

17. On Tuesday 7 February 2023, William attended at the Glen Waverley Medical Centre where Dr Ebrahim advised him he would need to be admitted to Mulgrave Private Hospital as soon as possible to be treated for an infection.[13]

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[12] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[13] Coronial Brief, statement of William Daw dated 16 February 2023.

18. William returned home and discussed Dr Ebrahim's advice with Claudette, who encouraged him to go to hospital and said that she would stay at home and look after the cats while he was away.[14]

19. On the morning of Wednesday 8 February 2023, Claudette was chatty and upbeat, and spoke optimistically to William about his upcoming treatment. At approximately 2:00 pm, William left home to travel to Mulgrave Private Hospital. Claudette was left with a fridge full of food and well stocked medication.[15]

20. William did not have any further communication with Claudette after this time as she tended not to answer the phone when it rang. No other person is known to have spoken to Claudette after 2:00 pm on 8 February 2023.[16]

21. At around 6:00 am on Saturday 11 February 2023, Claudette and William's neighbour at number 41 Vermont Street, Mr Hee Gyuong Kim, heard a 'popping noise like crackers' and observed flames coming from number 43. He alerted his daughter, who called 000 at approximately 6:28 am.[17]

22. At approximately 6:30 am, an off-duty police member, First Constable Jack Turner, also noticed the fire while on his way home from work and stopped to assist. He observed the fire at the rear of the property to be well advanced and attempted to gain entry through the front of the house, but was unable to get through the locked security door. He was unable to see into the house through external windows because of the smoke and closed blinds. Not seeing a vehicle in the driveway and seeing no signs of life inside, he began alerting neighbours to the fire and made a secondary call to 000.[18]

23. At approximately 6:34 am, Fire Rescue Victoria units arrived on the scene and began combatting the fire, which by then had totally engulfed the rear of the property.[19]

24. At approximately 6:50 am, Claudette was located in the hallway by firefighters and was observed to be clearly deceased.[20] Claudette was found lying on her back and holding a

[14] Coronial Brief, statement of William Daw dated 16 February 2023.
[15] Ibid.
[16] Ibid.
[17] Coronial Brief, statement of Hee Kim dated 11 February 2023; statement of Gyu Li Kim dated 20 May 2023; Exhibit 11, audio recording of 000 call Gyu Li (Olivia) Kim.
[18] Coronial Brief, statement of First Constable Jack Turner dated 2 March 2023; Exhibit 12, audio recording of 000 call by Jack Turner.
[19] Coronial Brief, statement of Michael Gillies dated 9 June 2023.
[20] Coronial Brief, statement of Geoffrey Clarke dated 5 June 2023.

cigarette lighter in her hand, which was later found to be in working order.[21] On the ground beneath her body were a part of a match, a spent match, a tobacco pouch and 'Tally-Ho' cigarette papers.[22]

Scene examination

25. Once the fire was extinguished, a scene examination was performed by Forensic Officer Rachel Noble and Leading Fire Fighter Adam Prictor.

26. During the examination, Ms Noble identified that the north-western bedroom (usually occupied by Claudette) sustained the most fire damage, with heavy charring to its contents. The roof and ceiling had collapsed, and the plaster had fallen from the walls. All of the combustible material on the bed had been consumed by the fire except for some material at the southern edge of the bed.[23]

27. On the floor, at the northern end of the north-western bedroom among what appeared to be the remains of a drawer or similar, were approximately five cigarette lighters and 'Tally-Ho' cigarette papers. The cigarette lighters had all been damaged by the fire and it was not possible to determine whether they had been in working order. The floor showed evidence of deep charring near this location.[24]

28. On the roof in the lounge room was a bracket for a smoke detector, however there was no smoke detector on the ceiling, or on the floor in the vicinity of the bracket. There was no evidence of smoke detectors in any other rooms of the house, however, given the damage to the roof and ceiling at the northern end of the house, Ms Noble considered this to be a tentative conclusion.[25]

29. From her examination, Ms Noble concluded that the fire had started by the ignition of available materials in the north-western bedroom, such as the mattress and bedding, and spread from there. There was no evidence to suggest the fire originated in any other room or that there was another seat of fire.

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[21] Coronial Brief, statement of Geoffrey Clarke dated 5 June 2023, p.2; Coronial Brief, statement of Rachel Noble dated 10 March 2023 (Pg 5)
[22] Coronial Brief, statement of Rachel Noble dated 10 March 2023.
[23] Ibid.
[24] Ibid.
[25] Ibid.

30. Ms Noble found no indications that flammable liquid had been used to ignite or spread the fire, but acknowledged that the use of a small amount could not be excluded.[26]

31. The source of ignition was not able to be conclusively determined, but possible sources of ignition that could not be excluded were a carelessly discarded cigarette or direct ignition by a match or cigarette lighter. Ms Noble was of the opinion that the latter scenario was more likely, given the presence of the lighter and spent match located with Claudette.[27]

Identity of the deceased

32. On 15 February 2023, Claudette Marie Daw, born 10 January 1946, was identified via DNA comparison.

33. Identity is not in dispute and requires no further investigation.

Medical cause of death

34. Forensic Pathologist Dr Michael Duffy from the Victorian Institute of Forensic Medicine conducted an autopsy on 14 February 2023 and provided a written report of his findings dated 4 April 2023.

35. The autopsy revealed extensive thermal alteration to Claudette's body, soot in the upper airways and external burn injuries sufficient to cause death.

36. Toxicological analysis of post-mortem samples identified carboxyhaemoglobin at a significantly elevated level (~60% saturation), consistent with inhalation of incomplete products of combustion. This indicates that Claudette was alive when she began inhaling smoke. Dr Duffy explained that the presence of carboxyhaemoglobin in blood reduces binding of oxygen to haemoglobin, resulting in decreased circulating oxygen and ultimately hypoxia. Saturations above 50% and 70% can cause unconsciousness and death respectively.

37. Serum biochemistry showed an elevated cyanide level (1.2 mg/kg), which is a poison produced in fires involving nitrogen-containing materials such as plastic, vinyl, wool or silk. Cyanide causes shutdown in cellular respiration and cell death.

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[26] Coronial Brief, statement of Rachel Noble dated 10 March 2023.
[27] Ibid.

38. Apart from patchy left ventricular fibrosis,[28] Dr Duffy found no significant natural disease. He opined that the fibrosis alone would not have caused Claudette's death but may have contributed to it.

39. No unexpected injuries were identified.

40. Dr Duffy provided an opinion that the medical cause of death was 1(a) effects of fire.

41. I accept Dr Duffy's opinion.

FINDINGS AND CONCLUSION

42. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Claudette Marie Daw, born 10 January 1946;

    b) the death occurred on 11 February 2023 at 43 Vermont Street, Glen Waverley, Victoria, 3150, from effects of fire; and

    c) the death occurred in the circumstances described above.

43. Having considered all of the circumstances, I am satisfied that the fire that caused Claudette's death was accidentally lit, either by a discarded cigarette or accidental direct ignition of materials with a cigarette lighter or match. In reaching this conclusion, I note particularly that:

    a) Claudette's mental health appears to have been stable and well managed;

    b) there is no evidence that Claudette was suicidal or inclined towards self-harm; and

    c) there is an absence of evidence suggesting Claudette had any unhealthy interest in fires or fire-setting.

44. I consider that the presence of a smoke alarm in the immediate vicinity of the bedrooms may have acted to alert Claudette to the spreading fire and provided her additional time to evacuate.

45. I am further satisfied that the decision for Claudette to remain at home while William was in hospital was reasonable and considered, and a choice that was consistent with her preferences. It is clear that William was a sensible and attentive carer to Claudette, and that on earlier

[28] Scarring of the heart tissue.

occasions she had managed her day-to-day living well in his absence when his own healthcare needs required him to be away from home.

I convey my sincere condolences to Claudette's family for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

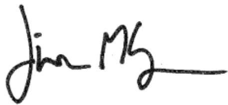
I direct that a copy of this finding be provided to the following:

William Daw, Senior Next of Kin

Kay Hotker, Mulgrave Private Hospital

Leading Senior Constable Matthew Lindsay, Coroner's Investigator

Signature:



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Coroner Simon McGregor

Date : 29 April 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.