FORM 38

Rule 60(2)

FINDING INTO DEATH WITHOUT INQUEST

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

Court reference: 1608/09

In the Coroners Court of Victoria at Melbourne

I, KIM PARKINSON, Coroner

having investigated the death of:

Details of deceased:

Surname: ALLEN
First name: RODERICK
Address: 29 Kent Street, Benalla, Victoria 3671

without holding an inquest:

find that the identity of the deceased was RODERICK ALLEN
and death occurred on 17th March, 2009

at Alfred Hospital, 55 Commercial Road, Melbourne, Victoria 3004

from
1a. DECOMPENSATED LIVER AND KIDNEY DISEASE
1b. ALCOHOLIC LIVER DISEASE
1c. RECENT BURNS AND INHALATIONAL RESPIRATORY INJURY

Pursuant to Section 67(2) of the **Coroners Act 2008**, an inquest into the death was not held and the deceased was not immediately before the person died, a person placed in custody or care; but there is a public interest to be served in making findings regarding the following circumstances:

1. Mr Roderick Allen was 48 years old. He resided at 29 Kent Street, Benalla, in a property owned by family members. Mr Allen suffered with chronic liver disease and alcohol addiction.

2. The circumstances of Mr Allen's death have been the subject of investigation by Victoria Police. Acting Sergeant Melanie Walker of Benalla Police Station provided a brief to the coroner setting out the investigations undertaken. The brief also included a comprehensive Fire Investigation Report prepared by Victoria Police Forensic Scientist John D. Kelleher. I have drawn from these investigations in my factual findings.

3. On 15 March 2009 at 3.17am a house fire at 29 Kent Street, Benalla, was reported by telephone to Benalla police by Mr Bob Burns of 31 Kent Street, Benalla. He advised police that he had attempted to contact 000 however was unable to get through and contacted police directly. Leading Senior Constable Gipp advised the Benalla Divisional Van to attend and attempted himself to contact 000. Senior Constable Gipp was also unable to get through to 000 and then contacted Wangaratta D24 directly to request CFA attendance. This call was made and logged at 3.18.33am.

4. Senior Constable Hartley and Leading Senior Constable Harry Verbaken proceeded to the premises, also contacting fire fighters from the divisional van through D24. When they arrived at the scene at 3.18am, they report that the house was fully engulfed in fire with flames coming out of the windows on the right hand side of the property. The property was a three bedroom weatherboard dwelling located on the southern side of the street, facing north. A driveway was located on the eastern side of the premises leading through double gates to a garage. The house appeared to have been recently painted.

5. A number of neighbours were at the scene, including, Mr Bernie Eschholz who police knew to be a resident at the premises. Mr Eschholz advised them that Mr Roderick Allen was still inside the premises. Senior Constable Hartley approached the front door and observed Mr Allen crouched in the doorway of what she knew to be the kitchen. He was four metres inside the house, the kitchen door being to the left of the front door. Flames ran along the ceiling and around the front door frame and Senior Constable Hartley described observing a wall of flames, with the room to the right of the front door fully engulfed.

6. Senior Constable Hartley describes yelling at Mr Allen to get down on his hands and knees and crawl towards her. She continued to call out to him in case he could not see her for the smoke. She observed that he started to crawl towards her and then collapsed approximately 2-3 metres from the doorway. At this point Leading Senior Constable Verbaken entered the premises through the front doorway and into the hallway. He located Mr Allen, reached down, grabbed him and dragged him to and out of the front door and onto the porch, where with Senior Constable Hartley's assistance they moved him onto the front yard.

7. Fire fighters arrived at the scene at approximately 3.25am and the fire was extinguished.

8. Mr Allen was transported by ambulance to the Wangaratta Hospital. He had sustained full thickness burns to 6% of his body and he had suffered injury as a result of smoke inhalation. His recovery was complicated by his pre-existing severe alcoholic liver disease and he developed renal failure. He was transferred to the Alfred Hospital at Melbourne. His condition continued to deteriorate and he died on 17 March 2009.

9. The Victoria Police fire investigator, Mr Kelleher noted extensive internal damage with heat and smoke damage throughout the building. Mr Kelleher reported:

> *"There was a clear pattern of increasing damage towards the central bedroom, closest to the front door. The second and third bedrooms had heavy sooting and relatively moderate heat effects. Damage in the lounge room and kitchen was essentially sooting, with relatively minor heat damage. Burning on the back porch was more significant with extensive burning of furniture and household items, major damage to the northern wall and deep charring to the floor. In the central bedroom the southern wall was almost completely burnt, and there was major structural damage to the other walls, the ceiling and the floor ..The pattern of burning suggested that the fire had started in the south eastern corner of this central bedroom, probably on the bed, given the complete burning of the mattress. There was an electric heater nearby, but this was in reasonable condition, with no obvious evidence to suggest that it was involved in starting the fire.*
>
> *There was evidence of smoking in most rooms. There were ashtrays and cigarette butts around the house, inside and out. While many of the cigarette butts were in ashtrays, some were on the ground and on the floor. There were candles in the lounge room, but none were located in the bedroom.*
>
> *The cause of the fire was ignition of the combustible material in the central bedroom, close to the southern wall, probably the mattress and/or bedding. While accidental ignition by the heater being too close to the bed remains a possibility, ignition by a carelessly discarded or improperly extinguished cigarette is in my opinion more likely to have been the source of ignition".*

10. I have considered the reports as to circumstance of the fire and note that neither police nor fire investigators report any evidence of suspicious circumstances.

11. Dr Paul Bedford, Forensic Pathologist with the Victorian Institute of Forensic Medicine undertook an examination and reported the cause of death as:

> 1a. Decompensated liver and renal disease;
> 1b. Alcoholic Liver disease;
> 1c. Recent burns and inhalation injury to the respiratory injury.

12. Dr Bedford commented:

> *"The extent of the burns is not in itself considered to be directly related to the cause of death. There is a clear background of severe alcoholic liver disease and multi organ failure has developed within this background."*

13. Having considered all of the available evidence, I am satisfied that no further investigation is required. I am satisfied that there were no suspicious circumstances. I am satisfied that it is likely that the fire was started as a result of a discarded and not fully extinguished cigarette, which ignited bedding in the bedroom of the premises.

14. Whilst the pathologist has reported that Mr Roderick died as a consequence of renal and liver disease, I am satisfied that Mr Allen's pre-existing illness was complicated by the burns and smoke inhalation he experienced as a result of the fire and in turn compromised his recovery.

15. The prompt action of the members of Victoria Police both in attending the scene, notifying emergency services through D24 and their actions at the scene resulted in Mr Allen being rescued from the premises as soon as was likely to be practicable. In such circumstances, the delay in response by Telstra emergency service call answering could not be said to have contributed to the death.

16. I find that Mr Roderick Allen died on 18 March 2009 and that the cause of death was decompensated liver and renal disease and alcoholic liver disease in the circumstance of recent burns and inhalation injury to the respiratory tract.

COMMENTS:
Pursuant to Section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

1. It is appropriate to comment upon the bravery and professionalism of the police officers who initially attended the fire on 15 March, 2009. Leading Senior Constable Verbaken entered the premises, which were well alight to drag Mr Allen to safety, at great risk to his own safety. Senior Constable Hartley's efforts in maintaining contact with Mr Allen and encouraging him to make his way towards the front door of the premises enabled Leading Senior Constable Verbaken to successfully locate Mr Allen. Both police officers should be commended for their efforts on this evening.

2. In this case there was a failure of the 000 system to meet identified targets regarding the answering of emergency calls. Telstra acknowledge that this occurred on two occasions. Police and neighbours report that they made calls to the 000 number and that their calls went unanswered. Telstra Emergency Service Answer Point Support Officer, Ms Joanne King, in a statement to the coroner dated 26 August 2009, advised that her records identified two calls, one of which was said to have been answered. However in a further statement dated 5 November 2009, Ms Jane Louise Elkington, Group Manager for Telstra Triple Zero, documented a further call, which she acknowledged, also went unanswered. That call was a second call from the Benalla Police Station. The calls were as follows:

At 03:16:15 a call was made to 000 from a neighbour of the premises on fire, with a duration of 52 seconds from dial to termination. The call went unanswered and the caller terminated the call. At 03:17:04 a call was made to 000 from Benalla Police Station, 037621545 with a duration of 31 seconds from dial to termination. The call went unanswered and the caller terminated the call. At 03:21:22 a call was made to 000 from Benalla Police Station, with a duration of 92 seconds from dial to termination. The call was answered by an emergency call operator.

3. It is of concern that two of these calls were not answered within the target answering performance time frames. Telstra stated that the target time frame, as agreed with regulators, for the answering of 000 calls is 5 to 10 seconds and that in these cases the calls were not answered within the required time. Telstra stated:

> *"The first call is not in keeping with the target answering performance. The answering performance is dependant on the answering performance of the Emergency Service Organisations (ESO) nationally as the ESP operator is required to stay on the line with the caller until the call is transferred and answered by an ESO call taker. Delays in answer to an ESO may impact the answering performance of the ECP. During the period 3.15am to 3.30am on 15 March 2009, the ECP was experiencing delays in answer to a number of Emergency Service Organisations nationally, which directly impacted Telstra's ability to answer incoming calls. In an attempt to manage unplanned peaks in calling volumes, the staffing levels within the ECP answer point are well above what would normally be required to answer calls as per the legislative requirements. In addition, in an attempt to stop callers hanging up and redialling when there is a delay in answering by the ECP, a short delay Recorded Voice Announcement (RVA) is played to callers in queue. This RVA is automatically activated if any call to 000 is not activated within 30 seconds. It is also automatically reactivated every 30 seconds thereafter."*

4. This statement explains that the delays on the evening were as a result of factors outside of Telstra's control, resulting from emergency services delays in answering calls directed to them by Telstra. Ms Elkington does not specify the emergency services to which she is referring and it is beyond the scope of this inquiry to investigate those matters. However, it appears that these delays, which are apparently known to occur, are outside of Telstra's control, yet impact upon the delivery of timely response to emergency calls by Telstra.

5. It also appears that the recorded message RVA, does not commence to operate until 30 seconds after the call has connected to 000. This is a period of time well outside the response time designated by legislature as appropriate. Hence, as in this case it is likely that callers have disconnected the call before they hear the RVA.

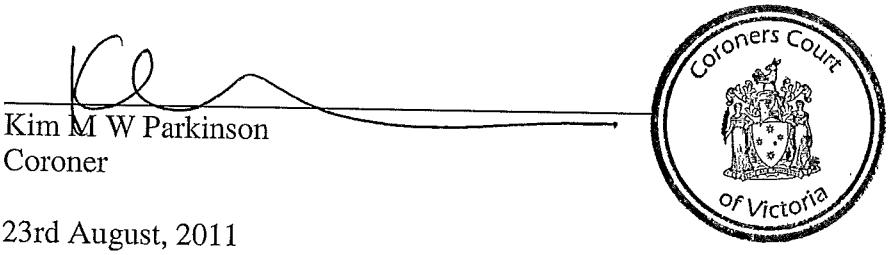
RECOMMENDATIONS:
Pursuant to Section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

1. In light of the difficulties that Telstra Corporation reports arising from its dealings with emergency service providers outside of its control, that Telstra Corporation review the criteria by which it determines staffing numbers at the emergency call centre to ensure that there are sufficient staff members available to meet unexpected call demand and delays arising from emergency service providers.

2. That Telstra configure its emergency RVA to commence no later than 10 seconds after connection of a 000 emergency call.

3. I direct that a copy of these findings be provided to the: family; interested parties; Honourable Mr Peter Ryan MP, Minister for Police and Emergency Services (Victoria); Chief Commissioner of Police (Victoria); Officer in Charge Benalla Police Station; Telstra Corporation Legal Services Director.

Signature:



Kim M W Parkinson
Coroner

23rd August, 2011