Court Reference: 3654/08

#### **FORM 38**

Rule 60(2)

### FINDING INTO DEATH WITHOUT INQUEST

Section 67 of the Coroners Act 2008

In the Coroners Court of Victoria at Bendigo

I, Jennifer Tregent Coroner having investigated the death of:

#### Details of deceased:

Sürname:

**CULLEN** 

First name:

Phillip Anthony

70 Church Street, Kangaroo Flat

## without holding an inquest:

find that the identity of the deceased was Phillip Anthony Cullen and the death occurred on the 19<sup>th</sup> of August 2008 at the Alfred Hospital, 55 Commercial Road, Prahran, Victoria from the effects of fire.

\*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:

At the time of his death Mr Cullen was a forty nine year old man who resided at a residential address in Kangaroo Flat. It was a common practice for him to frequent the Kangaroo Flat Hotel a few times per week after work and on Saturday and Sunday.

On the Sunday the 17<sup>th</sup> of August 2008, the day prior to his death, Mr Cullen attended the Windameer Hotel in High Street, Kangaroo Flat where he met his friend Colin Dennis. It was approximately 3pm when they arrived and Mr Dennis estimates they drank

approximately twenty pots of full strength beer before departing to his home at around 8pm.

Once at the home of Mr Dennis they consumed a further couple of beers and the deceased fell asleep sitting at the kitchen table around 11:30pm. Mr Dennis put a doona around Mr Cullen and went to bed. When he woke at 8:30am on Monday the 18<sup>th</sup> of August 2008, the deceased was already awake.

They consumed a light breakfast of toast and got themselves ready for the day. Mr Cullen did not have to work this day, as it was a rostered day off. At about 10:30am they each consumed a can of Carlton Draft beer. Mr Dennis detailed in his statement that he did not feel drunk at this time but did appreciate that both he and the deceased would still have alcohol in their systems from the previous evening.

At about 11:00am Mr Cullen and Mr Dennis attended at the Windameer Hotel, where they had been drinking the night before. They played pool and drank beer for the best part of the day. Mr Dennis estimates they had about fifteen pots of full strength beer each. They left this hotel at about 7.00pm, at which time Mr Dennis described the deceased as being very drunk but still in control. He stated he was able to walk normally but was looking drowsy and "sloppy".

They walked to the Kangaroo Flat Hotel on High Street and entered through the back entrance that leads into the beer garden. Mr Dennis went inside the hotel to get a beer, leaving the deceased in the beer garden smoking a cigarette.

Another male friend, Mr Robert Dole, also accompanied the deceased to the Kangaroo Flat Hotel after leaving the Windameer Hotel. There are significant variations as to the time they arrived at the Kangaroo Flat Hotel between this witness stating it was around 5pm and another witness being Ms Collier placing it at approximately 6pm. It matters not for the purposes of this enquiry.

Mr Dole states he purchased a beer for the deceased and a squash for himself. On returning to the beer garden, he noticed the deceased sitting on the brick hearth of the fireplace with his back to the fire. He noted the guard had been removed and the fire burning in the fireplace was only small. This is consistent with the evidence of other witnesses who noted the guard to the fire had been placed to the side of the fireplace.

In the statements of the other hotel users, it was apparently common practice that the guard would be removed to allow closer access to the fire and to allow sitting on the hearth.

Throughout the course of the night, numerous other patrons who knew the deceased entered the beer garden to have a cigarette. They all spoke to him for a period before either returning inside or leaving to go home. The observations of these witnesses were the

deceased was affected by alcohol, but they did not describe him as drunk or otherwise unsteady on his feet.

It appears from the statements of the witnesses, the last person to see the deceased alive was Mr Glenn Mitchell. Mr Mitchell purchased a beer to take home with him and walked through the beer garden to leave. He had a brief conversation with the deceased and estimated he left to walk home at about 7.45pm. At the time, the deceased was standing directly in front of the fire with his back to it.

At around this time one of the Licensee's of the hotel Ms Leanne Collier went out to the beer garden to check everything was in order. Upon entering the garden, she noticed flames coming from the vicinity of a fern. At this point, she noticed the deceased was on fire and leaning up against the nearby fence. She described the flames as being between one and two inches high and that his clothes were smouldering. Ms Collier yelled for someone to call an ambulance, grabbed a garden hose, and started to hose the deceased down from his shoulders. Another employee, Ms Kathy Matthews came out and assisted in keeping the deceased upright whilst water was applied.

Ms Collier estimates some five to ten minutes later, an ambulance arrived and the paramedics took over in the treatment of the deceased. Paramedic Eric Lee questioned Mr Cullen as to what had occurred, but his speech was mumbled and Mr Lee could not understand what he said.

On examination of Mr Cullen, it was estimated he had suffered 70% burns to his body, which extended from his legs, upper anterior and posterior torso and head. Mr Cullen's airway was open and unblocked but there was some blackness noted on the end of his tongue. Mr Cullen did not complain of difficulty in breathing.

Mr Cullen was transported by ambulance to the Bendigo Hospital where he was admitted at approximately 8:30pm. On examination by Surgical Registrar Dr. Kostantinos Syrakos, he noted Mr Cullen had a total of 67% of his body surface with full thickness burns and 6% with partial thickness burns. Following initial treatment to stabilise Mr Cullen he was transferred by air ambulance to the Alfred Hospital in Melbourne. At 2.45 am on the 19<sup>th</sup> of August 2008, life was pronounced extinct in the Intensive Care Unit at the Alfred Hospital.

Forensic pathologist Doctor David Ranson conducted a post mortem on the 24<sup>th</sup> of August 2008. The following comments were contained in the report of medical investigation of Doctor Ranson:

1. The autopsy revealed evidence of significant heat damage to the body affecting a large area of the skin of the body and hair. An internal examination revealed features in keeping with an individual who has suffered severe burns with marked pulmonary oedema and congestion and brain swelling.

- 2. Examination of this man's heart revealed evidence of significant natural disease with severe coronary artery atherosclerosis of a degree known to cause arrhythmias and sudden death. This feature was not associated with any macroscopic fibrosis or old or recent myocardial infarction, although some early microscopic areas of diffuse fibrosis were seen in one section of the myocardium. An individual with this degree of coronary artery stenosis may suffer from an arrhythmic event and could be subject to blackouts or alleged fainting episodes.
- 3. The toxicology results from the ante mortem specimens show evidence of probable medical treatment related analgesia in keeping with his burns. However, the blood alcohol is 0.3g/100ml, which would be expected to cause significant motor skill impairment and a variety of psychological effects. A finding of this degree of intoxication may be relevant to the circumstances in which he suffered his burns.

Dr Ranson stated the cause of death as being from the effects of fire.

A thorough police investigation took place in an effort to seek to establish how it was that Mr Cullen received the burns to his body, as there were no witnesses as to what had occurred. An expert scientist, Mr John Desmond Kelleher, from the Victoria Police Forensic Services Centre made an examination of Mr Cullen's clothing. These items were examined for the possible presence of flammable liquid. Flammable liquid was not detected on any of the burnt clothing, which led Mr Kelleher to the conclusion that it was never present or if it had been it had burnt or evaporated to below a detectable level.

The investigating police officer in this matter, S/C John McIlrath, attended the Kangaroo Flat Hotel on the night and made a number of observations of the location of where Mr Cullen was found. On arrival, S/C McIlrath observed the deceased standing and two females hosing him down with water and the arrival shortly after of the paramedics who commenced treatment.

In addition to speaking to a number of potential witnesses, S/C John McIlrath inspected the scene. He observed a fire burning in a fireplace with a small flame. The fireguard was to the left of the fireplace. S/C McIlrath located a burnt pair of spectacles with the glass in them broken in an ashtray on the mantle piece above the fire. There was also a purple lighter and a black glasses case containing glasses on the fireplace. On a table a short distance away, he located a burnt packet of Tally-Ho wrappers.

On a subsequent day, S/C McIlrath took measurements of the fireplace. The hearth was approximately 300 mm from the ground and he observed that it was a good height for sitting on. S/C McIlrath was informed there was no Closed Circuit Video of the beer garden area.

As part of my investigation into the circumstances surrounding Mr Cullen's death, I sought assistance from the Coroner's Prevention Unit (C.P.U). The Coroner's Unit is a

specialist service for coroners created to strengthen their prevention role and provide them with expert assistance.

The information I sought from the C.P.U was whether there were any similar deaths associated with public fireplaces and whether there were any standards/ guidelines or regulations governing the need to place "guards" on open fireplaces.

As part of the research, the C.P.U investigator conducted a search for each state and territory using the National Coroners Information System (NCIS) for the years July 2000 to the present. In order to extract relevant information the terms "fireplace", "hotel", "open fire" and "burns" were used to determine if any previous deaths had occurred relating to similar circumstances. The advice I received from the CPU was that no deaths in similar circumstances of Mr Cullen's death had been identified.

The C.P.U did not find any relevant standards, guidelines or regulations on the need to place "guards" on open fireplaces in public places. In the absence of such they looked to other information relating to workplaces and residential homes.

The Australian Standard *Guidelines for safe housing design*<sup>1</sup> in section 6.1.3.6 advises that:

"...Freestanding and in-built heaters and open fireplaces should be adequately guarded to prevent people from coming into contact with any hot surface".

The C.P.U observed that the relevance of guarding for open fireplaces in public places could be considered analogous to guards for workplace machinery. The *Occupational Health and Safety Regulations 2007* (the Regulations) in Victoria prescribe the use of guards for plant (Appendix A).

In part, they state that where an employer cannot completely eliminate a risk associated with plant, they must ensure that the risk is reduced as far as reasonably practicable by either: <sup>2</sup>

- Substituting the plant with plant that has a lower level of risk; or
- Using engineering controls; or
- Isolating the plant from people.

The use of guarding could be considered as an engineering control when applied in the context of a fireplace, as a firescreen does not isolate the fire but rather reduces risk of contact with flames and coals. Furthermore, Regulation 3.5.25(4) states:

<sup>&</sup>lt;sup>1</sup> Australian Standard AS 4226-2008 Guidelines for safe housing design

<sup>&</sup>lt;sup>2</sup> Occupational Health and Safety Regulations 2007, 3.5,24(2)

If an employer uses guarding as a measure to control risk in relation to plant the employer must ensure that the guarding-

- (a) makes by-passing or disabling of the guarding, whether deliberately or by accident, as difficult as is reasonably possible; and
- (b) does not cause a risk in itself.

As noted by the C.P.U an engineering solution such as the locking of the fire guard into place would provide a sufficient mitigation of the hazard. This of course may pose a problem with maintenance of the fireplace, including stoking the fire when lit. The Regulations however, as they relate to guarding of machinery, do allow for the guarding to be removed for maintenance and cleaning. The same could be applied to fireplaces such that the guarding could be removed for maintenance and cleaning when not in operation and stoking with fuel when in operation.

It cannot be concluded on the available evidence how it was that Mr Cullen suffered his fatal burns. It cannot be said that he fell into the fire due to his level of intoxication or alternatively may simply have been sitting on the hearth in front of the fire when his clothing caught alight. It is however, and opportunity in this finding to communicate to licensed venue operators the importance of patron safety associated with fireplaces.

The C.P.U. also considered the Responsible Alcohol Victoria (RAV)-Design Guidelines for Licensed Venues and Venue Safety Audit. The guidelines referred to, aim to assist all licensees and venue managers to minimise risks associated with licensed venues. The Guideline's goal is to create a safe environment for a venue's patrons. While the Guidelines do not currently include fireplaces, the inclusion of risk management issues involving open fireplaces would be in keeping with the purpose of the document.

The C.P.U. advised that Responsible Alcohol Victoria are currently reviewing their *Venue Safety Audit* publication, which is a detailed "check list" for licensees and venue managers to ensure they are appropriately addressing patron safety. The Audit does not currently consider fireplaces, however the inclusion of fireplace safety information (such as the fitting of fireguards) would be in keeping with the document's purpose.

### \*RECOMMENDATIONS:

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

- 1. That the Australian Hotels Association Victoria use the circumstances of Mr Cullen's death to encourage their members to consider open fireplaces as a hazard that requires appropriate controls, such as the installation of guarding that cannot readily be removed by patrons.
- 2. That the Director of Liquor Licensing Victoria provides information to all new and existing licensees regarding the management of patron risks associated with open

fireplaces. This information could be incorporated into existing publications provide to licensees, such as the *Design Guidelines for Licensed Venues* and the revised *Venue Safety Audit*. Licensees should be encouraged to guard open fireplaces, and have a process to prevent the removal of fireguards by patrons in order to prevent fire related injuries.

Signature:

Jennifer TREGEN

Coroner

Date: 20 April 2012

# Appendix A - Occupational Health and Safety Regulations 2007

# Regulation 3.5.25 - Guarding

- (1) If an employer uses guarding as a measure to control risk in relation to plant (definition below), the employer must, so far as is reasonably practicable, ensure that guarding designed for that purpose will prevent access to the danger point or area of the plant.
- (2) If an employer uses guarding as a measure to control risk in relation to plant, the employer must ensure that
  - (a) if access to the area of the plant requiring guarding is not necessary during operation, maintenance or cleaning of the plant, the guarding is a permanently fixed physical barrier; or
  - (b) if access to the area of the plant requiring guarding is necessary during operation, maintenance or cleaning of the plant, the guarding is an interlocked physical barrier that allows access to the area being guarded at times when that area does not present a risk and prevents access to that area at any other time; or
  - (c) if it is not reasonably practicable to use guarding referred to in paragraph (a) or (b), the guarding used is a physical barrier that can only be altered or removed by the use of tools; or
  - (d) if it is not reasonably practicable to use guarding referred to in paragraph (a), (b) or (c), a presence-sensing safeguarding system is used that eliminates any risk arising from the area of the plant requiring guarding while a person or any part of a person is in the area being guarded.
- An employer must ensure, so far as is reasonably practicable, that any pipe or other part of the plant associated with heat or cold, is adequately insulated or guarded in a manner that ensures that any risk to health or safety
  - (a) is eliminated, so far as is reasonably practicable; or
  - (b) if it is not reasonably practicable to eliminate the risk, is reduced so far as is reasonably practicable.
- (4) If an employer uses guarding as a measure to control risk in relation to plant the employer must ensure that the guarding
  - (a) makes by-passing or disabling of the guarding, whether deliberately or by accident, as difficult as is reasonably possible; and
  - (b) does not cause a risk in itself.
- (5) If an employer
  - (a) uses guarding as a measure to control risk; and

- (b) the plant to be guarded contains moving parts and those parts may break or cause work-pieces to be ejected from the plant the employer must ensure, so far as is reasonably practicable.
- (6) Despite anything to the contrary in this regulation, any guarding an employer uses as a measure to control risk in relation to plant may be of a kind that is able to be removed to allow convenient repair, servicing and maintenance of plant at any time that the plant is not in normal operation.

\*Note a similar obligation with the exception of subsection 3 applies in relation to a plant designer (See, Regulation 3.5.4).

Section 5 of the Occupational Health and Safety Act 2004 defines plant as follows;

Plant includes -

- (a) any machinery, equipment, appliance, implement and tool; and
- (b) any component of any of those things; and
- (c) anything fitted, connected or related to any of those things.