



- 1 AUG 2013

Ms Leah Walsh  
Coroners Registrar  
Coroners Court of Victoria  
Level 11, 222 Exhibition Street  
MELBOURNE VIC 3000



Our ref: CD/13/179762  
Your Ref: 3654/2008

Dear Ms Walsh

### INVESTIGATION INTO THE DEATH OF PHILLIP A CULLEN

I refer to your letter dated 18 May 2012 regarding the finding without an inquest and recommendations made by the Coroner under the *Coroners Act 2008* resulting from an investigation into the death of Phillip A Cullen.

It is noted that the Coroner made the following recommendation as part of the findings "*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 provided to licensees, such as the Design Guidelines for Licensing 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.*"

I confirm that this recommendation is accepted and that the Victorian Commission for Gambling and Liquor Regulation (VCGLR) will amend the publications titled *Design Guidelines for Licensing Venues* and *Venue Safety Audit* to include information relating to guarding open fireplaces to prevent fire related injuries.

The VCGLR will also use other communication methods to advise all new and existing licensees about the risks associated with open fireplaces, such as publishing an article on the VCGLR website and in the VCGLR quarterly newsletter *VCGLR News*.

Yours sincerely

**Bruce Thompson**  
Chairman