Australian Government

Department of Health and Ageing

**ACTING SECRETARY**

Mr Mark Rogers
Coroners Registrar
Coroners Court of Victoria
Level 11
222 Exhibition Street
MELBOURNE VIC 3000

Dear Mr Rogers

**RECOMMENDATIONS IN THE MATTER OF THE FINDINGS INTO THE DEATH OF PEARL RECHT – (CASE REFERENCE: COR2011 003161)**

I refer to your letter dated 13 December 2012 seeking the Department of Health and Ageing's (the Department) response to the Deputy State Coroner's recommendations (below) arising from the Death with Inquest of Pearl Recht.

**Recommendation 1(a):**
*That the 'Basic Home Fire Safety Training Materials', as endorsed by the Australasian Fire and Emergency Service Authority Council, are mandated for use by community aged care providers in Victoria, through inclusion of the information into the induction process for new community aged care workers. These materials should also be used for skills maintenance sessions/programs conducted by community aged care providers for existing workers.*

and

**Recommendation 1(b):**
*That basic home fire safety is incorporated into policy and practice guidelines for assessment processes used to assess older people for 'in home' services. In residences where the client is considered at greater risk due to health or lifestyle factors (as defined in Essential Knowledge: Basic Home Fire Safety, Section 2), additional smoke alarms should be installed to provide the earliest possible warning of a fire for the occupant.*

The Department notes that the Deputy State Coroner's recommendations are consistent with the Community Care Common Standards (the Standards) as set out in the *Aged Care Act 1997* (the Act), in particular Expected Outcomes 1.6: Risk Management, 1.7: Human Resource Management, and 1.8: Physical Resources. The Standards provide a framework to ensure community aged care providers meet their requirements under the Act and continue to look for ways to improve their practices and policies.

The Act requires community aged care providers to manage their human resources to ensure that staff are appropriately skilled and trained for the safe delivery of care and services to service users, however it is up to individual service providers to determine and provide the

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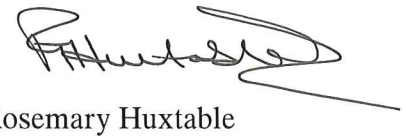
training that meets the requirements of clients and the organisation. The Department does not specify individual training programs or materials for use by service providers.

The Department accepts that service providers, through appropriate risk management strategies, may help reduce the number of preventable fire fatalities involving older people who receive "in home" support to assist them to live in the community. In line with our practice to alert and educate community aged care providers on high risk matters, the Department issued an alert to Commonwealth community care service providers to make them aware of the Coroner's recommendations and to remind them of their responsibilities under the Act. The alert suggests service providers make key personnel aware of the recommendations and take appropriate action.

The alert also contains reference to the complementary recommendations issued by Victorian Coroner Heather Spooner on 15 November 2012 in relation to the death of Audrey J Svikers. Ms Svikers' death also resulted from a fire in her home.

A copy of the alert is attached for your information.

Yours sincerely



Rosemary Huxtable
Acting Secretary

1 February 2013

Australian Government
Department of Health and Ageing

# Industry feedback alert

## Basic home fire safety

**Office of Aged Care Quality and Compliance**

1 February 2013

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| **Who is this alert for?** | All Australian Government subsidised providers of home care services. |
| **What is an industry feedback alert?** | Industry alerts outline an issue, trend or risk we have identified through an analysis of our data and other sources. They provide suggestions of areas that you may wish to review within your service. **Alerts are not advice or directions.** |
| **Issue** | We are alerting service providers in all jurisdictions to findings made by the Victorian Coroner and Deputy State Coroner. The findings relate to two separate investigations into fatalities caused by fire in care recipients' homes. |

**Observations**

The combined recommendations from both Victorian coronial reports are that:

- during initial needs assessment, you advise care recipients that it is mandatory for all homes in Victoria to have a working smoke alarm
- where care is to be provided and there is no smoke alarm, the installation of a smoke alarm is organised in line with service provision. In homes where smoke alarms are installed, these are checked by you to ensure they are in working order
- you promote regular testing and maintenance of smoke alarms to the care recipient and their family/friends, or provide assistance to care recipients to test and maintain smoke alarms
- in homes where the care recipient smokes, you promote the use of high-sided ashtrays or sealed containers to allow for properly discarded smoking materials
- fire safety training materials be included in induction and skills maintenance training for aged care workers in Victoria and basic home fire safety be incorporated into policy and practice guidelines for assessment of older people for "in home" services
- where the care recipient is considered at a greater risk due to health or lifestyle factors, additional smoke alarms should be installed.

The reports also highlight that in Victoria there has been an increase in the number of preventable fire fatalities involving older people and people with disability who receive "in home" care. As demand for these services is predicted to grow, there is a need to identify common risk features and to deliver an improved safety outcome for those most at risk.

Current state and territory legislation dictates that smoke alarms are:

- mandatory for all homes in New South Wales, Queensland, Victoria and South Australia
- mandatory for all new homes and homes undergoing renovations in Australian Capital Territory, Northern Territory, Tasmania and Western Australia

**Suggestions for your consideration**

We consider the Victorian coronial findings pertinent to all jurisdictions. While the findings are recommendations and not legislated requirements, we suggest that you:

- make your key personnel aware of the information in this alert
- include fire safety training materials in training for all personnel
- take appropriate action to promote fire safety in the home, such as
  - ensuring your assessment process includes consideration of fire-related risks to the care recipient's safety
  - advising your care recipients of smoke alarm legislation relevant to your state or territory
  - promoting regular testing and maintenance of smoke alarms to care recipients and their family/friends or providing assistance to care recipients to test and maintain smoke alarms
  - promoting the use of high-sided ashtrays or sealed containers to care recipients who smoke to allow for properly discarded smoking materials.

These recommendations are consistent with the *Community Care Common Standards:*

- *Expected Outcome 1.6: Risk Management*, which requires service providers to be actively working to identify and address potential risk to ensure the safety of service users, staff and the organisation.
- *Expected Outcome 1.7*: *Human Resource Management* which requires service providers to manage human resources to ensure that adequate numbers of appropriately skilled and trained staff/volunteers are available for the safe delivery of care and services to the service users.
- *Expected Outcome 1.8: Physical Resources* which require service providers to manage physical resources to ensure the safe delivery of care and services to service users and organisation personnel.

**For more information**

The Victorian Coroner's Court publishes findings and recommendations on its website at coronerscourt.vic.gov.au - select 'Case Findings' and search for Case IDs 215808 and 316111

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