IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 004839

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Nigel Raymond Willoughby
Date of birth:	2 March 1946
Date of death:	2 September 2020
Cause of death:	1a: Complications of burns in a fire
Place of death:	The Alfred 55 Commercial Road Melbourne Victoria 3004
Keywords:	Fire, public housing, DFFH, Fire Rescue Victoria, Country Fire Authority, smoking, smoke alarms, fire sprinklers, hoarding and squalor

INTRODUCTION

1. On 2 September 2020, Nigel Raymond Willoughby was 74 years old when he died from burns sustained in a house fire. At the time of his death, Nigel was living in Traralgon with his friend Ashleigh Mills[1], who died in the same fire.

2. The owner and landlord of Nigel's home was the Director of Housing[2] (established by the *Housing Act 1983* (Vic)), with its administrative functions and public housing tenancy management provided by the Department of Health and Human Services (**DHHS**)[3].

Background

3. In 1973, Nigel married Cheryle and they had three children, Brett, Raymond and Marcia. Their marriage broke down due to family violence perpetrated by Nigel.

4. Nigel was an alcoholic and according to Marcia, *"smoked like a chimney"*.

5. Nigel initially moved into the Traralgon property on his own in around 2010. At first, he kept the house clean and tidy and was an avid gardener. Due to his declining health including cataracts and requiring knee replacements, he was unable to continue maintaining the home.

6. By the time Ashleigh had moved into the home in early 2020, friends and family of both residents described the living conditions as very poor. A friend of Ashleigh's stated that they could not enter the premises because of the strong smell related to the cats in the house – there was cat litter, cat urine, faeces all around the house. Marcia had heard that he had over 37 cats at one stage but recently had reduced this to three.

7. Nigel spent most of his time at home, drinking and smoking in an armchair in the living room. Ashleigh would find him passed out in the armchair in the mornings. Nigel would also discard his cigarette butts on the ground around the armchair

[1] COR 2020 004808.
[2] Since Nigel's death, amendments to the Housing Act had the effect of replacing the Director of Housing with Homes Victoria.
[3] A Machinery of Government change took place on 1 February 2021 creating the Department of Health and Department of Families, Fairness and Housing from the former Department of Health and Human Services (DHHS).

8. Marcia described Nigel's history of unsafe smoking habits, including discarding cigarette butts on the floor inside. She thought that his declining health impacted both the squalid conditions of the property and his careless discarding of cigarette butts.

THE CORONIAL INVESTIGATION

9. Nigel'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.

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

11. 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.

12. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Nigel's death. The Coronial 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.

13. This finding draws on the totality of the coronial investigation into the death of Nigel Raymond Willoughby 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.[4]

[4] 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.

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

Circumstances in which the death occurred

14. At around 6pm on 30 August 2020, a friend of Ashleigh's dropped him at home. They had planned to collect firewood the next morning and for the friend to come by again at 8am.

15. At some time during the evening, Ashleigh went to bed. At about 10:30pm, he awoke to smoke and called Triple Zero. On the call, Ashleigh could be heard breathing heavily and was only able to speak in short sentences before having to pause for breath. He stated that he was trapped in the house, the front door was locked, and that he could not find Nigel. He told the call-taker that the fire was in the loungeroom.

16. Ashleigh was transferred to the ambulance call-taker while waiting for emergency services to attend. After a few minutes, his breathing became more laboured, and he stopped responding to the call-taker.

17. Firefighters from various crews and stations attended and forcibly entered the property. They observed thick smoke engulfing the property and identified the living room as where most of the fire activity was confined to.

18. Firefighters were able to extinguish the fire and located Nigel unconscious and not breathing under the kitchen table in the dining room. He was removed from the property and treated by paramedics.

19. Firefighters continued to search for Ashleigh, who they found on top of his bed, unresponsive and not breathing. They removed him from the home and commenced CPR until paramedics took over. Unfortunately, Ashleigh was declared deceased at the scene.

20. Nigel remained unconscious and was conveyed to Latrobe Regional Hospital (**LRH**) by road ambulance with the intention of further transport by air to a larger centre. On arrival to LRH, Nigel was only responding with groans to painful stimuli and was otherwise unresponsive. Doctors sedated and intubated him in preparation for transfer.

21. Nigel arrived at the Alfred at 1:33am and was observed to have sustained significant full thickness burns to most of his body with evidence of airway burns. He had high fluid requirements but poor urine output and was referred to the respiratory team for bronchoscopy to further examine the airway burns.

22. Nigel had a CT scan which showed lung cancer with metastatic disease in the brain and an additional primary cancer in the bowel. Given the multiple malignancies with metastatic disease, the treating team did not think that active treatment of the burns was appropriate and instead referred him for palliative care.

23. Nigel died at 3:22pm on 2 September 2020.

Identity of the deceased

24. On 2 September 2020, Nigel Raymond Willoughby, born 2 March 1946, was visually identified by his daughter, Marcia Willoughby., who completed a Statement of Identification.

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

Medical cause of death

26. Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on the body of Nigel Willoughby on 9 September 2020. Dr Burke considered the Victoria Police Report of Death (Form 83), post mortem computed tomography (**CT**) scan and E-Medical Deposition Form from the Alfred and provided a written report of his findings dated 16 October 2020.

27. The autopsy confirmed airway burns and showed 50% mixed superficial and full thickness burns. It also showed a left upper lobe lung carcinoma with metastases to the brain and carcinoma of the transverse colon. Dr Burke opined that the bowel cancer was the primary lesion.

28. Toxicological analysis of ante mortem blood samples identified the presence of morphine, midazolam and lignocaine, which were administered by paramedics and clinicians as part of medical treatment.

29. Dr Burke provided an opinion that the medical cause of death was 1(a) COMPLICATIONS OF BURNS IN A FIRE.

FURTHER INVESTIGATIONS

30. The property was a single storey brick veneer dwelling with plasterboard interior walls and ceilings, timber flooring, carpet in most rooms and linoleum through the wet areas.

31. The internal layout comprised of a loungeroom across the south-east (front corner), a kitchen and meals area at the north-east (rear) corner, two bedrooms across the south-west corner and a third bedroom in the north-west corner. A laundry, toilet and bathroom were separate rooms along the northern side.

32. The home's gas heater had last been serviced on 6 September 2018, and a carbon monoxide detector installed. A new gas stove had been installed on 24 November 2019. The smoke alarm had last been serviced on 7 August 2009 and had been listed for replacement in 2020/2021.

Victoria Police

33. Forensic Officer George Xydias of the Victoria Police Fire and Explosion Unit attended the scene on 1 September 2020 to investigate the fire. He provided a statement detailing his findings.

34. Mr Xydias observed widespread moderate to light burning and/or associated heat effects across most rooms, but the fire appeared to have originated inside the loungeroom where the damage was quite heavy. The lounge had sustained significantly more damage than any other room, comprising moderate to severe charring to and/or partial consumption to several of the furnishings and fixtures. The most intense burning was across the north-western quarter.

35. Mr Xydias noted that the house was occupied and furnished, but most of the contents were haphazardly scattered throughout the premises. There was significant rubbish about, including numerous cans and bottles, wine casks, papers and cardboard and food wrappers. Many cigarette butts and several cigarette packets also littered the floor.

36. Mr Xydias observed the partly melted remains of a hard-wired smoke detector hanging from the ceiling in the central passageway outside the three bedrooms. He could not determine if it was functional, and there were no other smoke detectors fitted to the house.

37. Mr Xydias formed the belief that a single fire started in the vicinity of the armchair in the loungeroom. At this location, the furniture, carpet and other fixtures and small items were intensely burnt and/or largely consumed by the fire. In general, the extent of the damage to the remaining regions of the room decreased with distance from the presumed seat of the fire.

38. Mr Xydias opined that the cause of the fire was the ignition of the available combustible materials in this region, such as the armchair frame and inner/covering materials, the bed

clothes, papers, clothing, the carpet, and or/other items present in the vicinity. There was no indication of the presence of any flammable liquid.

39. In the circumstances, the source of ignition could not be definitively determined. However, Mr Xydias observed burn patterns to the armchair and surrounds which suggested careless smoking practices and formed an opinion that a carelessly discarded or dropped cigarette butt was the likely cause of the fire. Several smoking related items including cigarette butts, a cigarette packet and a lighter were located around the armchair.

40. Mr Xydias considered the contribution of the wall heater to the fire and noted that while it was an unlikely source of ignition, its operation would have assisted the spread of the fire from a smouldering cigarette (or similar).

Fire Rescue Victoria

41. Officers from Fire Rescue Victoria (**FRV**) also attended the scene on 1 September 2020 to investigate the fire. They subsequently completed a Fatality Fire Investigation Report.

42. Officers noted significant clutter and squalid living conditions, with discarded cigarette butts littered throughout the property including on the carpet. They classified the conditions as level 6 on the Clutter Image Rating Scale (**CIRS**).[5] Of concern, the amount of clutter blocked the path to the rear exit of the property and impeded the ability to escape. The clutter also likely added fuel to the fire. The report also identified an additional fire safety concern being that the front door was deadlocked with no key.

43. The report included, in an attachment, an investigation by Energy Safe Victoria (**ESV**) of the gas wall furnace and gas installation to the property. ESV found that while the gas wall furnace was in the vicinity of the point of origin, there was no evidence that it was involved as an ignition source. The gas pilot burner and gas control were operating at the time of the fire. It was not possible to determine if the fan was operating at the time of the fire. This could have aided the fire in the incipient stage by providing a supply of air.

44. FRV found that the smoke alarm had activated as a result of the fire.

45. FRV deemed the cause of the fire as accidental, from a discarded cigarette.

[5] The Clutter Image Rating Scale is a visual tool developed to help assess the severity of clutter in different areas of a home. It features a series of images ranked from 1 (least cluttered) to 9 (most cluttered). See for example: https://www.hoardingsqualormaroondah.org.au/wp-content/uploads/2016/12/clutter-image-rating-scale.pdf.

46. Geoff Kandoorp, Acting Manager of the FRV At Risk Groups team provided an accompanying prevention report. The prevention report outlined risk factors for the fire and provided recommendations to the Court.

47. Mr Kandoorp identified the following risk factors:

    i. Behavioural risks – unsafe smoking, alcohol use

    ii. Environmental risks – hoarding at level 6 of the CIRS throughout the premises including severe squalor, deadlocked door and blocked rear exit

    iii. Personal risks – person aged over 65 (Nigel), person aged over 45 (Ashleigh)

    iv. Other risks – gas heater

48. Mr Kandoorp suggested that the coroner consider the following recommendations:

    i. That the coroner maintains a watching brief on fire related deaths which occur as a result of an ignition caused by a cigarette;

    ii. That the coroner maintains a watching brief on deaths which occur in homes in which hoarding and/or squalor are identified; and

    iii. That the coroner recommends that the Victorian Government reconvene the Hoarding and Squalor Taskforce to:

        - Review and update the hoarding and squalor practical resource for service providers document; and

        - Explore how agencies across various sectors may be able to further coordinate their efforts to reduce risk for people affected by hoarding and/or squalor.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

1. Fire deaths in residential properties are unfortunately not a rare occurrence and are a significant public health issue. A 2019 report by the Bushfire and Natural Hazards

Cooperative Research Centre, Preventable residential fire fatalities: July 2003 to June 2017[6], identified that on average, more than one fire-related death occurs in a residential context every week in Australia.

2. Deaths from residential fires have wide ranges impacts – socially, economically and emotionally – on individuals, families, communities and the emergency services who respond.

3. In rental properties in Victoria specifically, 55 fire-related deaths were reported to the Court for the period of 1 January 2010 to 16 June 2025.

4. The Bushfire and Natural Hazards CRC report highlighted that the conceptualisation of fire fatality risk is complex, and it follows that so too is preventing it. The report noted that single risk factors alone are unlikely to significantly increase someone's risk of dying, but *it is the co-occurrence of a range of factors surrounding the person, their behaviours, their residential environment and other external factors that is likely to impact their overall level of risk of having a fire that results in their death.*

5. The report identified that the majority of preventable residential fire fatalities were found to be caused by human errors or unsafe behaviours. Preventable fires are defined as *fires where individuals, fire services or other stakeholders may have been able to identify the risks (related to a person and/ or a physical environment) and take actions or develop intervention strategies which, if applied, may have reduced the risk of a fire taking place.*

6. Nigel's case appears to me to fall within the above definition of a preventable fire fatality. Several risk factors contributing to his increased risk of dying in a fire, including living in hoarding and squalor and unsafe smoking practices in the home. I have kept these risk factors front of mind in considering the prevention opportunities that arise from his death.

7. I was assisted in my investigation and prevention role by Fire Rescue Victoria and the Country Fire Association, who I was grateful to meet with to discuss my investigation, and five other cases occurring in similar circumstances around the same time as Nigel's death. They provided me with important knowledge and insight and put forward recommendations for me to consider.

<u>Public/social housing</u>

[6] Coates, L et al. 2019, *Preventable residential fire fatalities in Australia: July 2003 to June 2017*, Bushfire and Natural Hazards CRC.

8. Of the 55 fire related deaths occurring in rental properties investigated by the Court, 18 occurred in properties owned by the Director of Housing, or Homes Victoria as it is now.

9. Homes Victoria owns considerable property. At December 2022, Homes Victoria owned approximately 72,300 properties, of which approximately 64,300 are used as public housing. Public housing properties owned by Homes Victoria are single dwellings (Class 1a), small and large rooming houses and crisis accommodation (Class 1b and 3(a)) and multi-storey dwellings (Class 2).[7]

10. The fact that someone lives in public/social housing is not necessarily a risk factor in and of itself. Moreso, the nature of public housing is that many of its residents have unique vulnerabilities and risk factors that may make them more at risk of a fatal residential fire than the general population.

11. The Final Report of the Victorian Government's Social Housing Regulation Review[8] acknowledged that social housing tenants represent a disproportionate share of victims in preventable house fires. It noted the following factors that can be attributed to the higher incidence of house fires in social housing:

    - Hoarding, recorded as an issue in around 8% of properties, which increases the fuel load available to any fire and assists fire to spread. It can also make escape difficult.

    - Chronic illness, mental and physical disability and old age, which can contribute to the starting of fires and can also make escape difficult.

12. Accordingly, Homes Victoria, or the Director of Housing as it then was, has a unique responsibility in considering their tenants' health, wellbeing and risk. As stated in the DHHS operational guidelines in force at the time of Nigel's death:

    As a Social Landlord the Director has an obligation to combine responsibilities for property management and tenant well-being. Some of the Social Landlord principles that are relevant for home visits and inspections are:

[7] Buildings are classified under the National Construction Code (NCC) 2022. See https://www.vba.vic.gov.au/building/regulatory-framework/building-classes.

[8] Engage Victoria, Social Housing Regulation Review, Final Report < file:///C:/Users/vicrv3r/Downloads/social-housing-regulation-review-final-report_f0bb.pdf>.

- *to actively visit tenants to consider the repairs or works needed so their properties are maintained to a reasonable standard*

- *where underlying causes for tenancy issues are understood or risks to a person's well-being are identified (for example during home visits), the best efforts are made to arrange referrals to relevant services*.[9]

13. Homes Victoria manages Capital Development guidelines for its own operations and on behalf of DFFH, which detail the policies, procedures and processes to manage the risk to life due to fire in its properties, including public housing. The Guidelines were developed in collaboration with fire authorities and jointly signed off and endorsed.

14. Guideline 7.8 requires the following fire safety inspections and testing:

All fire safety equipment must be inspected and tested:

- *Prior to the commencement of a new tenancy*

- *As part of any upgrade works*

- *Within 24 hours of a fault being reported*

- *At least once every five years*

Smoke alarms (dusting and testing) should be checked by tenants on a regular basis and should be a requirement included in the tenant agreement unless otherwise expressed.

For single dwellings owned by Homes Victoria, each property will be subject to a compliance check at least once every five years.

15. The smoke alarm in Nigel's home had not been serviced since 2009, which falls short of what was required. Despite this and fortunately, it was operational at the time of the fire.

16. Homes Victoria advised that all existing properties have been upgraded by installing mains powered smoke alarms complying with the applicable standard, AS3786-2014, and comprising of an inbuilt, non-removable rechargeable battery with an expected lifespan of 10

[9] Home Visits and Inspections in Public Housing Operational Guidelines, 1 January 2020. Available at <https://providers.dffh.vic.gov.au/home-visits-and-inspections-public-housing-operational-guidelines>

years. Tenants are unable to remove the battery from the device to stop it from working. This also reduces reliance on the tenant to regularly test smoke alarms.

17. Homes Victoria have advised that since Nigel's death[10], they have implemented several other measures to reduce the risk of fire related deaths in Homes Victoria-owned public housing properties, including:

- Developing a new Client Risk Assessment Form that Housing Officers can use for public housing tenants who are identified as posing a potential fire risk to themselves or need assistance to evacuate. The completed form is referred to the DFFH Fire Services Team who arrange for a fire risk assessment, to assess the required fire safety measures.

- Working with FRV and the CFA to develop fire safety brochures to warn renters of potential fire risks in their homes, including portable heaters and smoking.

- Regularly engaging with FVA, the CFA, Victoria Police, Institute of Engineers Australia and Victorian Public Tenants Association through the Public Housing Fire Safety and Arson Committee. These meetings are aimed at determining how Homes Victoria can improve fire safety in public housing and discuss any new policies and new fire safety issues that may be apparent in their properties.

- Retrofitting fire sprinklers and other fire safety measures to properties where it was assessed that renters were unable to physically evacuate in the event of a fire.

- Retrofitting fire sprinklers to the common corridors of high rise public housing towards (where units were already protected) and installing smoke lobbies in front of the lifts.

- Updating the standard specification for all new builds (including Class 1a properties) to prohibit the use of combustible aluminium composite panels and rendered Expanded Polystyrene on external walls.

- Developing a program to sprinkler protect all family violence refuges.

18. I am satisfied that Homes Victoria and DFFH are cognisant of the risks of fatal fire in their residential properties. I encourage them to continuously consider whether improvements can

[10] These measures were not implemented as a response to Nigel's death but rather occurred around the same time period.

be made to their policies and processes and housing stock to reduce the risk of a fatal fire in their properties, particularly for those tenants with vulnerabilities.

Hoarding and squalor

19. Hoarding is defined by the Department of Health as *..the persistent accumulation of and lack of ability to relinquish, large numbers of objects or living animals, resulting in extreme clutter in or around premises.* Hoarding was classified as a distinct disorder with its own diagnostic criteria in the 2013 edition of the Diagnostic and Statistical Manual published by the American Psychiatric Association (DSM-5).

20. Squalor describes an unsanitary living environment that has arisen from extreme/prolonged neglect and poses substantial health and safety risks to people living in the affected premises and their neighbours.

21. Hoarding significantly increases the risk of fire in the home because for several reasons:

    i. The accumulation of items increases both the opportunity for ignition of a fire, and the fuel load for any fire that does occur;

    ii. Accumulated items block exits and narrow pathways, inhibiting egress of occupants and access for firefighters; and

    iii. Accumulated items and lack of maintenance may lead to unsafe or non-functioning utilities and unorthodox and high fire risk practices related to cooking, heating, lighting and electrical use.

22. Fires in properties affected by hoarding also present an increased risk to firefighters responding:

    i. High fuel load means a faster developing fire;

    ii. Inhibited egress means the increased likelihood that a person may become trapped and require rescuing, which is an inherently risky activity; and

    iii. Rescues in the context of hoarding are undertaken in an environment where access is limited and where structural damage from fire, resulting in building collapse, is more likely.

23. The Metropolitan Fire Brigade (**MFB**) (as it was then known) first identified hoarding as an emerging trend in late 2007, following three fatal residential fires in Melbourne within a four-month period where hoarding and/or squalor were identified as common features. Since then, the MFB and now FRV have undertaken a range of activities seeking to understand the risk and prevalence of fires associated with hoarding, engage agencies with a shared interest in and broader responsibility for addressing the needs of affected people, and reduce the risks to firefighters responding to fires in properties affected by hoarding.

24. FRV has a current, significant programme of work aimed at addressing the issues associated with hoarding and squalor. For example, agencies and individuals are able to make referrals to FRV where an increased fire risk has been identified at a residential property due to hoarding and/or squalor. A member of the At Risk Groups Unit will then provide advice on how to reduce the fire risk in the home environment. They also provide practical advice to the community via their website.

25. The Victorian Government had previously convened a Hoarding and Squalor Taskforce (**HST**) whose role it was to establish a framework and publish a guide to assist in the coordination of services to address hoarding and squalor in residential settings. It sought to promote a multidisciplinary approach and coordination across service providers and experts to address the individual risks and needs of people affected by hoarding.

26. In 2013, the HST published a guide *Hoarding and squalor: a practical resource for service providers*. The guide provided resources for service providers and promoted best practices for responding to hoarding and squalor. To my knowledge the guide has not been updated since its inception in June 2013.

27. Effective treatment and risk reduction in hoarding and/or squalor situations is highly complex. It often requires a service coordination approach to support the affected person over a long period of time, with engagement across multiple agencies. In many situations people with hoarding behaviour or who live in a squalid environment are not receptive to receiving services into the home, due to possible embarrassment, the condition of the property, as well as an overwhelming sense of the living environment being out of control.

28. I consider that a body such as the Hoarding and Squalor Taskforce is best placed to develop and identify the appropriate responses to hoarding and squalor. I will make a recommendation that such a body be reconvened, and that the 2013 hoarding and squalor resource is updated.

Smoking

29. Smoking is a significant risk factor. The Bushfire and Natural Hazards CRC report identified that smokers are over-represented to a large extent in residential fire fatalities. For cases where the fire cause was known, 26.7% were caused by smoking materials and over a third related to smoking in bed.

30. Smoking and alcohol use are interconnected as risk factors – research from Victoria found that the odds of smoking materials being the cause of the fire were 4.4 times greater where the victim had consumed alcohol.[11]

31. It is difficult to envision how to reduce or prevent fire deaths associated with smoking as it involves human choice, behaviour and addiction.

32. I note that as of 2010, all cigarettes manufactured or imported into Australia must be reduced fire risk cigarettes, which are designed to self-extinguish if the smoker does not draw on them. While this was certainly a positive step, I am unsure the extent to which this has contributed to a reduction in fires, fatal and non-fatal. While there is limited data, the Bushfire and Natural Hazards CRC report suggested that they may not have had a significant impact in reducing the number of fatal fires caused by cigarettes. I also note the huge upshot in the prevalence of illegal tobacco in recent years – which I assume are not subject to the same standard as legal imports.

33. There is ample information available about safe smoking practices, including on the FRV website which suggests:

- If you can, smoke outside the home in a single location.
- If smoking occurs in the home, there should be a smoke alarm in every room.
- Never smoke in bed.
- Don't smoke when affected by alcohol, drugs or medications that may cause drowsiness.

[11] Bruck, D, et al. 2011, *Fire Fatality and Alcohol Intake: Analysis of Key Risk Factors,* Journal of Studies on Alcohol and Drugs, 72(5), pp 731 – 736.

- Use heavy, high-sided, non-combustible ashtrays to dispose of cigarette butts. Pour some water on the ash and butts to make sure they're out.

- "Stick it don't flick it" – never flick cigarette butts, either inside or outside.

- Never leave a lit cigarette unattended and butt out your cigarette before you walk away.

- Keep matches and cigarette lighters out of reach of children.

34. Evidenced by the presence of cigarette butts littering the ground at Nigel's home, people are not taking heed of such advice, and I would assume are even less likely to do so while also under the influence of alcohol.

35. I intend to make a recommendation to the Department of Health around the inclusion of fire warnings on cigarette packaging, so that the risk is front of mind. However, again, these would only apply to cigarettes legally sold in Australia.

Smoke alarms

36. Smoke alarms are arguably the most important fire safety device – they are reliable, inexpensive and are mandated by law to be present in residential properties. Although the smoke alarm at Nigel's home was operable, I still consider it important to comment on them.

37. The Bushfire and Natural Hazards CRC report noted that the risk of death in a residential fire is higher in homes which do not have a smoke alarm. The Australian and New Zealand National Council for fire and emergency services (AFAC) reported in 2005 that the absence of smoke alarms can increase the possibility of a fatal fire by 60%, and low-income households are least likely to have a smoke alarm installed.

38. In 37 of the fire-related deaths in rental properties investigated by the Court, information was known about the presence of smoke alarm in 37 deaths. In 19 of those 37 deaths, a smoke alarm was either not present or was inoperable.

39. All Victorian residential properties must have smoke alarms installed on every level. If the property was built before 1 August 1997, they must be battery powered. If the property was built or majorly renovated after that time, they must be hard wired and have a back-up battery. Properties constructed or majorly renovated after 1 May 2014 are required to have interconnected, hard wired smoke alarms and have a back-up battery.

40. In rental properties, section 68AA of the *Residential Tenancies Act 1997* (Vic) requires that:

> (2) A residential rental provider must ensure that any smoke alarm installed in rented premises is—
>
> (a) correctly installed and in working condition; and
>
> (b) fitted with batteries or replacement batteries; and
>
> (c) tested at least once every 12 months in accordance with any instructions by the manufacturer of the smoke alarm.

41. Tenants must notify the rental provider if a smoke alarm is faulty or not working, and they must not deactivate or remove a smoke alarm or interfere with its operation in any way.

42. FRV advised me that they believe there are gaps in the current legislative and technical frameworks, which have been in the same form for many years and reflect minimum requirements. They noted that other Australian jurisdictions have additional requirements around smoke alarms such as requiring smoke alarms in bedrooms, interconnected smoke alarms in all residential buildings, and compliance checks upon property sale.

43. FRV and the CFA suggest that smoke alarms must:

- Meet the applicable Australian Standard (AS3786-2014);
- Be less than 10 years old;
- Operate when tested; and
- Be interconnected with every other required smoke alarm within the dwelling so all activate together.

44. They suggest that smoke alarms be installed in every living area and bedroom, including hallways and stairways, and be required in any garage that is connected to a building.

45. Of course, the utility of a smoke alarm relies on it being operable, which is not the case where the alarm has been tampered with or removed by the resident. FRV and the CFA have suggested measures that make removing or tampering with the smoke alarm more difficult, including flush mounting the alarm to the ceiling, the installation of damage stoppers over the alarm, and the use of 10-year batteries that are unable to be removed.

46. I will make a recommendation that the Victorian Government consult with FRV and the CFA to improve smoke alarm requirements.

Fire sprinklers

47. I consider improved smoke alarm requirements to be a significant prevention opportunity to reduce the risk of deaths in residential fires. However, the risk certainly still exists, particularly where the resident tampers with that smoke alarm or has other risk factors impeding on their ability to escape the fire, such as mobility issues or hoarding blocking egress.

48. In such cases, home fire sprinklers appear to be an obvious infrastructure improvement that may reduce fatalities, by allowing occupants extra time to escape or be rescued.

49. Fire sprinklers control the spread of fire significantly by reducing its size and damage but also have a positive environmental impact by reducing the size and amount of combustible material consumed by the fire, subsequently reducing the carbons and toxic gases released.

50. The evidence is clear that fire sprinklers save lives. According to a 2020 study by the US National Fire Protection Association that examined structure fires between 2017 and 2021, civilian death and injury rates in home structure fires were sprinklers were present were 89% and 31% lower, respectively, than in home structure fires with no sprinklers.[12]

51. The issue of fire sprinklers in residential buildings has previously been identified and discussed by Victorian coroners.

52. In November 2022, Coroner Simon McGregor handed down his finding into the death of DVR[13], a young boy who died at the Royal Children's Hospital from smoke inhalation from a fire at his apartment, owned by DFFH. Coroner McGregor made three recommendations, including, relevantly:

I recommend that the Department of Families, Fairness, and Housing (DFFH) consult with relevant organisations and conduct a feasibility study into whether fire sprinkler systems could be installed in all current (and future) public housing premises.

[12] McGree, T. 2024, *US Experience with Sprinklers*, National Fire Protection Association. Available at <https://homefiresprinklers.org.au/wp-content/uploads/2025/04/ossprinklers.pdf>.
[13] COR 2020 004470.

53. DFFH advised the Court that it supported the recommendation and agreed to work closely with relevant organisations to investigate whether it is feasible to install fire sprinklers in all current and future public housing properties.

54. In 2023, Coroner John Olle made a recommendation to the Australian Building Codes Board, which produces and maintains the National Construction Code:

I recommend that the Australian Building Codes Board commence consultation with other appropriate organisations to consider whether there is a strong rationale to amend the National Construction Code 2019 to require all new residential buildings, regardless of storeys or height, to have fire sprinkler systems installed to significantly reduce the risks and consequences from fire.

55. The Australian Building Codes Board replied to the recommendation, stating:

The [Australian Building Codes Board] recently commenced a process of stakeholder and community consultation on the opportunities and challenges related to new buildings in Australia. We have included a topic on Sprinklers, with a particular focus on home sprinklers, within that dialogue and we will work with relevant stakeholders and organisations to consider options.

56. Fire sprinklers are currently mandated in Class 2 and 3 buildings with a rise of four or more storeys, but not required in Class 1a dwellings[14], as was Nigel's home, and 1b dwellings[15].

57. FRV and the CFA have been advocating for home fire sprinklers, particularly in social housing, and have worked with the Home Fire Sprinkler Coalition Australia (**HFSCA**), the leading national resource for independent, non-commercial information about home fire sprinklers.

58. In doing so, FRV, the CFA and the HFSCA have identified barriers to the cost-effective installation of home fire sprinklers, including:

[14] A single dwelling being a detached house; or one of a group of attached dwellings being a town house, row house or the like.

[15] A boarding house, guest house or hostel that has a floor area less than 300 m^2 and ordinarily has less than 12 people living in it.

- Water pipes and meters to a residential property are generally 20mm in diameter. Home fire sprinklers require a 25mm diameter pipe and meter to be effective. Water authorities do not have policies that support the installation of home fire sprinklers.

- A lack of clarity as to who can design, install and certify home fire sprinklers.

59. I intend to make recommendations aimed at addressing these barriers. I also support the recommendations made by my colleagues. I encourage DFFH to install fire sprinklers in its properties where feasible, and for the Australian Building Codes Board to consider expanding the requirements for fire sprinklers to other classes of buildings in the next edition of the National Construction Code, expected to be released in 2028.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

i. With the aim of preventing like deaths and promoting public health and safety, I recommend that that the Department of Families, Fairness and Housing consider reconvening the Hoarding and Squalor Taskforce with the aim of promoting best practice and inter-agency responses to hoarding and squalor.

ii. With the aim of preventing like deaths and promoting public health and safety, I recommend that the Department of Families, Fairness and Housing update and reissue the 2013 publication *Hoarding and squalor: a practical resource for service providers* or compile a similar publication for service providers.

iii. With the aim of preventing like deaths and promoting public health and safety, I recommend that the Victorian Government consult with Fire Rescue Victoria and the Country Fire Authority to introduce improvements to the smoke alarm requirements within the Victorian Building Regulations.

iv. With the aim of preventing like deaths and promoting public health and safety, I recommend that the Victorian Government consult with Fire Rescue Victoria and the Country Fire Authority to introduce an auditable regulatory compliance inspection process for domestic smoke alarms as part of the sale of residential property.

v. With the aim of preventing like deaths and promoting public health and safety, I recommend that the Victorian Building Authority publishes guidance to clarify who can design, install and certify home fire sprinklers to the FPAA101D specification.

vi. With the aim of preventing like deaths and promoting public health and safety, I recommend that the Department of Energy, Environment and Climate Action work with Victorian water authorities to develop policies that streamline the approval process to allow for the cost-effective installation of water meters that meet the pressure and flow requirements for home fire sprinklers to be installed.

vii. With the aim of preventing like deaths and promoting public health and safety, I recommend that the Department of Transport and Planning and the Australian Building Codes Board conduct research (either jointly or individually) in consultation with Fire Rescue Victoria, the Country Fire Authority and the Home Fire Sprinkler Coalition Australia into adopting home fire sprinklers to the FPAA101D technical specification within the National Construction Code (NCC), where not currently required under the NCC.

viii. With the aim of preventing like deaths and promoting public health and safety, I recommend that the Australian Government Department of Health, Disability and Ageing consider whether warnings about the risk of fire/and or burns should be included as part of the mandatory health warnings on cigarette packaging.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Nigel Raymond Willoughby, born 2 March 1946;

    b) the death occurred on 2 September 2020 at the Alfred, 55 Commercial Road, Melbourne, Victoria 3004;

    c) I accept and adopt the medical cause of death ascribed by Dr Michael Burke and I find that Nigel Raymond Willoughby died from complications of burns sustained in a fire;

2. AND, having regard to the available evidence, including that provided by Victoria Police and Fire Rescue Victoria, I find that the residential fire causing Nigel Raymond Willoughby's death was caused by an improperly extinguished/discarded cigarette setting alight an armchair, in circumstances where hoarding and clutter and a deadlocked front door may have prevented his swift egress.

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

Pursuant to section 73(1A) 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:

Marcia Willoughby, Senior Next of Kin

Department of Families, Fairness and Housing

Victorian Building Authority

Consumer Affairs Victoria

Department of Energy, Environment and Climate Action

Department of Transport and Planning

Department of Health, Disability and Ageing

Australian Building Codes Board

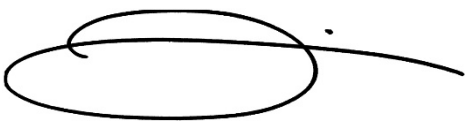
Fire Rescue Victoria

Country Fire Authority

Home Fire Sprinkler Coalition Australia

Sergeant Michael McNamara, Coronial Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 3 March 2026

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.