IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 000829

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	Simon Peter Scarff
Date of birth:	29 May 1969
Date of death:	12 February 2022
Cause of death:	1(a) EFFECTS OF FIRE
Place of death:	1/13 Almurta Street, Alfredton, Victoria, 3350

INTRODUCTION

1. On 12 February 2022, Simon Peter Scarff was 52 years old when he died during a fire in the single storey unit where he lived alone at 1/13 Almurta Street, Alfredton, Victoria.

THE CORONIAL INVESTIGATION

2. Mr Scarff'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.

3. 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.

4. 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.

5. Victoria Police assigned Detective Senior Constable Scott Gordon (**DSC Gordon**) to be the Coroner's Investigator for the investigation of Mr Scarff's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family members, neighbours, Mr Scarff's support worker, the forensic pathologist, and forensic investigators – and submitted a coronial brief of evidence.

6. This finding draws on the totality of the coronial investigation into the death of Simon Peter Scarff 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.[1]

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[1] 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

7. On Saturday, 12 February 2022, at 6:21am an Emergency Services Telecommunications Authority (**ESTA**) police call taker (**PCT-1**) answered a 000 call from Mr Scarff. PCT-1 initiated a 'police event' into the Computer Aided Dispatch system. The event was coded as '573-P-EME-SAR WELFARE CHECK' and assigned a 'Priority 2', the default priority for this event.

8. PCT-1 asked numerous questions of Mr Scarff applying the structured call taking process. PCT-1 managed the call for 2 minutes and 48 seconds but was not able to obtain any response from Mr Scarff in respect of either the nature of the incident or the caller's location. During this part of the call Mr Scarff yelled, '*I can't get out*' and repeated this. He sounded highly distressed with laboured breathing.

9. PCT-1 accessed Caller Line Identification (**CLI**) information which provided the billing address for Mr Scarff's mobile phone as a location in Victoria Street, Sebastopol. PCT-1 also utilised Advanced Mobile Location (**AML**), a facility that uses GPS, WiFi or mobile phone towers to triangulate the location of a mobile phone within a radius of approximately 42 metres. The AML inquiry result returned a GPS location[2] outside 13 Almurta St, Alfredton.

10. At 6:24:16am PCT-1 telephoned Sgt Pickersgill, the Police Communications Liaison Officer (**PCLO**) for guidance. PCT-1 informed him that it had not been possible to obtain the caller's location or additional details but they were still trying to do so. Sgt Pickersgill took over the call from PCT-1 and subsequently made the following note: '*attempted to speak to male who let out a scream every now and then but no answer or response to questions. Unable to get location. AML putting him in Victoria Park*'. At 6:28:40am Sgt Pickersgill ended the telephone call after making the determination not to dispatch any emergency services.

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[2] +143.8059, -37.55151

11. At 6:32:18am a member of the public called 000 to report a house fire at Mr Scarff's location at 1/13 Almurta St, Alfredton (**the premises**). An ESTA fire services call taker took the call and subsequently a multi-agency response was initiated involving Victoria Police, Ambulance Victoria and Fire Rescue Victoria (**FRV**). While still enroute, an FRV unit advised Firecom[3] that smoke was visible. Responding units were subsequently informed that a call had been received by ESTA, possibly from the occupant, informing them they were trapped inside the premises.

12. When emergency services arrived, the front room (the loungeroom) of Unit 1 was well alight as was a vehicle that was parked just outside the front door. The fire had breached the roof in a central location in the front room and flames were also coming out of the northern and eastern side windows. Initially, firefighters could not access the front door due to flames issuing from a nearby window and the proximity of the vehicle. By 6:43am the fire was sufficiently under control for firefighters to approach the front door. They soon located Mr Scarff's body behind it.

13. FRV crews extinguished the fire and endeavoured to protect the area around Mr Scarff. There was a brick wall separating each unit that also separated the roof space – this prevented the fire from spreading in the roof space to other units. The premises were declared a crime scene and control was handed over to Victoria Police.

14. Later the same day, the scene was examined by Forensic Officer Laura Noonan of Victoria Police, Forensic Services Department and Commander Anthony Pearce and Station Officers Ewan Glassey and Damian O'Toole, FRV fire investigators.

Cause and origin of the fire

15. Sonny Watts was Mr Scarff's support worker from Mind @ Home who were engaged via the NDIS[4] to assist Mr Scarff. Mr Watts had worked with Mr Scarff for the preceding two years, visiting the premises for two hours, twice per week. Mr Watts stated:

    a) At times when he visited, Mr Scarff would be intoxicated. Mr Scarff would have been drinking all day before and all night and, on occasions, Mr Watts would clean up the empty bottles laying on the ground. 'When Si was drinking it was usually for several days. He wouldn't sleep much during this time but would "crash" at

[3] The Fire Rescue Victoria communications centre.
[4] National Disability Insurance Scheme

the end of any bender that he may have'. However, Mr Scarff was very respectful and adhered to the restriction that he was not permitted to drink whilst support workers were there.

b) Mr Scarff was 'a big man, about 6' 4" and 170kg' and he 'lacked motivation and it would take a lot of effort for him to get off the couch and get active'.

c) Although the premises had two bedrooms, Mr Scarff would always sleep on the couch in the loungeroom. He would sleep with his head at the southern end of the couch near the front door. He would usually be able to unlock the front door without getting off the couch by simply reaching over and unlocking it.

d) The main bedroom contained some items but the spare bedroom was full of clothes and mattresses which Mr Scarff refused to get rid of. Mr Scarff was 'a hoarder and he found it difficult to clean up'.

e) Mr Scarff smoked cigarettes and would only smoke when he was drinking.

f) Mr Watts was not sure if there was a smoke alarm fitted inside the unit.

g) Mr Scarff had several power boards plugged in and would have a lot of devices plugged in.

16. The key evidence of Forensic Officer Laura Noonan (Victoria Police Fire Investigator) may be summarised as follows:

a) The front door opened from the southern end of the verandah directly into the loungeroom. The unit was occupied, fully furnished, and appeared to be in a cluttered state. In the loungeroom there were couches on the eastern and western sides of the room, with a coffee table in the middle, and an entertainment unit across the northeastern corner. On the floor in the loungeroom, beside the coffee table, was a metal cigarette rolling machine.

b) The front door had been closed at the time of the fire. The handle lock was unlocked, but a small bolt-lock which was situated higher up on the door, was locked. There was no damage to any external doors or windows suggestive of forced entry and there was no graffiti, vandalism or evidence of ransacking within the premises.

c) There was a power point behind the entertainment unit, in the northeastern corner of the loungeroom, along with a power board. Both the power point and the power board were heavily heat affected, and it was not clear if the power board had been plugged in, or if there were any appliances connected to it; however, the television was presumably plugged into the power board or the power point prior to the fire.

d) A second power point was located on the southern wall, on the western side of the heater. A power board was connected to this power point, which had the heater, the fan, and a second power board plugged in. The second power board was located on the floor between the coffee table and the eastern couch and had a phone charger (or similar item) and a third power board was connected. The third power board was on the floor between the entertainment unit and the western couch and had a charger (or similar type of item) plugged in. Throughout the middle of the room, close to the power boards, were a lamp, a laptop computer, a monitor, and distilling equipment. Due to the extent of fire damage, it was not clear if these appliances had been connected to power at the time of the fire, but many of the broken/heat affected leads led to the area of a power board.

e) The most significant fire damage in the lounge room was at the northern end of the room, around the couch and the entertainment unit. The pattern of burning to the furniture and structural timbers indicated that the fire had originated in this area.

f) There were no other separate areas of ignition and there was nothing to suggest the involvement of flammable liquid.

g) Mr Scarff was located on the floor in the southeastern corner of the loungeroom, inside the front door. He was on his back, angled across the corner of the room, with his head against the eastern wall and his lower left leg against the southern wall. Located on the floor between his left arm and torso were the remains of two large glass bottles and a torch.

h) The carpet beneath Mr Scarff's body was not burnt, indicating that he had fallen to the floor in the relatively early stages of the fire. He had also been covered with fallen plaster, burnt roof timbers and tiles.

i) The position in which Mr Scarff was found, along with the torch on the floor beside him, raised the possibility that he had been trying to escape the fire by the front door, before being overcome by smoke and collapsing.

j) There was no smoke detector located inside the unit, nor were there any reports of an alarm sounding at the time of the fire.

k) The cause of the fire was the ignition of combustible materials in the loungeroom, including the western couch and surrounding fittings and furniture.

l) The source of ignition was not determined, however the following possibilities were considered:

i. Direct ignition by a match or cigarette lighter – although this was considered unlikely;

ii. A smoldering cigarette;

iii. An electrical fault, close contact, and/or radiant heat related to an appliance. There were three power boards 'piggy backed' to the one outlet with numerous appliances connected which raised the possibility of a power board being overloaded and/or an electrical fault occurring.

iv. Distilling equipment located between the western couch and the entertainment unit. The boiler was close to the couch and to the curtains covering the northern window. If the boiler was operating at the time of the fire, either the couch or the curtain being close to, or in contact with the boiler, was then considered to be the most likely source of ignition.

Assessment of response to Mr Scarff's call to 000

17. The audio recording of the call to 000 reveals that both PCT-1 and Sgt Pickersgill were unable to get any further response from Mr Scarff after he yelled, 'I can't get out'. PCT-1 stayed on the call with Mr Scarff for 5 minutes 12 seconds but could not elicit anything. PCT-1 repeatedly tried to get a response from Mr Scarff by asking simple and appropriate questions and then sought the assistance of Sgt Pickersgill in a timely manner. I am satisfied that PCT-1 managed the call appropriately.

18. At the time of Mr Scarff's death, ESTA used the following systems to determine the location of origin of a call to 000:

    a) *Four step verification process* – the purpose of which is to extract as much information as possible from the caller including asking the caller for the street or road name, number, and suburb, intersection, nearest cross streets.

    b) *Advanced Mobile Location (AML)* – AML uses GPS, WiFi or mobile phone towers to triangulate a caller's location, providing an estimated location for a call within a radius of approximately 42 metres. AML data is automatically generated and appears on a police call taker's CAD screen as soon as a call is answered.

    c) *Caller Line Identification (CLI)* – provides an ESTA call taker with information regarding the telephone from which the call is being made. If the call originates from a mobile phone, only information available is the billing address of the account holder.

19. In the circumstances of Mr Scarff's call to 000, the 'four step verification process' could not establish anything meaningful.

20. The second facility, *Caller Line Identification* returned the billing address for Mr Scarff's mobile phone, which was an address in Victoria Street, Sebastopol. This appears to be the address of Mr Scarff's former partner and is approximately 6 km from Mr Scarff's premises.

21. The third facility, *Advanced Mobile Location (AML)*, generated a GPS location outside 13 Almurta Street, Alfredton.

22. However, ESTA placed a caveat on the utility of a GPS location generated by AML. An ESTA Quality Improvement Investigator stated:

    > [AML] *provides an estimated location for a call within a radius of approximately 42 metres around the originating location of the call. This information is, however, not precise enough to enable a police call taker to dispatch a police unit, particularly where the circumstances surrounding the call are unknown. For instance, if a caller states there is a fire, the AML data alone may be sufficient to dispatch FRV because on arrival to the identified area, the crew would likely be able to see smoke or flames to pinpoint the caller location. Similarly, if a caller reports a motor vehicle accident, the event is likely to be obvious to police officers dispatched to the area*'.

23. The recording of the 000 call reveals that the word '*fire*' was not mentioned and there is no sound of a smoke alarm. ESTA submits 'this information was not precise enough to dispatch a police unit as the reason for Mr Scarff's call was not clear. Mr Scarff stated that he was "trapped"; however, this may have referenced any number of possible scenarios'.

24. Sergeant Pickersgill stated:

> *I could not hear any background noise and only heard the male yell twice. At no time during the call was there mention of a fire or why the caller was distressed … … this call was similar to many we receive where there is no response from the caller, they vary from hoax callers to mobile phones in pockets accidently dialling or drop out due to poor mobile reception … … with the information I had I was unable to dispatch units as they would be looking for an unknown male with an unknown situation*.

25. It is important to analyse the response to the 000 call with an awareness of the potential for hindsight bias. Listening to the 000 call now evokes a terrible picture in one's imagination because the tragic outcome is known in all its detail. However, for PCT-1 and Sgt Pickersgill, the 000 call was heard in isolation. I am satisfied that Sgt Pickersgill has genuinely described the character of the call, as he perceived it at the time.

26. I am satisfied that Sgt Pickersgill also managed the 000 call appropriately. Despite his efforts, he was unable to ascertain the nature of the incident or Mr Scarff's location. In those circumstances, it was a reasonable decision not to dispatch police or other emergency services to the location generated by AML.

Assessment of the presence or absence of a smoke alarm

27. Two questions concerning smoke alarms arise: firstly, was a smoke alarm (either hard-wired or battery operated) installed at the premises and, if so, was the smoke alarm operable.

28. As part of the coronial investigation, advice was sought from the Victorian Building Authority concerning Part 9 of the *Building Regulations 2018*. The building permit for the four units was approved by the Shire of Ballarat on 22 January 1977.[5] The requirements for smoke alarms for unrenovated residential buildings of this age are: 'a self-contained smoke alarm[6] complying with AS 3786-1993 … … in each dwelling or sole-occupancy unit (which is or forms part of a building to which this regulation applies) in appropriate locations on or near the ceiling of every storey of the dwelling or sole-occupancy unit'. The Victorian Building Authority further advised that 'as at 12 February 2022, regulation 145(4) of the *Building Regulations 2018* imposed the compliance obligation upon the owner (as defined in regulation 144) of the building'.

29. In the audio recording of Mr Scarff's call to 000 there is no sound of a smoke alarm. Mr Watts could not recall from his visits to the premises whether a smoke alarm was fitted.

30. Mr Scarff's lease of the premises commenced on 20 December 2019 and documents associated with the lease refer to smoke alarms. Adrian Faulkner of Ballarat Real Estate completed an Entry Condition Report dated 17 December 2019. He referred to the inspection and report in a statement in which he recalled, 'the inspection by me would have been done within the previous 24 hours. During my inspection I took a series of photographs of the unit and detailed what was clean, undamaged and working'. In respect of the presence of a smoke alarm, Mr Faulker stated, 'I can't say yes or no as to whether one was fitted because I can't recall, however I have crossed the box within the report stating that one was fitted, so I think I would have sighted one'.

31. The Entry Condition Report is unsigned by Mr Scarff.

32. Within the report under 'Information regarding safety' the following appears:

Information regarding safety

The rental provider must keep records of gas and electrical safety checks. The rental provider must provide records of the gas and electrical safety checks on request by the renter.

Date of last smoke alarm test   /   /

[5] Certificate of Occupancy was issued 21 December 1982

[6] The requirement did not, at that time, require smoke alarms to be hard wired to the mains electrical supply.

33. The Entry Condition Report also contains the following:

Insert Y/√= Yes; Insert N/X = No	Clean	Undamaged	Working	Renter Agrees	
General					
Smoke alarms					Fitted

34. The estate agent's file relating to lease of the premises reveals photographs were taken at various inspections, however there is no smoke alarm visible in any of the photographs. The inspections were:

    a) 25 November 2019 – 15 photographs;

    b) 17 December 2019 (pre-entry prior inspection for Mr Scarff's lease) – 58 photographs;

    c) 30 June 2020 (routine inspection) – 5 photographs;

    d) 11 January 2021 (routine inspection) – 12 photographs; and

    e) 16 November 2021 (routine inspection) – 7 photographs.

35. Notwithstanding the caution that 'an absence of evidence is not necessarily evidence of absence' – the absence of a smoke detector in any of the photographs is significant. Numerous images show areas of the ceiling in the bedrooms and loungeroom and it is unlikely that a smoke detector, if present, would not be captured in one or more of these images.

36. The Entry Condition Report does not meaningfully support any contention that a smoke alarm was installed. The following features of the document are problematic:

    (a) The typed reference to 'Fitted' has been included next to 'Smoke alarms' but there are no corresponding indications of 'Y' or 'N' which are clearly intended to record whether the smoke alarm is 'clean', 'undamaged', 'working' or whether the 'renter agrees'. Entries of 'Y' or 'N' have been made for 'clean' and 'undamaged' with respect to many other items the subject of inspection.

(b) The report has been prepared with the bulk of the entries typed in. However, the date of the report (pages 2 and 10) has been handwritten. This suggests that the typed information was not entered at the same time the date was included.

(c) Whilst Mr Faulkner has initialled and signed the report, Mr Scarff has not done so. This is despite the typed inclusion of Mr Scarff's name in anticipation of his signature and the report clearly having been designed for him to sign or initial every page.

(d) Under the heading, 'Information regarding safety' is a field for the date of the last smoke alarm test, but this has been left blank.

37. These features render the Entry Condition Report a document of little weight to support the contention that a smoke alarm was fitted.

38. Ryan Ballard, the FRV Firefighter who was first to arrive at the fire, did not mention the sound of a smoke alarm in his initial observations. He stated, 'the car horn was sounding intermittently, and I could not hear much else besides the car horn and the sounds of the fire activity'.

39. Laura Noonan, Victoria Police Fire Investigator stated, 'there was no smoke detector located inside the unit, nor were there reports of an alarm sounding at the time of the fire'. In a supplementary statement, Ms Noonan provided further detail:

> *'During my scene examination, which was conducted on Saturday 12 February 2022, with respect to the presence of a smoke detector, I noted that there was no evidence of a smoke detector on the ceiling, with no obvious wire present in the areas where I would typically expect a smoke detector to have been installed. The plasterboard ceilings had largely collapsed throughout the unit, and the floor was cleared of the fallen plasterboard and roof tiles in the areas where I would expect a smoke detector to be located. There were no remains of a smoke detector located on the floor. I did not see a smoke detector on a shelf or bench when examining other areas of the unit, but cupboards and drawers that were not directly related to the fire were not inspected. I cannot positively state that there was not a smoke detector in the unit; however, I am confident that there was not a working smoke alarm installed correctly in the unit prior to the fire*.

40. On 8 September 2023 a portion of these findings, in draft, was sent to the owner of the premises, Peter Dawes. The relevant section of the draft finding concerned the question whether a smoke alarm was in the premises at the time of the fire. On 11 October 2023, Mr Dawes sent an email to the court in response, together with four photographs. Also attached to the email was a letter from the general manager of Ballarat Real Estate Pty Ltd (the managing agents for the property) addressed to Mr Dawes dated 17 October 2023 (**Ballarat Real Estate letter**).

41. Mr Dawes stated in his email:

> *… I visually sighted and tested all smoke alarms in each of the four (4) units after purchase.*
>
> *And directly following the fire in the first unit on the 12/2/2022, I visually sighted smoke alarms in the remaining three (3) units.*
>
> *(Photos attached)*
>
> *To this day smoke alarms are evident in the remaining three units. (3) …*

42. One of Mr Dawes' photos shows what is, presumably, debris from the scene of the fire and part of the distilling equipment or 'boiler' referred to in the report of Forensic Officer Noonan[7] (**PD photo 1**).[8] The other three photos show a smoke alarm attached to the ceiling near what appears to be a bedroom (**PD photos 2, 3, 4**).[9] It is not clear whether PD photos 2, 3 and 4 are meant to show a smoke alarm in each of the other three units or the one smoke alarm photographed three times. A close examination of these photos favours the latter proposition.

43. Mr Dawes does not say when the photos were taken or who took them. However, if his email was intended to convey that PD photos 2, 3 and 4 were taken on or shortly after 12 February 2022, I do not accept that to be the case. The file names attached to each of PD photos 2, 3 and 4 suggest they were taken on 27 September 2023 – with the first eight digits of each file name appearing as the date in reverse order (year, month, day).

[7] See sub-paragraphs 16(d) and (l)(iv)
[8] IMG_20231011_100756.jpg
[9] Respectively: 20230927_160727.jpg; 20230927_160732.jpg; and 20230927_1608801.jpg

44. Moreover, on 16 December 2022, DSC Gordon advised the court as follows:

> *I attended 13 Almurta Street, Alfredton this morning to assess the remaining units for smoke alarms.*
>
> *There was no sign of any smoke alarm in unit 2 (or indication of any previous smoke alarm). Unit 3 appeared to have had a smoke alarm previously. Connecter* [sic] *was attached to ceiling. Unit 4 was fitted with smoke alarm. …*

45. DSC Gordon also took a series of photos showing no smoke alarms on the ceiling of the kitchen/living areas of Units 2 and 3. Photos of Unit 4 show a single smoke alarm on the ceiling in the short hallway to a bedroom – this appears very similar to the smoke alarm depicted in PD photos 2, 3 and 4.

46. I accept the evidence of DSC Gordon. Notwithstanding the statement by Mr Dawes that 'directly following the fire' he 'visually sighted smoke alarms in the remaining three (3) units', by 16 December 2022 smoke alarms were absent from Units 2 and 3.

47. Having considered all available evidence, I am satisfied there was no smoke alarm installed in the premises (Unit 1) at the time of the fire. Even if a smoke alarm was installed, which I consider most unlikely, the recording of the 000 call and the evidence of Leading Firefighter Ballard would compel a conclusion that it was not operating at the time.

Smoke Alarms within Rental Premises and recent Legislative Change

48. Regrettably the issue of smoke alarms in rental properties, and related issues surrounding their operation, maintenance and repair, have been the subject of multiple coronial findings and recommendations.[10]

49. There have however been significant statutory changes following the introduction of the *Residential Tenancies Amendment Act 2018* and *Residential Tenancies Regulations 2021.*

[10] For example, the Finding into the deaths of Sunil Patel, Jignesh Sadhu and Deepak Prajapati per Coroner White on 29 August 2014 in respect of the death of three people in a house fire in Footscray (COR 2008 0041-43); the Finding into the deaths of DQ and LQ per by Coroner Carlin on 29 May 2019 in respect of the death of two infants in a house near Geelong (COR 2018 4614).

50. The *Residential Tenancies Amendment Act 2018* was passed by the Victorian Parliament on 7 September 2018 and implemented more than 130 changes in respect of residential tenancy agreements. Whilst some of these reforms were introduced in stages beginning in April 2019, for the purposes of this Finding, the relevant amendments commenced on 29 March 2021.

51. As part of the coronial investigation, advice was sought from the Department of Government Services in respect of these legislative amendments.

52. In respect of smoke alarms, the significant changes are at s.27C(2) *Residential Tenancies Amendment Act 2018* (and now incorporated in the *Residential Tenancies Act 1997*). A residential rental agreement in the standard form may include a prescribed term setting out *safety-related activities* to be completed by the residential rental provider and the renter during the term of the agreement.

53. Regulation 13 of the *Residential Tenancies Regulations 2021* states that, for the purposes of s.27C(2) of the Act, the prescribed terms are in Schedule 3:

3 Smoke alarm safety activities

(1) The residential rental provider must ensure that—

(a) each smoke alarm is correctly installed and in working condition; and

(b) each smoke alarm is tested according to the manufacturer's instructions at least once every 12 months; and

(c) the batteries in each smoke alarm are replaced as required.

(2) The residential rental provider must immediately arrange for a smoke alarm to be repaired or replaced as an urgent repair if they are notified by the renter that it is not in working order.

Note

Repair or replacement of a hard-wired smoke alarm must be undertaken by a suitably qualified person.

(3) The residential rental provider, on or before the commencement of the residential rental agreement, must provide the renter with the following information in writing—

(a) information about how each smoke alarm in the rented premises operates;

(b) information about how to test each smoke alarm in the rented premises;

(c) information about the renter's obligations to not tamper with any smoke alarms and to report if a smoke alarm in the rented premises is not in working order.

(4) The renter must give written notice to the residential rental provider as soon as practicable after becoming aware that a smoke alarm in the rented premises is not in working order.

Note

Regulations made under the **Building Act 1993** require smoke alarms to be installed in all residential buildings.

54. However, these amendments do not apply retrospectively to existing rental agreements entered before 29 March 2021, or any fixed term agreement of less than 5 years that rolls over to a periodic agreement on or after 29 March 2021.

55. Mr Scarff's lease was initially for a fixed term of 12 months commencing on 20 December 2019 and ending on 19 December 2020. On 20 December 2020 the lease converted to a periodic tenancy (month-by-month).

56. The Department of Government Services confirmed that Clause 16(3) of Division 5 of Schedule 1 of the *Residential Tenancies Act 1997* provides, *inter alia*, that s.27C, as inserted by the *Residential Tenancies Amendment Act 2018* does not apply to a periodic lease that commenced before applicable amendment. Accordingly, the new provisions concerning smoke alarms did not apply to Mr Scarff's lease.

57. Had Mr Scarff's lease been subject to the amended legislative framework, the residential rental provider (real estate agent) would be required to ensure that: each smoke alarm was correctly installed and in working condition; each smoke alarm was tested according to the manufacturer's instructions at least once every 12 months; and the batteries in each smoke alarm were replaced as required.

58. A response was sought from the Department of Government Services as to whether it knew the number of existing rental agreements that fell within the transitional arrangements and were not subject to the new requirements concerning smoke alarms. Using data provided by the Residential Tenancies Bond Authority (active bonds), as at 5 July 2023, 43.5%[11] of existing rental agreements were not required to comply with the new smoke alarm safety related requirements.

[11] 321,105 of 738,414 rental agreements

59. As existing leases expire and new leases are entered, this percentage will diminish. Although, there is insufficient information available to say how quickly this is likely to occur. The Court inquired with the Department of Government Services to understand the rationale for the legislative changes not being made to apply retrospectively to existing leases. Unfortunately, the response from Department of Government Services[12] was not particularly illuminating. Aside from explaining the new requirements and the effect of the transitional provisions of the *Residential Tenancies Amendment Act 2018,* it advised:

> *The agreed rationale applying to the package of reforms to the RTA carried out by the Residential Tenancies Amendment Act 2018, was that the reforms would not apply to retrospectively vary the terms of residential rental agreements entered into prior to the commencement date of the relevant reforms. …*

60. I can only presume from this response that the imposition of new requirements affecting the terms of existing leases was thought to be, legislatively, too problematic. However, it is difficult to imagine that any legislative challenges connected with retrospective application are insurmountable.

61. A proportion of the Victorian population will be long term or lifetime renters and a percentage of those people will, after having secured a rental property, remain there for a lengthy period, well after their initial lease period has expired and their lease has converted to a periodic tenancy. They are no less deserving of the protections afforded by these important amendments to the *Residential Tenancies Act 1997* in respect of electrical, gas and smoke alarm safety activities.

62. Accordingly, I recommend that the Minister for Government Services/Minister for Consumer Affairs consider amendments to the *Residential Tenancies Act 1997* (or other such amendments as may be necessary) so that the safety related activities defined within section 27(2) of the Act [the prescribed terms of which appear in Schedule 3 *Residential Tenancies Regulations 2021* in respect of electrical, gas and smoke alarm activities], may apply to all rental agreements, including rental agreements entered before 29 March 2021.

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[12] Letter from Department of Government Services dated 4 August 2023

Identity of the deceased

63. On 15 February 2022, Simon Peter Scarff, born 29 May 1969, was identified via DNA comparison. Identity is not in dispute and requires no further investigation.

Medical cause of death

64. Forensic Pathologist, Dr Gregory Young of the Victorian Institute of Forensic Medicine, conducted an autopsy on 15 February 2022 and provided a written report of his findings dated 20 September 2022.

65. The post-mortem examination revealed soot in Mr Scarff's airways. He also had a carboxyhaemoglobin saturation of approximately 25% and a hydrogen cyanide blood concentration of 1.3mg/L. These results indicate that Mr Scarff died in the course of the fire, in keeping with the reported circumstances. Whilst some degree of natural disease was detected, this has not contributed to Mr Scarff's death.

66. Toxicological analysis of post-mortem samples identified the presence of ethanol at 0.17g/100ml, and amphetamine and fluoxetine.

67. Dr Young provided an opinion that the cause of death was 1 (a) EFFECTS OF FIRE.

68. I agree with this conclusion.

FAMILY CONCERNS

69. Mr Scarff's family outlined a number of concerns in correspondence to the Court dated 22 March 2022, 16 August 2022 and 20 October 2023. In summary, their questions and concerns are:
    a) The response to the 000 call.
    b) The issues concerning smoke alarms.
    c) Electricity safety.
    d) The position in which Mr Scarff was found, post-mortem findings and toxicology.
    e) The cause and origin of the fire.

70. These concerns have been canvassed, save perhaps for a further observation concerning electrical safety. The 'piggy-backing' of the three power boards and the loading of multiple electrical appliances in this array is patently unsafe. It risks overloading the circuit and places reliance on overload protection measures which may fail to perform as anticipated. In this case, electrical overload remains a potential cause of the fire. However, there is insufficient evidence to find, on the balance of probabilities, that it was the cause of the fire.

FINDINGS

71. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities.[13] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

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

    a) the identity of the deceased was Simon Peter Scarff, born 29 May 1969;

    b) the death occurred on 12 February 2022 at 1/13 Almurta Street, Alfredton, Victoria, 3350, from EFFECTS OF FIRE; and

    c) the death occurred in the circumstances described above.

73. I accept the opinion of Forensic Officer Laura Noonan in respect of the cause and origin of the fire, and find that:

    a) the fire originated at the northern end of the loungeroom;

[13] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

b) the cause of the fire was the ignition of combustible materials in the loungeroom, such as the western couch as well as the surrounding fittings and furniture;

c) the source of ignition cannot be conclusively determined and may have been caused by a smouldering cigarette, an electrical fault, or close contact and/or radiant heat from an electrical appliance.

74. I find that Mr Scarff succumbed to the effects of the fire while trying to escape the premises.

75. I find that, at the time of the fire, there was no smoke alarm installed in the premises despite being required pursuant to the *Building Regulations 2018*.

RECOMMENDATION

76. Pursuant to section 72 of the *Coroners Act 2008*, I recommend –

> that the Minister for Government Services/Minister for Consumer Affairs consider amendments to the *Residential Tenancies Act 1997* (or other such amendments as may be necessary) so that the safety related activities defined at section 27(2) of the Act [the prescribed terms of which appear in Schedule 3 of the *Residential Tenancies Regulations 2021* in respect of electrical, gas and smoke alarm activities], may apply to all existing rental agreements, including rental agreements entered before 29 March 2021.

CONCLUSION

77. I convey my sincere condolences to Mr Scarff's family for their loss.

78. I direct that a copy of this finding be provided to the following:

    a) Joan Scarff, Senior Next of Kin

    b) Peter Dawes, Building Owner

    c) Allister Morrison, General Manager, Ballarat Real Estate Pty Ltd

    d) Emergency Services Telecommunications Authority, c/- Lander & Rogers

    e) Shane Patton APM, Chief Commissioner, Victoria Police

    f) Jo de Morton, Secretary to the Department of Government Services, Department of Government Services

    g) David Brockman, Executive Director, Regulatory Operations, Victorian Building Authority

    h) Detective Senior Constable Scott Gordon, Coroner's Investigator

Signature:

Coroner Paul Lawrie

Date : 26 October 2023

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.