



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 000345

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	Coroner Dimitra Dubrow
Deceased:	RTD ¹
Date of birth:	1978
Date of death:	17 January 2023
Cause of death:	1a: Effects of fire
Place of death:	Glengala Road, Sunshine West, Victoria, 3020
Keywords:	Fire; Residential Building; Smoke Alarms; Rental Properties

¹ This Finding has been de-identified by order of Coroner Dimitra Dubrow which includes an order to replace the name of the deceased, and the names of other persons related to or associated with the deceased, with a pseudonym of a randomly generated letter sequence for the purposes of publication.

INTRODUCTION

1. On 17 January 2023, RTD was 44 years old when she died in a fire at her home in Sunshine. RTD moved in around August 2022 and lived with her partner of four years, WUN.
2. RTD suffered an ankle injury sometime after moving and was largely bedridden from about November 2022. RTD's mental health had declined significantly, and she refused to attend hospital to have her ankle treated as requested by her family.
3. In the six weeks leading to her death, RTD required assistance to get out of bed and would spend most of her days sleeping. She was known to smoke cigarettes and recreational drugs inside the house.

THE CORONIAL INVESTIGATION

4. RTD'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.
5. 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.
6. 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.
7. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of RTD's death. The Coronial Investigator conducted inquiries on the Court's behalf, including taking statements from witnesses and submitted a coronial brief of evidence.

8. The Court was assisted by the Coroners Prevention Unit² (CPU) who provided assistance with research related to smoke alarm requirements and other fire safety measures as well as collating and summarising previous coronial findings and recommendations.
9. I took carriage of this investigation after my appointment to the Court in September 2024 for the purposes of finalising the investigation and making the required findings.
10. This finding draws on the totality of the coronial investigation into the death of RTD 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.³

BACKGROUND

The Property

11. RTD rented the upstairs residential dwelling⁴ of a two-story building in a strip of shops on Glengala Road. The ground floor was a drycleaning business.
12. The Property Owners rented the entire premises, including the upstairs dwelling, to the owners of the drycleaning business (**Head Renters**). The Head Renters then sublet the upstairs dwelling to RTD and WUN.
13. The rental agreement between the Property Owners and the Head Renters was in a standard form for a commercial lease and was prepared by a solicitor.
14. The sublet agreement was a verbal agreement only. The Property Owners were aware that the upstairs dwelling was being sublet.

² The CPU was established in 2008 to strengthen the coroners' prevention role and assist in formulating recommendations following a death. The CPU is comprised of health professionals and personnel with experience in a range of areas including medicine, nursing, mental health, public health, family violence and other generalist non-clinical matters. The unit may review the medical care and treatment in cases referred by the coroner, as well as assist with research related to public health and safety.

³ 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.

⁴ A Class 4 building as classified by the National Construction Code.

15. Upon purchasing the drycleaning business in around 2016, the Head Renters installed smoke alarms both upstairs and downstairs. No maintenance is believed to have been performed nor the batteries changed since that time.
16. There is one entrance to the upstairs residential dwelling via a rear stairwell to the north of the building. The front door opens into a kitchen and there is a hallway along the eastern side of the property beyond the kitchen. There are two bedrooms which come off the hallway, and a door at the end of the hallway leads to the lounge room.

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

Circumstances in which the death occurred

17. On 17 January 2023, RTD and WUN were at home. WUN washed RTD's hair for her in the lounge room while she was resting. RTD seemed happier after this and was moving around a bit more than usual.
18. At some stage between 3pm and 3:30pm, WUN left the apartment and told RTD that he would be back shortly.
19. When WUN returned about 45 minutes later, he opened the front door to the apartment to black smoke and immediately thought that there was a fire inside. He saw flames from the lounge room area but could not walk beyond the kitchen because of the heat and the smoke.
20. He called out to RTD but could not hear a reply. He attempted multiple times to gain entry and ended up on the roof to try and get access through a window.
21. Meanwhile, at about 4:15pm, a neighbour called Triple Zero to report the fire. The neighbour could hear shouting inside and observed smoke and flames coming out the windows.
22. At 4:21pm, the first fire unit arrived. The Senior Station Officer saw WUN on the roof attempting to forcibly gain entry through a window. WUN was told to come down, and he told firefighters that RTD was still inside and unaccounted for.
23. There was no evidence that a smoke alarm sounded.
24. At around 4:35pm, a Leading Fire Fighter entered the address and located RTD deceased in the living room near the hallway door.

Identity of the deceased

25. On 26 January 2023, RTD, born 1978, was identified via DNA comparison.
26. Identity is not in dispute and requires no further investigation.

Medical cause of death

27. On 20 January 2023, Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy and provided a written report of her findings.
28. The autopsy found extensive full thickness burns over the entire body as well as soot in the airways.
29. There was a remote cervical fracture (an old and healing fracture of the neck). No reference to this could be found in medical records, and the fracture was found to be stable at autopsy. Dr Archer did not consider this to have contributed to the death. There was no other significant trauma.
30. Dr Archer commented that natural disease did not feature in mechanism of death. However, there was natural disease in the form of:
 - a) Chronic active hepatitis (likely to be hepatitis C given the deceased's medical history)
 - b) Severe focal coronary artery atherosclerosis (blockage of the coronary arteries). This was in excess of that expected for woman of the deceased's age. Referral has therefore been made to Family Genetic Health Unit of the VIFM in case of genetic factors.
 - c) A small focus of bronchopneumonia in the right lung.
31. Toxicology analysis of post-mortem samples showed a mixture of drugs in the deceased's system including codeine and morphine, which may derive from heroin use. There was also methylamphetamine (and its metabolite amphetamine) and dimethylamphetamine.
32. The benzodiazepine sedative diazepam (and its metabolite nordiazepam) was detected in blood.
33. There was no detection of novel psychoactive substances nor volatile compounds, which are sometimes given off by burning accelerant or burning natural synthetic products.

34. Dr Archer provided an opinion that the medical cause of death was 1(a) Effects of fire.
35. I accept Dr Archer's opinion.

FURTHER INVESTIGATIONS

Forensic Chemist Report

36. A Forensic Chemist examined the scene and provided a report of the findings. The overall pattern of damage indicated that the fire started in the lounge room, specifically on the couch. There were no other obvious sources of accidental ignition in the vicinity such as appliances, exposed wiring, or other works.
37. The report identified three possible ignition sources: a carelessly discarded or improperly extinguished cigarette, direct ignition, and an electrical fault or misuse of an appliance. The latter two were considered unlikely as there were no multiple seats of fire, no flammable liquid, no fuel containers, or anything else which might point to a directly ignited fire.
38. The report ultimately concluded that the most likely source of ignition was a cigarette butt that had fallen onto the couch. It also concluded that RTD was possibly asleep on the couch at the time of ignition, and on awakening, may have been overcome by smoke.
39. There was a partly melted smoke detector from the hallway. This was described as an older-style stick-on detector, which had initially been stuck to the ceiling immediately outside the lounge room door.
40. It was a battery-operated detector which was melted and quite distorted. As such, the manufacturer could not be identified but appeared to be an early model, probably from the 1990s.
41. The 9V battery enclosed was marked "NOT FOR RETAIL SALE" which suggested that it may have been the original battery sold with the detector. Nonetheless, the report found that the output voltage was probably adequate at the time of the fire to operate.
42. The detector was also outside the closed lounge room door which would have considerably increased the time required for it to operate, considering that the fire began in the lounge room.

Fire Rescue Victoria Investigation Report

43. A Fire Rescue Victoria (FRV) review identified multiple fire safety issues. There was a possible failure of the smoke alarm to operate, RTD had diminished capacity to evacuate from the property, and there were smoking materials located throughout the property.

At-Risk Groups Report

44. The matter was referred to the At-Risk Groups, a unit within the Community Resilience Department at FRV which focusses on residential fire prevention and risk reduction for groups most at-risk from fire in the home. The unit provided a supplementary report to the FRV report.
45. This report noted 28 other preventable residential fire fatalities which may have been caused by cigarettes. It also noted that of these 28, 19 were also identified as having no evidence that a smoke alarm was either present or operated.
46. The report referred to the requirement that all residential properties must have working smoke alarms complying with Australian Standard *AS 3786:2014 Smoke alarms using scattered light, transmitted light or ionisation*.⁵
47. The report went on to say:

'Smoke alarms have a lifespan of around 10 years, after which it is recommended by manufacturers that the smoke alarm is replaced. This is because the sensor may degrade over time. Australian Standard 3786:2014 requires that all smoke alarms have a recommended date of replacement legibly and indelibly marked on the alarm ...

However, it is commonly marked on the back of the alarm or inside of the casing and can be very difficult to find. The difficulty in identifying the age of a smoke alarm and lack of awareness in the community about the limited lifespan of smoke alarms means that there may be large numbers of smoke alarms in Victorian homes that are over 10 years old.'

48. The report recommended review and strengthening of existing smoke detector legislation in Victoria with specific comparison to Queensland legislation.

⁵ An updated Australian Standard 3786:2023 has been published but there is no current requirement for smoke alarms already in place and compliant with Australian Standard 3786:2014 to be replaced to accord with the new standard.

49. The report explained that following the Slacks Creek disaster in 2011, a house fire in Queensland which killed eleven people, the Queensland Government strengthened its smoke alarm legislation by mandating that by 2027, all smoke alarms in all homes regardless of when built must either be hardwired or powered by a non-removable 10-year battery, located in each bedroom and hallway on every level of a dwelling, be interconnected, and be less than 10 years old.
50. In comparison, the report explained that the requirements in Victoria for homes constructed after 1 August 1997 or homes which have undergone a major renovation, must have smoke alarms connected to mains power with battery backup.⁶ Homes constructed before 1 August 1997, such as the dwelling in this case, may have battery-operated smoke alarms.⁷
51. While not a legislated requirement in Victoria, FRV nonetheless recommends the additional requirements as contained in the Queensland legislation.
52. The report reiterated the key message of “*only working smoke alarms save lives*”.

FINDINGS AND CONCLUSION

53. Pursuant to section 67(1) of the Act I make the following findings:
 - a) the identity of the deceased was RTD, born 1978;
 - b) the death occurred on 17 January 2023 at Glengala Road, Sunshine West, Victoria, 3020, from 1(a) effects of fire; and
 - c) the death occurred in the circumstances described above.
54. I find that the cause of the fire was an improperly extinguished cigarette.
55. While the testing of the smoke alarm battery indicates that it ought to have operated, in the absence of any evidence of anyone hearing an alarm, the lack of ongoing maintenance, and the age of the alarm, I am not satisfied that it did operate.

⁶ Australian Building Codes Board Housing Provisions, Part 9.5.1(c). Similar provisions exist in the relevant National Construction Code in force at the time of construction after 1 August 1997.

⁷ *Building Regulations 2018*, r 145.

56. Considering RTD's reduced mobility, I am also unable to find that earlier sounding of a smoke alarm would have allowed her to evacuate safely. Nonetheless, this would have improved her chances of survival.
57. I find that this was a terribly tragic but preventable accident.

COMMENTS

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

1. The Coroners Court investigates multiple house fire related deaths each year. Many of these involve smoke detectors and alarms that have been inadequately maintained or otherwise rendered nonfunctional. I emphasise the message that "*only working smoke alarms save lives*".
2. Many of these also featured cigarettes as the likely ignition source, and so I also reiterate the dangers of smoking inside.

Previous Smoke Alarm Requirements in Rental Properties

3. It was unclear to the parties involved in this case who had the responsibility, if anyone, to maintain and inspect the smoke alarms at the property.
4. The Property Owners stated:

"We had no idea who was meant to be responsible for the smoke detectors. I thought maybe if you rent it then you look after it. I thought it was maybe the tenant's responsibility."
5. The Head Renters stated:

"[the property owner] never asked me to install the smoke alarms, I just thought I would do it for my own safety...I never did any maintenance on the smoke alarms after installing them. I can't remember if I ever changed the batteries or not."
6. As noted in the At-Risk Groups report, all residential properties must have working smoke alarms. This includes Class 4 buildings such as in this case. This obligation resides with the property owner.

7. When a property is sublet, the head renter takes on all the responsibilities of a rental provider including meeting minimum rental standards and dealing with urgent repairs.⁸
8. The requirement for working smoke alarms was not contained in the minimum rental standards. Instead, it was found in the Standard Form – the form that must be used where there is a written rental agreement.⁹
9. Clause 16 of the Standard Form reads:

16. Smoke alarm safety activities

- (a) The rental provider must ensure that—
 - (i) any smoke alarm is correctly installed and in working condition;
and
 - (ii) any smoke alarm is tested according to the manufacturer's instructions at least once every 12 months; and
 - (iii) the batteries in each smoke alarm are replaced as required.
- (b) The 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.

- (c) The rental provider, on or before the commencement of the agreement, must provide the renter with the following information in writing—
 - (i) information about how each smoke alarm in the rented premises operates;
 - (ii) information about how to test each smoke alarm in the rented premises;
 - (iii) 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.

⁸<https://www.consumer.vic.gov.au/housing/renting/starting-and-changing-rental-agreements/different-rental-agreements/subletting>

⁹ *Residential Tenancies Act 1997* (Vic), s 26(1).

- (d) The renter must give written notice to the 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.

10. This made smoke alarm requirements a written contractual agreement between the rental provider and the renter rather than an independent legal duty. For the smoke alarm safety activity requirements to apply to verbal agreements, they would have to have been implied terms.
11. Considering the omission of a requirement for short-term agreements to be written (compared to agreements of more than five years which must be written¹⁰), the inclusion of smoke alarm safety activities in the Standard Form only, and the right to request a verbal agreement become a written agreement,¹¹ it is difficult to accept the proposition that parliament intended for these requirements to be implied terms in verbal rental agreements.
12. Therefore, there was an apparent lacuna whereby rental providers appeared to not have an obligation to perform smoke alarm safety activities where there was a verbal rental agreement. However, this lacuna has been addressed following recent legislative changes to the *Residential Tenancies Act 1997* as outlined below.

Strengthened Smoke Alarm Requirements in Rental Properties

13. Another lacuna relating to smoke alarm safety activities was identified in the coronial investigation into the death of Simon Scarff.¹²
14. His Honour Coroner Paul Lawrie noted that the smoke alarm safety clauses in the Standard Form did not apply retrospectively to existing rental agreements entered before 29 March 2021, or any fixed term agreement of less than 5 years that rolled over to a periodic agreement on or after 29 March 2021.

¹⁰ *Residential Tenancies Act 1997* (Vic), s 26(1A)

¹¹ *Residential Tenancies Act 1997* (Vic), s 29B.

¹² [COR 2022 00829](#).

15. Simon Scarff's death fell into this category of leases which were not captured by these changes, and it was found that had they applied the death may have been prevented. Coroner Lawrie recommended that the smoke alarm safety clauses apply retrospectively.
16. This recommendation was accepted, and the subsequent legislative changes now impose a duty on all residential rental providers irrespective of when the residential rental agreement was entered into. In particular, residential rental providers are responsible for ensuring smoke alarms are correctly installed and in working condition, are fitted with batteries or replacement batteries and tested annually.¹³
17. This incidentally addresses the lacuna in this case as the proposed duty is not limited to written agreements.
18. This clearer requirement for all rental providers, together with the presumed public awareness campaign, will go some way to ensure that renters are afforded appropriate early warning of fires through smoke detectors and alarms.
19. Taking this a step further, a stronger protection would be afforded by smoke detection and alarm systems which do not require battery changes or yearly maintenance such as hardwired systems. The recommendation I have made below echoes the suggestions by Fire Rescue Victoria to strengthen smoke detector and alarm system requirements in Victoria in this way. A copy of this finding will be provided to the Minister for Housing and Building with this recommendation.

Further Strengthening Smoke Alarm Requirements

20. While smoke alarms allow for early warning, they do not prevent nor extinguish fires. There is considerable residual risk, particularly for people with limited mobility, such as RTD in this case.
21. Therefore, in addition to reviewing and updating smoke alarm legislation in relation to existing residences, this case also highlights the need for continued safety in the construction

¹³ *Residential Tenancies Act 1997* (Vic), s 68AA inserted by section 17 of the *Consumer and Planning Legislation Amendment (Housing Statement Reform) Act 2025* (in force from 25 November 2025).

of new dwellings, such as the inclusion of sprinkler systems in all new residential buildings, regardless of height,¹⁴ as supported by Fire & Rescue New South Wales.

22. In their Fire Research Report, it was noted that sprinkler systems and smoke alarms in combination markedly improve the safety of occupants in the event of a fire.¹⁵
23. I note that consultation in relation to amending the National Construction Code to provide for sprinkler systems has been previously recommended to the responsible body, the Australian Building Codes Board, including by my colleague Coroner Olle in 2023¹⁶ and more recently referred to by my colleague Coroner Giles in 2025.¹⁷
24. The presence of a sprinkler system in conjunction with a working smoke alarm would afford occupants, including vulnerable members of our community, greater opportunity to escape and survive fires, lending weight to the call to consider:
 - a. Strengthening smoke alarm requirements including mandating smoke alarms in every bedroom; and
 - b. Mandating sprinkler fire systems in all new residences.
25. While only new residences would provide this kind of ‘double protection’, in time, more people would benefit from such protection.

Improving Enforcement of Smoke Alarm Requirements

26. The remedies for non-compliance with smoke alarm safety activities sits squarely with renters. They must either request an urgent repair or apply to VCAT to compel compliance. The inherent power imbalance between rental providers and renters presents a significant barrier to reporting, particularly for vulnerable people in precarious housing situations who are at risk of, or perceive a risk of, eviction or not wanting to ‘rock the boat’. Renters must also be aware of the requirements and available protections.

¹⁴ Sprinkler systems are currently required in all buildings over 25 metres or 4 storeys or more, Specification 17, National Construction Code 2022, <https://ncc.abcb.gov.au/editions/ncc-2022/adopted/volume-one/e-services-and-equipment/17-fire-sprinkler-systems>

¹⁵ Fire & Rescue New South Wales, ‘Fire research report – Residential Sprinkler Research’, <https://www.fire.nsw.gov.au/gallery/files/pdf/research/FRNSW%20Residential%20Sprinkler%20Research%20Report.pdf>

¹⁶ COR 2020 003017

¹⁷ COR 2022 006787 and COR 2022 006788

27. In a related matter at the Court,¹⁸ Consumer Affairs Victoria (CAV) confirmed that the smoke alarm safety requirements are not conduct obligations. This means that while CAV provides information and education to renters and rental providers, it has no formal powers to inspect, investigate, or enforce compliance with smoke alarm safety requirements.
28. Similarly, local councils do not have enforcement powers under the *Residential Tenancies Act 1997*. In the same related matter, Brimbank City Council, who are also the local council in this case, clarified that councils do not have any power, role, or function in relation to the obligation to have working smoke alarms as required by the Building Regulations.
29. However, Brimbank City Council clarified that they owe a duty of care where a property within its municipality likely poses a danger to the life, safety, or health of any person and the council is aware of the facts and has power to act.
30. Accordingly, when Brimbank City Council is aware of a danger, it takes steps to mitigate this danger, mostly commonly through the enforcement powers in Part 8 of the Building Act and the issuing of Emergency Orders or other orders for compliance with the Building Act and Regulations.
31. This includes the requirement to have working smoke alarms in residential buildings.
32. Brimbank City Council noted that non-compliant smoke detection and alarm systems are most commonly observed in relation to boarding houses. They take a more active management approach to these dwellings including collection and storage of enforcement data as well as purchasing and installing temporary smoke alarms.
33. Auditing and enforcement of smoke alarms in rental properties by council or CAV may impose a disproportionate administrative burden. This finding will also be distributed to other stakeholders to consider how external bodies such as CAV and local councils can assist in achieving compliance for smoke alarm safety activities and reducing the onus on renters to have to advocate for themselves.

¹⁸ COR 2024 001661.

RECOMMENDATION

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

- i. That the Minister for Housing and Building consider and assess Fire Rescue Victoria's recommendation to strengthen smoke detector and alarm system requirements in Victoria along the lines of the reforms introduced in Queensland including mandating that smoke alarms in all homes, regardless of when built, be either hardwired or powered by a non-removable 10-year battery, be interconnected and less than 10 years old and to consult with Fire Rescue Victoria, the Country Fire Authority, the Victorian Building Authority and the responsible Queensland Minister in relation to the implementation of the legislative changes in that state. It is acknowledged that any mandatory changes to smoke alarm requirements may cause financial and other hardship to Victorian homeowners such that it is recommended that the Minister consider an appropriate lead time and support by way of rebates or discounts akin to that provided as part of the Victorian Energy Upgrades.

I have elected to publish this finding to contribute to the community's awareness of the risk and sometimes fatal and devastating impact of residential fires. A copy of the finding will be provided to a number of organisations involved in the continued discussions around residential fire risk, safety improvements and public information campaigns.

I convey my sincere condolences to RTD's family for their loss. I acknowledge the important role and brave efforts of the first responders to this incident.

Pursuant to section 73(1A) of the Act, I order that a de-identified version of 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:

WUN, Senior Next of Kin

ULD

Detective Acting Sergeant Alexandra Bradley, Coroner's Investigator

The Hon. Nick Staikos, Minister for Housing and Building

Fire Rescue Victoria

Country Fire Authority

Australian Building Codes Board

Home Sprinkler Coalition Australia

Brimbank City Council

Consumer Affairs Victoria

Signature:



Coroner Dimitra Dubrow Date: 19 May 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.
