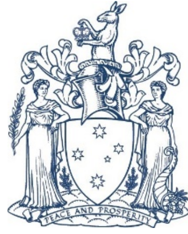

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 004470

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	DVR[1]
Date of birth:	12 December 2016
Date of death:	15 August 2020
Cause of death:	1(a) Smoke inhalation
Place of death:	Royal Childrens Hospital Melbourne, 50 Flemington Road, Parkville, Victoria, 3052
Keywords:	RCH, DFFH, fire, fire hose, FRV, State Fire Investigation Unit, AS 1851

[1] This finding has been de-identified by order of Coroner Simon McGregor to replace the names of the deceased and their family members with pseudonyms of randomly generated three letter sequences to protect their identity and redact identifying information.

INTRODUCTION

1. On 15 August 2020, DVR was three years old when he died at the Royal Children's Hospital (**RCH**). At the time of his death, DVR primarily lived in Richmond with his father.

THE CORONIAL INVESTIGATION

2. DVR'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 an officer to be the Coroner's Investigator for the investigation of DVR's death. The Coroner's 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.

6. This finding draws on the totality of the coronial investigation into the death of DVR 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.[2]

[2] 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.

7. In considering the issues associated with this finding, I have been mindful of DVR's basic human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

8. On 14 August 2020 at approximately 7.00pm, YSF left DVR with his partner, XRK, at her residence in North Fitzroy, where she lived with their other son.[3] The unit complex consists of 12 units over three levels owned by the Department of Families, Fairness, and Housing (**DFFH**). XRK's unit was located on the third floor.

9. On 15 August 2020 at approximately 9.00am, XRK woke and prepared breakfast for DVR. She then went back to bed. At approximately 12.00pm[4], XRK got up and placed a small piece of charcoal for her incense burner on the stove, turning it on to a low heat using a lighter. She then went to the bathroom to have a shower.[5]

10. XRK stated that whilst she was in the shower, she heard the smoke alarm in the lounge room activate. XRK checked the kitchen and discovered that the charcoal on the stove was missing. She then ran to the lounge room and found a small fire behind her couch.[6] XRK stated that there were lighters and cigarettes in her apartment and that DVR knew how to use the lighter.[7]

11. XRK attempted to find DVR but was unsuccessful. She attempted to fill a pot with water to extinguish the fire however, by this stage, the fire had increased in size, so XRK retrieved her other son from the bedroom and exited the residence via the front door which was still closed. XRK contacted emergency services and alerted her neighbours to the fire. She then gave Noah to her downstairs neighbour before returning upstairs.[8]

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[3] Coronial brief, statement of XRK dated 15 August 2020, page 28.
[4] I note XRK's statement references a time of 'about 11.00am' whilst the statements from neighbours reference a time of approximately 12.00pm. I further note the dispatch times of the attending emergency service members as being '12.24pm'. Given the likely accuracy of the dispatch data, I am satisfied that the time of 12.00pm is correct.
[5] Coronial brief, statement of XRK dated 15 August 2020, pages 28-29, 30.
[6] Coronial brief, statement of XRK dated 15 August 2020, page 29.
[7] Coronial brief, statement of XRK dated 15 August 2020, page 30.
[8] Coronial brief, statement of XRK dated 15 August 2020, pages 29-30.

12. XRK attempted to utilise a nearby fire hose to extinguish the fire but was unable to unravel it.[9] She then asked for assistance for her neighbours to find DVR. A neighbour entered XRK's apartment but was go further than the entranceway due to the smoke and heat from the fire which had engulfed the apartment by this now.[10]

13. At approximately 12.30pm, members of Fire Rescue Victoria (**FRV**) attended the apartment block and began extinguishing the fire. FRV members in breathing apparatus gear located DVR unresponsive under the bed in the main bedroom in the apartment and carried him to a waiting ambulance.[11]

14. DVR was transported to RCH in an unresponsive condition, arriving at 1.10pm. Despite intensive resuscitation efforts by paramedics at the scene and clinical staff at RCH, he tragically passed away at 1.35pm.[12]

Identity of the deceased

15. On 15 August 2020, DVR, born 12 December 2016, was visually identified by his father.

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

Medical cause of death

17. Forensic Pathologist Dr Heinrich Bouwer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 16 August 2020 and provided a written report of his findings dated 21 January 2021.

18. The post-mortem examination revealed evidence of smoke inhalation with heavily congested lungs. There were no thermal injuries or evidence of other trauma that may have caused or contributed to the death.

19. The post-mortem computed tomography scan did not reveal any evidence of unexpected skeletal trauma. There was no evidence of natural disease.

[9] Coronial brief, statement of XRK dated 15 August 2020, pages 29-30.
[10] Coronial brief, statement of Kevin Georgiadis dated 15 August 2020, pages 83-84.
[11] Coronial brief, statement of SSO Nigel Shipperlee dated 23 February 2021, pages 108-109; Statement of FO Laura Noonan dated 7 September 2020, page 142.
[12] Dr Adam O'Brien, Medical E-Deposition dated 15 August 2020, page 1.

20. Toxicological analysis of ante-mortem samples identified the presence of carboxyhaemoglobin at a concentration of 40 per cent. Hydrogen cyanide was also detected, which was likely a by-product of the combustion process during the fire.

21. Dr Bouwer provided an opinion that the cause of death was from 1 (a) smoke inhalation.

22. I accept Dr Bouwer's opinion.

FURTHER INVESTIGATIONS

Scene examination

23. The scene was examined by Laura Noonan, a Forensic Officer with Victoria Police. FO Noonan noted that XRK's apartment was constructed of plasterboard ceilings, a linoleum floor covering in the kitchen and bathroom, with carpet in the bedroom and lounge room, under which was timber floorboards covered by Masonite. A smoke detector was installed in on the hallway ceiling.[13]

24. FO Noonan noted that the apartment was kept in a relatively tidy manner but observed the presence of several cigarettes and lighters, including in the bathroom sink and the kitchen bench beside the stove. There were numerous tealight candles throughout the apartment, and a bong in the second bedroom.[14]

25. The examination of the scene revealed substantial fire damage throughout the flat, with the most severe damage located in the lounge room around a couch which was positioned against the north-western wall. The couch had mostly been consumed by flames, with only the timber frame and internal metal springs remaining. The lounge room ceiling had collapsed but the roof timbers were unburnt.

26. The pattern of damage indicated that the couch was the area of the fire's origin, with no other locations considered to be additional points of ignition. There was no evidence to suggest that flammable liquids had been involved.[15]

[13] Statement of FO Laura Noonan dated 7 September 2020, page 141.
[14] Statement of FO Laura Noonan dated 7 September 2020, page 141.
[15] Statement of FO Laura Noonan dated 7 September 2020, page 141-142.

27. The front right burner on the stove was found to be in the on/high position at the time of the scene examination with a cylindrical piece of charcoal resting between the burner and trivet. The position of the charcoal indicated that XRK was heating it as per the recommended method. FO Noonan noted that the auto-ignition function on the stove top did not work, and the burners were required to be lit using a lighter or match. The pattern of burning in the kitchen indicated that the fire had spread from the lounge room and into the kitchen through the doorway, however.[16]

28. FO Noonan was unable to conclusively determine the source of the fire's ignition, however she posited three possibilities, including:

    i. A faulty electrical appliance, noting the presence of numerous electrical appliances located around the couch, including an iPad, mobile phone, aromatic diffuser, and power board. The fire damage to these was indicative of a fire spread rather than an ignition point however;

    ii. Direct ignition of combustible materials, including via a match or lighter. Several cigarette lighters were found in the apartment. Whilst no remains of a lighter or match was found in the debris in the lounge room, given the extent of the fire damage, any burnt remains would not necessarily be apparent. This could not be excluded as a source of ignition; and

    iii. Indirect ignition of combustible materials, by a burning object or material placed or thrown onto the couch. Given that the front gas burner on the stove was on prior to the fire, FO Noonan considered ignition of an object by the lit stove to be a probable source of ignition. This lit object may have then been transported to the couch in the living room, resulting in its subsequent ignition.[17]

29. FO Noonan concluded that direct or indirect ignition of the couch to be the most likely source of ignition and the subsequent fire.[18]

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[16] Statement of FO Laura Noonan dated 7 September 2020, page 143-144.
[17] Statement of FO Laura Noonan dated 7 September 2020, page 145.
[18] Statement of FO Laura Noonan dated 7 September 2020, page 145.

Fire hose examination

30. After receiving a report from attending FRV members that the fire hose at the property appeared to be tangled, members of the Building Inspection and Compliance (**BIC**) department at Fire Rescue Victoria (**FRV**) conducted an inspection of fire systems installed at the apartment complex.[19]

31. Members of the BIC team made several observations regarding the fire hose reel that XRK attempted to utilise when the fire started, including:

    a) The hose had been loosened and was wrapped unevenly and tangled around the drum, which had caused it to jam;

    b) The nozzle was not stored in the interlock and was left dangling towards the floor; and

    c) The strop valve inside the nozzle, which operates to control water supply, was not functioning correctly meaning the nozzle could not be used to stop the water supply.[20]

32. The service tag on the hose reel and services records at the property indicated that the reels were serviced on 8 July 2020 in accordance with the requisite Australian Standard (**AS 1851**) which should have included ensuring that the hose would not jam when unwound, determining if there were any leaks from the fitting, and ensuring that water was able to flow freely through the reel. Following servicing, the technician would have been required to wrap the reel closely, neatly, and evenly around the drum and store the nozzle in the interlock.[21]

33. Following the inspection of the hose reel, the BIC investigators posited that it was likely that either the hose reel had not been serviced in accordance with the relevant standard as indicated by the service tag and records, or that it had been manipulated or otherwise incorrectly used by a resident or visitor to the property since 8 July 2020, leading to the subsequent malfunction on 15 August 2020.[22]

34. The BIC investigators were unable to definitively conclude as to which was the more likely scenario, however, given the available information.

[19] Statement of Paul Horton dated 7 October 2022, page 2.
[20] Statement of Paul Horton dated 7 October 2022, pages 2-3.
[21] Statement of Paul Horton dated 7 October 2022, page 4.
[22] Statement of Paul Horton dated 7 October 2022, pages 3-4.

35. In their report, BIC investigators made several recommendations, including:

a) Due to the socio-economic status of the people living properties owned by the DFFH, sprinklers should be installed throughout all three-storey properties owned by the DFFH; and

b) Licences should be required for technicians who perform inspections and testing of fire systems, and any other essential safety measures work, so that servicing is performed to the requisite standard.[23]

36. I agree with these conclusions and intend to make similar recommendations accordingly.

<u>Paediatric fire safety</u>

37. On 12 October 2020, FRV's State Fire Investigation Unit (**SFIU**) published a report providing an overview of the incident that claimed DVR's life, as well as the statistics surrounding the risk of fire fatalities to children and vulnerable communities.

38. The SFIU referenced the 2019 research report "Preventable residential fire fatalities in Australia July 2003 to June 2019"[24] which noted that children aged 0-4 years of age comprised 7.8 per cent of fire related fatalities, the highest number of deaths in any five-year age range. The fire origin was often lighters or matches which may indicate that a significant number of fires were lit by children during fire-play, although this could not be definitively confirmed.

39. The report also noted a significant link to social and financial disadvantage, with almost half of deaths in the above age bracket occurring in locations in the top 10 per cent of socio-economic disadvantage, and 87.2 per cent of fatalities occurring in the top 40 per cent locations of greatest disadvantage. Victorian statistics mirrored Australia-wide data, with at least three other fatal fires occurring properties owned by the DFFH since October 2019.[25]

40. The SFIU drew attention to FRV's fire safety education programme designed to reduce and control risky fire behaviour in children and noted that fire safety messages for pre-school children should start by raising awareness of parents and prompting them to take actions to reduce their risk from fire.

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[23] Statement of Paul Horton dated 7 October 2022, pages 4-5.
[24] Coates et al, 2019.
[25] At the time of the report, responsibility for public housing was under the portfolio of the Department of Health and Human Services (DHHS).

41. FRV is developing a project to ensure that fire safety risks are considered in the home visit of a Maternal and Child Health Nurse (**MCHN**), with an aim to provide MCHNs with knowledge and resources on basic home fire risk reduction and pathways for referral to FRV.

42. At the conclusion of the SFIU report, the FRV recommended that the coroner "considers the potential role of MCHN services or other services that may have attended the household in identifying and improving the fire safety practices of parents of young children, particularly those facing social and financial disadvantage".

43. I believe this is a worthwhile proposal, and therefore intend to make a similar recommendation to the DFFH.

CPU REVIEW

44. To assist with my investigation into DVR's death, I requested that the Coroners Prevention Unit[26] (**CPU**) advise whether there are any mandated maintenance schedules for firefighting equipment in residential occupancies, whether such equipment could be improved for residents' use, and whether any further prevention opportunities could be identified.

<u>Maintenance schedules</u>

45. AS 1851 requires all fire hose reels (like the one that XRK attempted to use) must be inspected every six months and reported annual in the Annual Fire Safety Statement. The fire hose reels at the incident address were tested on 8 July 2020, just over a month before the fatal incident.

46. The FRV report that concluded that the nozzle of the fire hose reel did not shut off when XRK attempted to utilise it. The CPU noted that, if the fire hose reel had been serviced as stated on the service tag, the nozzle would have done the job of shutting off the water when the water was turned on (to release the nozzle), with the reel deploying as designed.

47. Furthermore, it is likely that the reel was not on the drum in even layers, with the CPU noting that the FRV inspected three other hose reels at the property which revealed evidence that they were not on the drums in even layers as per AS 1851.

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[26] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

Fire deaths in public housing

48. Between 1 January 2010 and 30 September 2022, there were 13 fire related deaths from 11 incidents where there was evidence that the fire occurred in public housing. Six of these properties had functioning fire alarms.

49. The CPU agreed with the recommendations made by the FRV investigators regarding the installation of fire sprinklers in public housing blocks over three storeys but posited that this should be extended out to all public housing blocks, regardless of height.

50. I agree with this conclusion and intend to make a similar recommendation.

FINDINGS AND CONCLUSION

51. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[27] 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.

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

    a) the identity of the deceased was DVR, born 12 December 2016;

    b) the death occurred on 15 August 2020 at the Royal Childrens Hospital Melbourne, 50 Flemington Road, Parkville, Victoria, 3052, from *smoke inhalation*; and

    c) the death occurred in the circumstances described above.

53. After considering the available evidence, it is reasonable to conclude that DVR's death was likely caused after he intentionally transferred a lit object from the stove top to the couch, resulting in the subsequent fire that claimed his life, and that no one else should be held accountable for this tragedy.

[27] *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…'.

RECOMMENDATIONS

54. After considering the circumstances, including the subsequent scene examination, SFIU investigation, and CPU conclusions, it is clear that there are continues to be significant dangers associated with risks posed by unintentional fires, especially in socio-economically disadvantaged communities living. Therefore, and pursuant to my prevention function under section 72(2) of the Act, I make the following recommendations:

   i. *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.*

   ii. *I recommend that the DFFH ensure that all technicians who perform inspections and testing of fire systems, and any other essential safety measures work, be required to hold appropriate licences so that servicing is performed to the requisite standard.*

   iii. *I recommend that the DFFH considers the potential role of MCHN services or other services in identifying and improving the fire safety practices of parents of young children, particularly those facing social and financial disadvantage*

I convey my sincere condolences to DVR's family for their loss, especially given the tragic circumstances in which it occurred.

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

YSF, Senior Next of Kin

JWA, Senior Next of Kin

Annabelle Mann, RCH

The Honourable Danny Pearson, Minister for Housing

The Honourable Mary-Anne Thomas, Minister for Health

Senior Constable Thomas Stalder, Victoria Police, Coroner's Investigator

Signature:

CORONER SIMON McGREGOR

CORONER

Date: 30 November 2022

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.