IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 006227
COR 2021 006228
COR 2021 006229
COR 2021 006230

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	QJW[1] KUW OPW RCW
Date of death:	21 November 2021
Cause of death:	1(a) Effects of fire
Place of death:	Werribee, Victoria
Keywords:	House fire – smoke alarms

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

INTRODUCTION

1. On 21 November 2021, four children from the W family died in a fire at their home in Werribee. QJW was one year old, KUW was three years old, OPW was six years old, and RCW was ten years old. At the time of their deaths, they lived with their parents, WGC and PHA, and their brother CSW who was eight years old.

BACKGROUND

2. WGC and PHA were born in Sudan. They married in 2008 and subsequently moved to Australia.

3. On 6 November 2019, the family moved into a property in Werribee. They rented the property from Quing Luo and it was initially managed by LifeIn Real Estate. The house was a single storey brick property with a tiled roof that was built in 2016. It contained four bedrooms and two living areas. Two hardwired and interconnected smoke alarms had been installed in the house, one along the main hallway and another towards the rear of the house.

4. On 5 November 2019, ZYL from LifeIn Real Estate conducted a property inspection and noted that the two smoke alarms installed in the house were clean, undamaged and in working condition.

5. On 7 April 2021, ZYL conducted a routine inspection of the property and noted that the smoke alarms needed to be serviced. WGC and PHA told ZYL that the smoke alarms were continually beeping which was bothering them, so they had disconnected them.[2] The photographs in the inspection report prepared by LifeIn Real Estate disclose that none of the smoke alarms were connected to the mains electricity. One of the smoke alarms had been removed from the ceiling bracket and the other smoke alarm was unclipped and hanging from the ceiling bracket.[3]

6. The owner of the property, Ms Luo, lived in China. ZYL communicated with her through an agent who would translate her messages into Chinese. On 7 April 2021, ZYL arranged for a request to be sent to Ms Luo for the smoke alarms to be serviced. A reminder was sent on 8 June 2021 and Ms Luo subsequently requested a quote for the servicing, which was then

[2] CB99.
[3] CB516.

provided by ZYL. Ms Luo responded that the quote seemed quite high and no approval to carry out the servicing was ultimately provided.[4]

7. On 1 September 2021, Aumeca Group took over the management of the property on behalf of Ms Luo. They were instructed to prepare the property for sale. DJT from Aumeca conducted a property inspection on 19 October 2021 and discussed the strategy of selling the house with WGC and PHA. DJT noticed a "*light cloud of smoke throughout the house*" and could smell the "*distinct aroma of burning incense*".[5] DJT took a series of photographs during her inspection, in which the smoke alarm in the main hallway is observed to have been removed from the ceiling bracket.[6]

THE CORONIAL INVESTIGATION

8. The deaths of the children were reported to the Coroner as they 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.

9. 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.

10. 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.

11. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of the deaths of the children. 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.

[4] CB100.
[5] CB238-CB239.
[6] Exhibit 34 (photograph 5).

12. This finding draws on the totality of the coronial investigation into the deaths of the children including evidence contained in the coronial brief. While 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.[7]

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

Circumstances in which the death occurred

13. In the evening on 20 November 2021, RCW, CSW, OPW and KUW decided to have a "*sleepover*" and sleep together in the same bedroom. QJW slept in her cot in her parents' bedroom. PHA recalled that the children were in bed by around 8.00pm and that she and WGC were asleep by around 11.30pm.[8]

14. At around 12.57am on 21 November 2021, CSW woke up and left the bedroom and saw flames between the chairs in the lounge room, next to the kitchen. He called out to his father. WGC and PHA woke and WGC tried to reach the children in their bedroom but was forced back due to the smoke and heat.

15. WGC, PHA and CSW escaped the house through the front door. WGC and PHA attempted to get back into the house by smashing bedroom windows and suffered burns in this process.

16. A number of calls were made to emergency services by neighbours between 1.02am and 1.15am, with the first call being directed to fire services at 1.04pm.[9] The Country Fire Authority (**CFA**) arrived at 1.12am followed soon afterwards by Fire Rescue Victoria (**FRV**). Second Lieutenant Paul Ryan, the Incident Controller, observed that the fire had penetrated the roof of the house when they arrived. He heard PHA screaming that "*my children are inside*" and WGC yelled "*hurry up my kids are in there*".[10]

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[7] 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.

[8] Exhibits 57 & 59.

[9] CB256.

[10] CB168.

17. The roof of the house partially collapsed soon after the arrival of fire services and they were unable to gain entry to the house due to the intensity of the fire and the risk of further structural collapse.[11]

18. Firefighters were eventually able to suppress the fire by which time the house was destroyed. RCW, OPW and KUW were all located in the bedroom in which they went to bed the previous evening and QJW was located in her parents' room.

19. There was no evidence that any firefighters or neighbours heard the alert tones of any smoke alarms during the fire.

Identity of the deceased

20. On 25 November 2011, QJW, KUW, OPW and RCW, were identified via DNA comparison.

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

Medical cause of death

22. Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine conducted an inspection on 22 November 2021 and provided a written report of her findings dated 28 April 2022.

23. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any commons drugs or poisons.

24. Dr Archer provided an opinion that the medical cause of death was 1 (a) Effects of fire.

25. I accept Dr Archer's opinion.

FURTHER INVESTIGATIONS

Victoria Police forensic report

26. Laura Noonan, a forensic officer with the Victoria Police Forensic Services Centre, examined the scene with investigators from FRV and prepared a report dated 19 January 2022.

27. Ms Noonan observed that the house had been severely damaged by fire with most of the roof having collapsed. She considered that the fire likely originated in the dining area of the house

[11] CB162.

(referred to by the family as the lounge room). She determined that the fire had breached the roof about 7 minutes before the first call was directed to fire services, and that the fire had likely been burning for some time prior to breaching the roof.

28. Ms Noonan located one smoke alarm in the debris of the house and also a burnt frying pan on the floor of the lounge room. There was no evidence that the smoke alarm contained a battery.

29. Ms Noonan concluded that "*the cause of the fire was the ignition of combustible material in the dining area, such as the armchair and/or the eastern couch, and the decorative cushions and blankets on the furniture*".

30. The source of the ignition of the fire could not be determined, although a number of possibilities were identified. Ms Noonan considered that a small electrical device charging on the couch or armchair in the lounge was a possible source of ignition of fire. Further, she could not exclude the possibility that the frying pan located on the floor in the lounge room was a source of ignition. However, Ms Noonan considered that a smouldering cigarette butt was "*a more likely ignition source*" given "*the timing and sequence of events*".

Interviews with family

31. Detectives from the Arson and Explosives Squad of Victoria Police spoke with WGC, PHA and CSW on 24 November 2021.

32. WGC is a smoker but he and PHA stated to police that he only smoked in the garage. Further, there is no evidence that any smoking had occurred within the house. WGC stated that he believed the smoke alarms were in working order. He could not explain why the frying pan would have been in the lounge room.

33. PHA stated to police that she believed that one of the smoke alarms was working, although she did not hear any alarm during the fire. She also could not explain why the frying pan was in the lounge room.

34. CSW stated to police that the smoke alarms had been disabled "*a long time ago*" as the smoke from a charcoal incense burner used by the family would activate the alarms.[12] He did not know why the frying pan would have been in the lounge room.

[12] CB666.

Fire Rescue Victoria report

35. Ben McLean, an investigator with FRV examined the scene and prepared a report dated 2 February 2022. The report stated that "*investigation of the scene and investigations conducted after the event indicate no working smoke alarms were present at the time of the fire*".

36. Mr McLean stated the following conclusion in his report:

> "*The presence of at least one working smoke alarm may have alerted the sleeping occupant/s to the presence of the fire during early fire development and may have assisted in the escape from this structure. The absence of at least one smoking smoke alarm for early fire detection had, on this occasion, a direct correlation to the survivability of the fire for sleeping occupants*".

37. FRV made a number of recommendations including consideration of the efficacy of mandating home fire sprinklers in all new homes. Currently in Australia, the National Construction Code requires sprinklers in all buildings over 25 metres in height, as well as all residential buildings of four storeys or higher.

38. On 23 May 2023, Coroner Olle delivered a finding relating to a death in a house fire in July 2021.[13] He recommended that the Australian Building Codes Board (**ABCB**) commence consultation with other appropriate organisations to consider whether there is a strong rationale to amend the national *Construction Code 2019* to require all new residential buildings, regardless of storeys or height, to have fire sprinkler systems installed to significantly reduce the risks and consequences from fire.

39. On 4 October 2023, the ABCB advised that it had recently commenced a process of stakeholder and community consultation on the opportunities and challenges related to new buildings in Australia which will include a topic on home sprinkler systems.

SMOKE ALARMS

40. Under the *Residential Tenancies Act 1997* (**the RTA**), rental providers must ensure that smoke alarms in rental properties are in working condition and tested regularly. The rental provider must ensure that each smoke alarm is correctly installed and in working condition, and that they are tested according to the manufacturer's instructions every 12 months. The renter must

[13] *COR 2021 003948.*

give written notice to the rental provider if they become aware that a smoke alarm is not working.

41. The rental provider must immediately arrange for the repair or replacement of a smoke alarm as an urgent repair if they are notified that it is not in working order. If a rental provider cannot be contacted or does not immediately fix a smoke alarm, the renter can authorise and pay for an urgent repair of up to $2,500 and the rental provider must pay them back within seven days.

42. The rental provider, on or before the start of the rental agreement, must provide the renter with information about how each smoke alarm works and how they are tested. The rental provider must also inform the renter about their obligation not to tamper with a smoke alarm.

43. The owner of the Werribee property did not act with the necessary urgency once she was notified by ZYL that the smoke alarms required servicing.

44. The respective agreements for the management of the property[14] between Ms Luo, LifeIn Real Estate and Aumeca authorised the estate agents to undertake urgent repairs up to the sum of $1,800.

45. An option available to the estate agents was to arrange the servicing of the smoke alarms as an urgent repair under their agreement with the owner. However, there is no certainty that the smoke alarms would not have been subsequently disabled even if they had been serviced.

FINDINGS AND CONCLUSION

46. The deaths of the four children from the W family in the house fire on 21 November 2021 were a tragedy, causing unimaginable grief, distress and devastation to their family and community. They are deserving of sympathy and compassion as they come to terms with their loss.

47. The fire began in the area of the armchair and couch in the lounge room of the house. Investigators have identified a number of possible sources of ignition for the fire but I am unable to determine with any certainty the precise cause.

[14] Referred to as an Exclusive Leasing and Managing Authorities (often called "the authority"); consumer.vic.gov.au/housing/renting/starting-and-changing-rental-agreements/using-a-property-manager-or-agent.

48. I am satisfied that there were no functioning smoke alarms operating in the house at the time of the fire.

49. Pursuant to section 67(1) of the Act, I make the following findings:

    a) the identities of the deceased were QJW, KUW, OPW, and RCW;

    b) the deaths occurred on 21 November 2021 at Werribee, Victoria, 3030, from effects of fire; and

    c) the deaths occurred in the circumstances described above.

COMMENTS

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

50. Smoke alarms increase the chances of survival in the event of house fires. It is of critical importance that property owners and tenants comply with their obligations under the RTA in relation to their installation and maintenance.

51. Estate agents should act with diligence and urgency when they identify that maintenance or repair of smoke alarms are required in properties they are managing. Where there are difficulties in communication with the property owner, this should include early consideration of whether the repairs can be arranged by prior agreement pursuant to their written authority.

RECOMMENDATIONS

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

(i) The Estate Agents Council consider the efficacy of an amendment to the *Estate Agents Act 1980* (or Regulations) to require agreements between rental providers and estate agents for the management of residential properties to specifically authorise estate agents to arrange the urgent repair or servicing of smoke alarms.

I convey my sincere condolences to the W family for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

PHA & WGC, Senior Next of Kin

Aumeca Group Pty Ltd

Liana Buchanan

Detective Senior Constable Heath Lyon, Coroner's Investigator

Signature:

Coroner David Ryan

Date :15 December 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.