Secretary
Department of Health & Human Services

50 Lonsdale Street
Melbourne Victoria 3000
Telephone: 1300 650 172
GPO Box 4057
Melbourne Victoria 3001
www.dhhs.vic.gov.au
DX 210081

e4069058

RECEIVED AT
11 MAR 2016
CORONERS COURT OF VICTORIA

Melissa Purdy
Coroners Registrar
Coroners Court of Victoria
65 Kavanagh Street
SOUTHBANK VIC 3006

Dear Ms Purdy

Re: Investigation into the death of Saber Sulieman - Coroners Court reference COR 2014 002875

I refer to the letter from your office dated 18 December 2015 and received on 22 December 2015, enclosing the finding and recommendation made by Coroner Rosemary Carlin without an inquest into the death of Saber Sulieman.

I wish to acknowledge the death of Mr Sulieman which occurred from the effects of a fire on the common property of a public housing block of units. I also wish to express my sadness at the loss of this young man's life in a tragic incident and thank the Court for its investigation of the circumstances surrounding Mr Sulieman's death.

I note your finding that the fire in which Mr Sulieman perished was caused by a lit cigarette making contact with a couch which Mr Sulieman was on and that he did not rouse due to his intoxication once the fire started. This occurred in a makeshift gazebo made from a timber frame and covered with a tarpaulin which had been erected on the common property by Mr Sulieman's sister who was a tenant living in one of the units on the block.

While the department has a range of fire risk management strategies in place for public housing properties, it is committed to raising awareness of the potential for this type of incident to occur and to making improvements to procedures which may reduce the risk of fires in situations of habitation and hoarding on common properties in outer metropolitan public housing blocks. In accordance with sections 72(3) and 72(4) of the *Coroners Act 2008* (Vic), I enclose a response to your finding and recommendation.

Should you require any further information regarding the department's response, please contact Ms Kirsty McIntyre, General Counsel and Chief Legal Officer on 9096 1557.

Yours sincerely

K Peake

Kym Peake
Secretary
9/3/2016
Encl.

VICTORIA State Government

Attachment 3

Department of Health and Human Services' response to the Coroner's recommendation into the death of Saber Zakaria Sulieman (Coroners Court Reference COR 2015 002875)

Recommendation

That DHHS Fire Risk Management Unit examine the circumstances of this case to determine if any fire risk management strategies can be implemented to reduce the risk of fires in common areas of low rise estates in the setting of possible habitation of those areas and the hoarding of personal items.

Department's response

The department's Fire Risk Management Unit has reviewed the circumstances in which this fire occurred and advised that its fire risk management strategies relating to common areas are mainly focused on common areas forming part of inner suburban high-rise public housing estates. This is based on known factors including the risk level associated with fires in high density multi-level buildings, and the incidence of fires involving common areas on public housing estates which, until the fire involving Mr Sulieman, had been limited to inner suburban high-rise buildings. The Fire Risk Management Unit was not aware of any fires occurring on the common areas of outer metropolitan public housing estates.

Existing strategies for identifying tenancy breaches and assessing risks in public housing properties, including on common areas, may be improved by a focus on training and raising awareness of departmental officers of the issues associated with habitation and hoarding on common areas in low rise outer metropolitan properties. The Fire Risk Management Unit is willing to action the strategies noted below.

In response to the fire involving Mr Sulieman and the Coroner's recommendation, the department is undertaking the following strategies to reduce the risk of similar fires occurring in the future:

1. The department's Service Implementation and Support Branch produced the department's '*Tenancy breaches operational guideline*' in September 2015 which draws attention to the need to balance the impact on household needs with the Director of Housings objectives in managing tenancy breaches. The guidelines have been reviewed and will be further updated to reflect the requirement to consider potential risk to the health and safety of household members, neighbouring occupants or visitors.

2. At the next scheduled meeting of Tenancy and Property Managers in March 2016, the department will raise awareness of the potential risk of fires on the common areas of low rise estates in the setting of possible habitation of those areas and the hoarding of personal items. These operational managers are located in housing offices across the State and are responsible for the day to day management of Housing Services Officers and other employees involved in managing public housing properties and tenancies. The circumstances of this case and the Coroner's findings will be used as a basis for discussion and sharing of best practice approaches currently in place at each of the department's 32 housing offices. The results of the consultation will also be considered when updating the department's *Tenancy breaches operational guidelines*.

3. The department's Centre for Learning and Organisational Development has been requested to develop a training program for senior housing staff, covering the causes for hoarding and squalor, other situations that may give rise to health and safety risks, the options available to address these issues and methods for assessing risks associated with each course of action. Departmental officers in some divisions have previously attended community seminars on hoarding and squalor. Whilst many are aware of the issues involved, the management of tenancies exhibiting hoarding behaviour is often complex and can involve several organizations and support agencies. The approach generally recommended has been to support tenants to modify their behaviour and to reduce clutter in and around their homes to acceptable levels to reduce risks to

themselves, neighbours and visitors. More severe responses such as issuing a notice to vacate which could lead to an eviction are usually implemented when collaborative approaches fail. Additionally, departmental officers are required to consider a range of factors when deciding on a strategy to address the behaviour, including the individual circumstances of the tenant and their household, and obligations under the *Residential Tenancies Act 1997*, the *Privacy and Data Protection Act 2014* incorporating the Information Privacy Principles, and the *Charter of Human Rights and Responsibilities Act 2006*.