IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 1453/11

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of ABDULLAH KOCOGLU

Delivered On:	5 April 2012
Delivered At:	Coroner's Court of Victoria Level 11, 222 Exhibition Street Melbourne Victoria
Hearing Dates:	6 February 2012
Findings of:	K. M. W. PARKINSON, CORONER
Police Coronial Support Unit:	Leading Senior Constable A Maybury

I, K. M. W. PARKINSON, Coroner having investigated the death of ABDULLAH KOCOGLU

AND having held an inquest in relation to this death on 6 February 2012
at Melbourne

find that the identity of the deceased was ABDULLAH KOCOGLU

born on 16 October 2006

and the death occurred on 24 April 2011

at Royal Children's Hospital, Flemington Road, Parkville, Victoria 3052

from:

1a. COMPLICATIONS OF CUTANEOUS THERMAL BURN INJURIES

in the following circumstances:

1. An inquest was conducted into the death of Abdullah Kocoglu on 6 February 2012 at Melbourne. The following police and emergency services witnesses gave evidence in the proceeding: Detective Senior Constable Michael Cashman of the Victoria Police Arson and Explosives Squad and Senior Station Officer Stephen Keating of the Country Fire Authority. The inquest brief contained statements made by attending emergency service officers and civilian witnesses to the events and by the treating doctor.

2. Abdullah died on 24 April 2011 at the Royal Children's Hospital Melbourne, as a result of injuries sustained in a fire on 14 February 2011.

3. Abdullah was born on 16 October 2006 and he was four years old at the time of his death. Abdullah is survived by his parents, his twin brother Omar and his sisters, Sena and Bucu.

4. Mr and Mrs Kocoglu had arranged to reside temporarily with Mr Kocoglu's parents and his younger brother, at 118 Fordham Road, Hampton Park. They were anticipating travelling to Turkey and remaining there for a significant time. They had therefore vacated their residence. On 14 February 2011, they spent the day moving their furniture and household goods into the garage at the parent's premises.

5. The evidence is that they stored a large amount of material in the garage, including couches, mattresses, baby high chair and other furniture and cartons of household goods and clothing. As it was too late in the day to take a trailer of rubbish to the tip, they also moved the trailer inside the garage. In order to fit the trailer they left the front roller door of the garage open.

6. Abdullah and his twin brother Omar attended childcare during the day and were collected by their parents at approximately 6.00pm. They returned to the home at approximately 6.20pm and dinner was prepared. Abdullah was described by family members as the more adventurous and inquisitive of the twins. Whilst they were eating dinner, Abdullah came into the lounge room, holding an extinguished match in his hand and saying with some glee 'fire'. He was also holding a box of matches. He was observed holding the match and match box by his mother, father and grandmother.

7. The evidence is that Abdullah suffered a mild speech impairment and that his mother and grandmother were surprised and delighted to hear him speak without any evidence of stutter. Abdullah's grandmother stated that both she and his mother smiled to hear him articulate his words. That they were pleased was likely to have been evident to the child. It may be that he regarded this as an endorsement of what he was doing with the matches. Whilst both of his parents spoke to him about the dangers of playing with matches, none of the adults removed the matches from Abdullah.

8. There is some evidence that Abdullah and Omar had shown interest in matches at the house previously. Abdullah's uncle, Mohammad stated that he had seen each of the boys in the previous months, pick up matches and play with them. He had seen Omar attempting to light a match but failing in his attempt. None of the other adults had noticed the boys playing with matches prior to the day of the incident.

9. Three of the adults at the premises were smokers and matches and cigarette lighters were within reach in various places around the house. There was also a table set up outside the back door which contained a makeshift ashtray and usually a box of matches to enable the smokers to smoke outside the house. Photographs of the premises reveal the presence of lighters and match boxes in various rooms and on a table outside the back door of the premises. There were no matches located by investigators at the table outside the back door.

10. It is noted that the house was one in which young children did not usually reside. It is not clear from the evidence exactly where Abdullah obtained the box of matches, however I am satisfied that they were obtained from the home and it is possible that they were obtained from the table outside the back door.

11. After dinner, Abdullah and Omar went out into the back yard to play, whilst the adults all remained inside. On the east side of the property is a driveway running approximately north-south, at the end of which is located a double garage, fitted with double roller doors. The garage also has a single entrance doorway on its west side, approximately one metre from the front of the garage, which opens onto the back garden. On this day, one of the roller doors of the garage had not been closed, due to the trailer impeding the door closure. The children apparently gained entry to the garage through the open roller door.

12. At approximately 7.15pm, Mrs Kocoglu went outside after that to make sure the front gates were closed and could hear the boys laughing in the garage. As she approached the front of the garage she observed through the open roller door, smoke coming from inside. She observed the boys to be further down the garage behind the couches, which she observed to be on fire. Mrs Kocoglu ran for the garden hose whilst screaming for her husband.

13. Mr Kocoglu heard the yelling and came outside after seeing the fire from the kitchen window. He said that by the time he got outside, the size of the fire had increased significantly. Mr Kocoglu called emergency services, but inadvertently dialled 911 at first before realising his mistake and dialling 000. It does not appear from the evidence that this mistake in any way extended or delayed the emergency services response time. It is clear that calls to emergency services were also made by neighbours and by other family members.

14. Mrs Kocoglu then attempted to reach the boys by the side door of the garage, however she reported that it appeared to be locked. She was unable to open the door. It appears that the door was jammed, however there is no evidence that the door was locked or that there was any large item impeding its opening. It is possible that expansion due to heat may have made the door difficult to open.

15. When the door did not immediately open, Mrs Kocoglu ran to the front of the garage where the roller door was open and called to the boys to come out. The smoke had become thick and the flames intense. It appears that the little boys were at the rear of the garage behind the couch, which was on fire. The couch stood in the way of access by the adults attempting to reach them and stood in the way of the boys escaping the fire.

16. The boys were likely to have been frightened by the smoke and the flames and had travelled to the back of the garage, instead of towards the more open front exit. Their ability to access the side door was impeded by items stored in the garage and probably also by flames and it is questionable that they would have been tall enough to be able to open the side door.

17. According to the expert fire fighter witness, it is not an uncommon response, particularly in children, that when faced with smoke and flames, people retreat backwards, even when it may involve retreating from the nearest accessible escape route. In this case, investigators believe however, that the fire quickly developed to a point where flame and smoke would have restricted access to both the side door and the open roller door exits.

18. Mrs Kocoglu screamed at the boys to come, as did her husband. The intensity of the fire thwarted the attempts by Mr and Mrs Kocoglu to enter the garage to rescue the boys. Mr Kocoglu sustained burns to his hands and feet. Abdullah and Omar eventually found their own way out of the garage through fire and around the furniture to the open roller door, but both were on fire, their clothing having ignited and they suffered severe burns as a result.

19. Neighbours attending the scene administered immediate aid by holding them and placing them under the garden tap and continuing a stream of water from the garden hose. MICA ambulance officers attended and both boys were transported to the Royal Children's Hospital by Air Ambulance suffering critical burn injuries. Omar survived burn injuries to 40% of his body.

20. Abdullah was treated for extensive deep burns to 80% of his total body surface area and for smoke inhalation injury and airway burns. He was admitted to the Intensive Care Unit and underwent intensive medical intervention, including extensive surgery over the following month.

21. Mr Tom Clarnette, paediatric burns surgeon at the Royal Children's Hospital, oversaw Abdullah's surgical burns management. He reported that after appropriate emergency burns management, Abdullah underwent emergency escharatomies. This involved incising burned skin and deeper tissue layers to prevent circumferential, deep burns acting as a tourniquet. He underwent this procedure on both upper limbs to maintain blood flow to the limbs.

    Mr Clarnette stated:

    "Abdullah's surgical burns management thereafter comprised staged excision of the extensive burns wound, commencing February 16, 2011. Due to the limited availability of autologous donor skin, coverage of the debrided burn wound was initially achieved with the use of the biosynthetic skin substitute, Biobrane. Following obtaining fully informed consent, wound coverage was further augmented by targeted use of human cadaveric donor skin as a biological dressing. Over the course of the numerous staged operative procedures, these skin substitutes were removed, and the debrided burn wound covered by autologous split skin graft .....Suffice to say however, Abdullah suffered the full complications of systemic, metabolic effects of severe burns, together with complications such as sepsis characteristic of this patient group." .

22. Careful and expert supervision of his progress was made by the treating team during the months of his admission. The surgeon reports that there was a trend towards slow improvement and Abdullah was discharged from the Intensive Care Unit to the Burns Unit on 21 April 2011. However, on the evening of 23 April, his condition deteriorated, resulting in a cardiac arrest. Aggressive resuscitation efforts were undertaken and Abdullah was again transferred to the Intensive Care Unit, however his prognosis was poor. He had developed respiratory distress syndrome, acidosis and persistent hypoxaemia. After discussion with family, intensive care measures were withdrawn and Abdullah died at 6.55am on 24 April 2011.

23. Mr Clarnette reported that whilst the timing of Abdullah's deterioration and death was to a degree unexpected, the mortality of severe burns is well recognised. It is apparent that the medical and nursing intervention was expertly planned, implemented and managed. Despite the efforts of all of the Royal Children's Hospital teams involved, Abdullah was unable to recover from the fire injury he had sustained.

24. An inspection and report was undertaken by Dr Noel Woodford, Senior Forensic Pathologist with the Victorian Institute of Forensic Medicine. He commented that examination of post mortem CT scanning revealed widespread opacity in both lung fields with pleural fluid and that his examination results were consistent with the history. He reported the cause of death as complications of cutaneous thermal burn injuries.

25. A purpose of the inquest was to understand the circumstances in which the fire occurred and if possible, to identify any factors, which might usefully be the subject of comment or recommendation, directed towards avoiding such a tragic event in the future.

26. Senior Station Officer Keating undertook an investigation into the fire together with Victoria Police Scientist and Arson Investigator, Mr John Kelleher and Detective Senior Constable Cashman.

27. Scene examination revealed extensive damage to the garage and its contents. Mr Kelleher reported:

"The property was on the southern side of the road, about 10 metres west of the intersection with View Street. The premises consisted of a three bedroom brick house with a relatively small front yard, and a driveway along the eastern side of the property. This led to a large, brick double garage in the southeastern corner of the block, with an adjoining metal garden shed.

All of the fire damage appeared to be in the garage and garden shed. The garage was approximately 8 metres wide and 12 metres deep, with two roller doors at the front. The shed was much smaller, approximately 4 metres wide and 3 metres deep, with western wall of the garage shared by the shed. The door was in the front wall close to the garage. A window in the garage wall, which would have opened into the shed, was blocked by a metal sheet. There was another window in the garage wall, looking over the back yard, and a small door, near the front of the western was, allowing access to the garage without opening the roller doors.

The garage was used for storage of furniture and household items. On the left (eastern) side, from front to rear, were a treadmill, a barbeque with a large gas cylinder, a refrigerator, a washing machine, a large stack of boxes and bags containing household goods, a large storage rack, several large lounge chairs and a bed frame. On the right (western) side were a trailer loaded with household goods, a lounge chair, a cot or similar item, and several large couches. In the back corner was a mower with a 5 litre plastic fuel container. This was partly melted, but was still capped and contained several litres of liquid.

There had been a fire in the garage, which had caused extensive and severe damage to the furniture on the right side, and had spread to the household goods on the left side as well as through the back window into the garden shed. While some timber in the garden shed ignited, this damage was clearly secondary, and the shed was not examined further. In the garage, the chair and cot immediately behind the trailer were essentially destroyed, with metal fittings and frames remaining among charred timber remnants. The couches further to the rear were largely intact, with a clear decrease in damage towards the rear of the building. The damage

was consistent with a fire starting around the centre of the right side, behind the trailer, between the cot and chair. Whether the cot or chair was the point of origin, or what may have been a table between them, was not determined, but there was a marked decrease in the level of burning with distance from this area".

28. Senior Station Officer Keating stated that they had concluded that the fire was likely to have been lit by matches as there was no evidence in the debris of metal components of a cigarette lighter, which would likely have been located if they had been present at the fire.

29. He concurred with Mr Kelleher's report that the fire was likely to have started around the centre right side of the garage, behind the trailer, probably in the vicinity of the chairs and the cot. The chairs and the cot and as stated, what appeared to be a table, had been consumed by the fire with only some metal components and charred timber fragments remaining. Couches in the location had also been burned, with no fabric or filling remaining and only springs and wooden frames identifiable. The fire had engaged almost every area of the garage to some degree.

30. Investigators excluded the involvement of any chemical accelerant in the lighting of the fire. There were flammable liquids, including lawn mower fuel, located in the garage after the fire was extinguished, which were not heat affected. Similarly, a barbeque gas bottle was intact. Aerosol paint cans, which had ruptured during the fire, were not considered to be involved in the initial ignition of the fire. They were located at the rear of the garage and away from the ignition point, which appeared to be centred on the chairs and cot. Examination of the electrical power box at the property did not reveal any fault or otherwise any evidence that an electrical fault may have caused or contributed to the fire.

31. There are no suspicious circumstances relating to the ignition of the fire. I am satisfied that the fire was likely to have been lit by Abdullah as a result of his playing with the matches he had been seen to have in his possession that evening. I am satisfied that Abdullah obtained the matches from the home, although the exact location from which they were obtained is unclear in view of there being a number of possible sources, both inside and outside of the house.

COMMENTS

I make the following comment(s) connected with the death including matters relating to public health and safety and (including any notification to the Director of Public Prosecutions under 67(3) of the **Coroners Act 2008.**

1. Some of the comments I make may appear to be stating the obvious. However, the obvious is often worthy of repeating as basic safety messages may sometimes be overlooked in the glare of current events and public safety messages directed to more current incidents.

2. These comments are made in the context of a very tragic event, which has touched forever many people, including the family, the neighbours, the police and emergency service workers who attended the scene and no doubt the medical and nursing staff who cared for Abdullah and Omar.

3. Both witnesses commented in their evidence on the possibility that the most basic of safety messages may require public reinforcement with parents. Whilst there is extensive fire safety education provided to children once they are at school, it appears that direct messaging to parents, particularly of pre-school children may again need to be the focus of campaigns.

4. I do however acknowledge that each of the fire services in Victoria publish extensive home fire safety advice and in joint publications particular directly address the issue of children playing with matches. These publications are issued in a number of languages. The Royal Children's Hospital Child Safety Unit has published extensively on the issue of home fire safety.

5. Perhaps and understandably because there are many urgent public health messages requiring of time and attention, more obvious safety measures are not the focus of attention. A tragic event like this however, is a timely reminder that sometimes it is necessary to restate and remind people of even the most basic safety messages.

6. It also appears that a contributing factor in this case was that the home was not one usually accommodating young children and that the types of measures which might be taken in a home usually occupied by young children, may not be implemented for temporary or short term visiting children.

7. Abdullah's death was preventable had the following safety messages and precautions been heeded:

   - Matches and other fire lighting implements and young children do not mix.
   - A child playing with, or in possession of matches or the like must immediately be, clearly and very firmly chastised.
   - Occupiers of premises must attend to childproofing any household where young children will be present, by attending to the removal of apparently dangerous items like matches and cigarette lighters.
   - Occupiers of premises must limit the access that children have to unsupervised areas such as garages and sheds, which are often used to store dangerous items or highly inflammable items.

7. Finally, it is appropriate to comment that many of the family's neighbours and bystanders responded immediately and bravely to a shocking situation where the little boys had suffered dreadful injuries. They are to be commended for their actions.

RECOMMENDATIONS

I make the following recommendation(s) connected with the death under s72(2) of the **Coroners Act 2008.**

1. That fire and child safety authorities give consideration to a public safety campaign reminding parents and householders of the need to review the safety of their household if young children are likely to attend the premises.

2. That fire and child safety authorities give consideration to a public safety campaign reminding parents and householders that matches and other fire lighting implements should be stored safely and out of the reach of young children.

3. I direct that a copy of these findings be provided to:

   The family; the Interested Parties; The Minister for Police and Emergency Services; The Minister for Community Services; The Child Safety Unit, Royal Children's Hospital; The Child Safety Commissioner; The investigating member, Detective Senior Constable Michael Cashman; Senior Station Officer Stephen Keating, Country Fire Authority Hallam; Mr Tom Clarnette; The Chief Fire Officer, Country Fire Authority and The Chief Fire Officer Metropolitan Fire Brigade.

Signature:

K. M. W. PARKINSON
CORONER

5 April 2012