IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2014 0742

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

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

I, AUDREY JAMIESON, Coroner having investigated the death of NICHOLAS STEPHEN BROWN

without holding an inquest:

find that the identity of the deceased was NICHOLAS STEPHEN BROWN

born 6 September 2010

and the death occurred on 7 February 2014

at Unit 4, 1 Potter Street, Dandenong Victoria 3175

from:

1 (a) CARBOXYHAEMOGLOBIN POISONING

1 (b) INHALATION OF SMOKE (HOUSE FIRE)

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Nicholas Stephen Brown was three years of age at the time of his death. Nicholas lived with his mother, Jacinta Musu in rented accommodation at Unit 4, 1 Potter Street Dandenong. They had lived in the two-storey unit for approximately three years, and Nicholas was his mother's only child. Nicholas did not attend crèche or kindergarten. He was a healthy child and did not suffer from any known ongoing medical conditions.

2. On the morning of Friday 7 February 2014, Ms Musu was caring for Nicholas and a friend's two young children who had stayed overnight at the unit. Ms Musu cooked scrambled eggs in

the frying pan on a gas stove in her kitchen. She used a lighter to light the stove. The children ate the eggs, and the father of the two other children took them home shortly afterwards.

3. Between 10.20am and 10.30am on Friday 7 February 2014, Ms Musu set off to purchase a new asthma inhaler at the chemist, and left Nicholas at home. Ms Musu closed the front door and locked the front security door, while Nicholas remained in the lounge room, watching television. Ms Musu told Nicholas not to open the door to strangers. The front wooden door was closed but could still be opened from the inside, and the front security door was locked from the outside. The back door in the laundry was also locked from the inside and had a sliding chain.

4. Ms Musu walked to the shopping strip in Hemmings Street, Dandenong, approximately 400 metres from her home. She briefly entered a dental surgery to enquire about an appointment, and then walked to the Dandenong West Pharmacy. Closed Circuit Television (CCTV) footage[1] indicates that Ms Musu walked past the IGA supermarket in Hemmings Street at approximately 10.39am that morning. Ms Musu purchased a new asthma inhaler at the pharmacy; a receipt of purchase indicates the transaction took place at 10.42am. Ms Musu then purchased some lollies for Nicholas and walked towards her home. As Ms Musu approached the unit she saw smoke and people crowding around.

5. At 10.47am, witnesses called emergency services. Some witnesses tried unsuccessfully to access the building, while others filmed the fire on their mobile phones. At approximately 10.53am, the first Country Fire Authority (CFA) members arrived and observed that the unit was burning intensely. The ground floor still had some fire activity, and the second storey was completely involved in the fire, which had already penetrated the roof. The front security door was closed and the wooden front door had been completely burnt away, with the hinges still attached to the door frame. Nicholas was unable to be located at this point. Fire suppression activity was commenced and the front security door had to be forcibly removed in order to gain entry into the unit. Police arrived at 10.55am and Sergeant Cassandra Stone immediately spoke with Ms Musu, who informed her that Nicholas was still inside.

6. CFA firefighters wearing breathing apparatus made entry through the front door and were unable to locate Nicholas on the ground floor. The fire in the second storey was very intense and firefighters were initially unable to see Nicholas. However, after moving a large amount of debris, at 11.25am a CFA firefighter located Nicholas lying face down on the bed in the main

---

[1] The timestamp on the CCTV footage was identified as having a five minute delay, so that 10.39am would be labelled 10.34am on the film.

bedroom of the unit. A large section of the roof structure had collapsed onto the bed, covering Nicholas' body with debris. It was apparent that Nicholas had not survived.

INVESTIGATIONS

Forensic pathology investigation

7. Following DNA testing, a Form 8 was issued on 14 February 2014, pursuant to section 24 of the *Coroners Act 2008* (the Act), determining that the identity of the deceased was Nicholas Stephen Brown.

8. By way of letter dated 7 February 2014, Detective Senior Constable Tina Kemp of the Arson Squad requested an autopsy be performed on Nicholas. By way of Form 9 dated 10 February 2014, issued pursuant to section 25 of the Act, I directed that an autopsy take place.

9. Dr Jacqueline Lee, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed a full post mortem examination upon the body of Nicholas, reviewed a post mortem computed tomography (CT) scan (that was also reviewed by Dr Timothy Cain of the Royal Children's Hospital), and referred to the Victoria Police Report of Death, Form 83. At autopsy, Dr Lee reported that the only injuries identified were those related to the effects of fire. In particular, Dr Lee noted that the CT scan reflected that Nicholas' skull fractures were heat fractures and not a consequence of inflicted trauma. Toxicological analysis of post mortem blood detected 58% carboxyhaemoglobin (which reflects carbon monoxide) and 0.7mg/L hydrogen cyanide.[2]

10. Dr Lee ascribed the cause of Nicholas' death to carboxyhaemoglobin poisoning, secondary to inhalation of smoke in a house fire.

Police investigation

11. Upon attending the Dandenong premises, Victoria Police did not identify any signs of third party involvement. Police did not pursue any criminal prosecutions in relation to the circumstances surrounding Nicholas' death. A potential charge of common law negligent manslaughter was averted on the basis of insufficient evidence. The charge of leaving a child

---

[2] Carbon monoxide and hydrogen cyanide are gases produced from the combustion of organic fuels and plastic products. Levels of carboxyhaemoglobin that exceed 30% saturation, alone, may be life threatening. Levels of hydrogen cyanide in excess of 1.0mg/L are considered as life threatening. Persons who die in fires can asphyxiate as a result of carbon monoxide and hydrogen cyanide produced during the combustion process. In victims of fire post mortem carboxyhaemoglobin and cyanide concentrations ranging from 25% to 85% and 0.1 to 4mg/L, respectively have been reported.

unattended[3] was not pursued on the grounds of it being contrary to the public interest, as police did not believe the consequences of Ms Musu's actions were reasonably foreseeable.

12. Detective Senior Constable (DSC) Dimitrios Gogorossis of the Arson and Explosives Squad, the nominated coroner's investigator,[4] conducted an investigation of the circumstances surrounding Nicholas' death, at my direction, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by Nicholas' mother Jacinta Musu on 7 February and 26 March 2014, 14 witnesses, CFA Dandenong employees Operations Officer Paul Carrigg, Leading Firefighters Aaron Jackson and Andrew Koscielecki and Firefighter Ryan Pole, and several Victoria Police employees including Forensic Officer at the Fire and Explosion Unit of the Victoria Police Forensic Services Centre (VPFSC) George Xydias. CFA Investigator, Senior Station Officer Glenn Proebstl also compiled an Investigation Report which formed part of the brief.

13. Other evidence in the coronial brief included Nicholas' medical records from Dandenong West Medical Centre, audio recordings from the Emergency Services Telecommunications Authority (ESTA), and evidence of a routine rental inspection carried out at the Potter Street premises on 29 November 2013 by Run Property. A general comment in the routine inspection owner notification report from that date indicated that the unit was 'overall messy, but not damaging the property.'

14. CFA Operations Officer Mr Carrigg noted that the unit was two storeys and of brick construction, with a tiled roof. The weather was fine on 7 February 2014, with a temperature in the low to mid 30s. Mr Carrigg observed that the wind at the time of the fire was slight and did not appear to be a factor in relation to the spread of the fire.

15. Sergeant Cassandra Stone stated that she spoke with Ms Musu after arriving at the Potter Street premises at approximately 11.00am on 7 February 2014. Sergeant Stone said that at this time, Ms Musu told her she had locked the front door while she cleaned out the garage, and made short trips around the corner to put hard rubbish on a pile. Sergeant Stone said that Ms Musu told her she had headphones on so did not notice the fire start. Ms Musu referred to two oven

[3] Pursuant to Section 494 of the Children, Youth and Families Act 2005 (Vic)

[4] A coroner's investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the coroner to assist the coroner with his/her investigation into a reportable death. The coroner's investigator takes instructions direction from a coroner and carries out the role subject to the direction of a corner.

lighters in the house and believed that both were out of reach, but mentioned she had cooked eggs on the stove that morning. Sergeant Stone searched Ms Musu's bag and located an inhaler medication script that had been filled at 10.42am, which caused her to doubt that she had been cleaning out the garage when the fire began.

16. Later that day, Ms Musu provided a video statement at Dandenong Police Station between 3.35pm and 4.06pm. During this statement, Ms Musu acknowledged that she had walked to the local shops while she left her son in the house alone. She believed she was away for approximately 30 to 45 minutes.

17. In her second statement dated 26 March 2014, Ms Musu noted that the lighter she used to light the stove was red in colour and had a long nozzle. She said she had two lighters in the house; the other lighter was blue and was finished. Ms Musu explained that there is a button so the lighter sits in your hand, you press the button with your finger, and it just sparks on - 'you just press it and it goes on'. She stated that the one action of pulling the trigger or button causes a flame.

18. Ms Musu added that Nicholas had 'a fascination with the lighter' and had recently started following her when she used the lighter and playing with it; he was capable of using the lighter and making a flame. On the night of 6 February 2014, Ms Musu saw him playing with the lighter in the kitchen; it had been on the bench and she had thought it was out of his reach. However, Nicholas was able to grab hold of the lighter and was playing with it, pressing it and looking at it. Ms Musu said this prompted her to put the lighter on the pelmet on top of a sliding door next to the stove.

19. Ms Musu stated that after she lit the stove on the morning of 7 February 2014, she was 'pretty sure' she put the lighter back on the pelmet. She stated that she put it up high because Nicholas could get to it when she left it on the bench. She said she remembered putting the lighter up there because she saw Nicholas watching her use it, asking 'what's that? What are you doing?' Ms Musu said she remembered telling Nicholas 'it's not a toy', as she placed the lighter on top of the door that morning. Ms Musu noted that Nicholas liked to climb on things but she did not think it would have been possible for him to reach the lighter on the pelmet, even with a chair.

20. Ms Musu did not believe there were any electrical appliances left on or anything else that may have caused the fire. She did not boil the kettle that morning and the microwave was not on. There were no air conditioners or heaters on in the house. Ms Musu stated that the only thing

she used was the stove. She was certain that she turned the stove off after using it, so as not to burn the eggs. Ms Musu stated that she is not a smoker and she did not believe there were matches in the house.

21. Forensic Officer George Xydias attended the Potter Street premises on the afternoon of 7 February 2014. Mr Xydias observed that the semi-detached, two bedroom, double storey dwelling faced east and was on the western side of the road. The ground level contained a lounge room, kitchen and dining area, as well as a laundry and separate toilet. The upper level contained a master bedroom, second bedroom and a bathroom. Mr Xydias noted that both the front and rear doors appeared to have been closed during the fire.

22. Mr Xydias observed that the fire had severely damaged both levels of the two storey apartment. The damage was particularly intense in the lounge room at the rear quarter, and to a significantly lesser extent the master bedroom directly above. Mr Xydias noted that there appeared to have been a single point of origin and seat of fire in the lounge room, where the level of destruction was significantly greater than any other region of the room. The most pronounced level of destruction was in the vicinity of the two-seater couch. The severely charred remains of a barbeque type gas lighter/igniter were also located amongst the charred debris, on the floor immediately beside the couch. It appeared to have been on the floor during the fire.

23. Mr Xydias observed no evidence of any ashtray, cigarettes, additional lighters or matches throughout the lounge room. However, he noted that the level of damage and effective consumption of most combustible contents of the room was such as to have destroyed or concealed any such smoking related items. Mr Xydias added that there was no evidence that the unit had been unlawfully entered at any stage prior to the fire.

24. Mr Xydias concluded that there was a single fire, which started on the lounge room's two-seater couch, or on the floor immediate beside it. The cause appeared to have been the ignition of the relatively abundant available combustible materials in this area. There were no electrical appliances, outlets or wires, nor any other obvious accidental sources of ignition identified at the determined point of origin of fire. A nearby television, overhead light and fitted wiring in the walls were excluded as possible sources of ignition.

25. In the circumstances, Mr Xydias stated that there were at least two probable means of ignition. The first was the barbeque type gas lighter / igniter, while the second was a carelessly

discarded, improperly extinguished or dropped cigarette, match or similar smoking related item. However, these alternatives were dependent upon whether the gas lighter / igniter was indeed gassed and functional; whether any occupants had used the gas lighter / igniter found in the area; or whether any occupants smoked.

26. The Investigation Report compiled by CFA Senior Station Officer Glenn Proebstl also noted the barbeque lighter and identified no other ignition source located in the area of origin of the fire. Mr Proebstl stated that the cause of the fire was accidental and was most likely the result of Nicholas playing with the barbeque lighter.

Coroners Prevention Unit investigation

27. Following my review of the coronial brief, I asked the Coroners Prevention Unit (CPU)[5] to review the circumstances surrounding Nicholas' death, in particular relating to statistical information regarding children who have died in house fires, and whether other house fires have involved barbeque or stove lighters.

28. The CPU sought advice from the Metropolitan Fire Brigade (MFB), as to whether stove lighters had been implicated in other fires. The MFB referred the CPU to a learning resource contained on the Australasian Fire and Emergency Services Authorities Council website,[6] which explained the dangers posed by fire to children, including the risks arising from access to matches and lighters. The MFB informed the CPU that the issue with stove lighters can be a lack of a child-proof lighting mechanism, as found on disposable cigarette lighters which have had to comply with a mandatory standard – including child resistance requirements – since 1997.[7]

29. Further research conducted by the CPU identified that between 1 July 2000 and 31 July 2015, 13 Victorian children under the age of 10 years died from burn injuries sustained in a fire

---

[5] 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, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

[6] Basic Home Fire Safety Materials – Learning Resource, http://www.afac.com.au/auxiliary/publications/newsletter/article/basic-home-fire-safety-materials. Accessed 2 August 2016.

[7] Product Safety Australia website. <https://www.productsafety.gov.au/standards/disposable-cigarette-lighters#child-resistance>. Accessed 2 August 2016.

started by themselves or another child.[8] It was noted that the ages of the children ranged from 22 months to eight years, and access to matches or lighters was apparent in all of these deaths. The CPU was unable to ascertain the type of lighter used in each case from the available documents.

Further investigation

30. By way of Form 4,[9] issued pursuant to section 42 of the Act, dated 6 October 2014, I requested a statement from the Victorian Department of Human Services,[10] detailing all of the Department's contact and involvement with Nicholas. The response indicated that Nicholas was subject to one 'unborn' report to child protection, in which concerns were raised that Ms Musu was isolated, homeless and living in crisis accommodation while pregnant. She was moved to medium term housing during her pregnancy, and was engaged with a number of services including Monash Medical Centre, Hanover Housing Service and Enhanced Maternal Child Health Services. The 'unborn' report was closed on 16 September 2010, 10 days after Nicholas was born, when child protection determined there were no protective concerns beyond unstable housing. A safety plan was established by the protective worker, with the services linked in to monitor the baby and report any future protective concerns to child protection if required. There were no further reports made to child protection regarding Nicholas.

31. By way of email dated 14 July 2016, Charles Charalambous, Senior Compliance and Enforcement Officer - Product Safety, at Consumer Affairs Victoria (CAV) wrote to the Court. Mr Charalambous noted that CAV does not administer safety standards on stove lighters. However, he did note that stove or barbeque type lighters normally have child locks to prevent ignition by children.

32. Mr Charalambous wrote that CAV and other state and territory Australian Consumer Law regulators, including the Australian Competition and Consumer Commission (ACCC), do administer mandatory safety standards on lighters designed to light cigarettes, cigars and pipes. Similarly, the Australian Border Force website indicates that restrictions are placed on the

---

[8] Intentional deaths and Victorian bushfire deaths from 2009 were excluded from this resesearch.

[9] A Form 4 'Request by the Coroner for Document or Prepared Statement', is issued pursuant to section 42 of the Coroners Act 2008, and requires that a document or prepared statement be provided within a specified period of time.

[10] I note that the Victorian Department of Human Services is now known as the Department of Health and Human Services.

import of 'refillable lighters with a customs value of AUD$5 or less, disposable lighters and novelty lighters that have been designed to light cigarettes, cigars and pipes.'[11]

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendations:

1. With the aim of preventing harm and like deaths, **I recommend** that the Hon. Michael McCormack MP, the Commonwealth Minister for Small Business, introduce a mandatory safety standard for barbeque type stove lighters similar to the standards applied to disposable cigarette lighters, particularly noting the need for child resistance requirements.[12]

FINDINGS

Nicholas' untimely death serves as a stark and terrible reminder of the inherent dangers posed by fire and sources of ignition to young children, especially while they are unsupervised.

In the circumstances, with particular reference to Mr Xydias' report, noting that Ms Musu was not a smoker, and acknowledging Nicholas' earlier fascination, the evidence leads me to find that the most probable means of ignition was the barbeque type gas lighter. I am unable to find whether or not Ms Musu inadvertently left the lighter within Nicholas' reach.

I note that Ms Musu left Nicholas unsupervised for what appears to be a period of approximately 30 minutes; it was sufficient duration to allow for these devastating consequences to occur.

I find that a lack of adult supervision, combined with access to a barbeque type gas lighter which may not have been equipped with child resistance mechanisms, contributed to Nicholas' untimely death.

I accept and adopt the medical cause of death as identified by Dr Jacqueline Lee, and find that Nicholas Stephen Brown tragically died from carboxyhaemoglobin poisoning, secondary to the inhalation of smoke in a house fire.

Pursuant to section 73(1A) of the *Coroners Act 2008,* I order that this Finding be published on the internet.

---

[11] See: https://www.border.gov.au/Busi/Impo/Proh; accessed 1 August 2016.

[12] I note that at the time of making this recommendation, the office of the Hon. Michael McCormack MP advised the Court that the responsibility for the Australian Consumer Law had not yet been allocated to the Minister. Should responsibility subsequently be assigned to another Commonwealth Minister, I ask that the office of the Hon. Michael McCormack MP direct this Finding to that Minister.

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

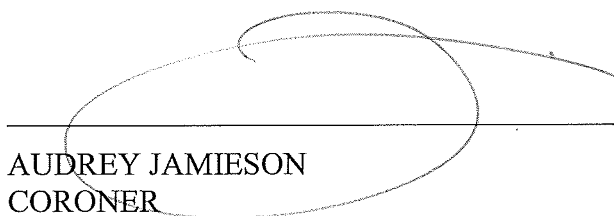
Ms Jacinta Musu

The Hon. Michael McCormack MP, the Commonwealth Minister for Small Business

Ms Kym Peake, Secretary of the Department of Health and Human Services

Senior Constable Dimitrios Gogorossis

Signature:



AUDREY JAMIESON
CORONER

Date: **4 August 2016**