IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 002875

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***

I, ROSEMARY CARLIN, Coroner having investigated the death of SABER ZAKARIA SULIEMAN
without holding an inquest:
find that the identity of the deceased was SABER ZAKARIA SULIEMAN
born on 26 September 1989
and the death occurred on 7 June 2014
at residential premises, Heidelberg Heights, Victoria
from:

1(a) EFFECTS OF FIRE

Pursuant to section 67(1) of the *Coroners Act 2008* there is a public interest to be served in making findings with respect to the following circumstances:

1. Saber Sulieman was born in Sudan on 26 September 1989 and he was 24 years old at the time of his death. He arrived in Australia in 2001 on a refugee visa and settled in Melbourne in April 2014. At the time of his death, he resided with his sister and her children in Heidelberg Heights, Victoria.

2. Victoria Police provided a brief to the Coroner which included statements from Saber's sister, friends, neighbours, investigating officers and a Fire Investigation Report from the Metropolitan Fire Brigade (MFB). I have also considered submissions received from the

Department of Health and Human Services (DHHS) relevant to the circumstances of Saber's death. I have drawn on all this material as to the factual matters in this finding.

3. Saber's sister, Julia Sulieman resided in a two bedroom unit rented from the DHHS. The unit was attached to another unit on a block of land. Ms Sulieman's unit was surrounded by a common garden area. There was also a common laundry which Ms Sulieman shared with her neighbour, David McMutcheon.

4. Ms Sulieman had constructed a gazebo in the common area and when Saber moved in with her, he used the gazebo as his bedroom. Over time he developed the gazebo by erecting a timber frame at the rear and putting a tarpaulin over the top. Synthetic grass was used as flooring and he furnished the space with a sofa, bed, stereo, gaming unit, computer and a small bar. He used an extension cord to access the power supply from the laundry.

5. Mr McMutcheon had made several complaints to DHHS regarding the state of the common area and laundry. DHHS reported that they made efforts to have Ms Sulieman clean up the common area including multiple home visits and office interviews, offers to connect her with support services and issuing notices under the *Residential Tenancies Act 1997* advising that she had breached her duties as a tenant by failing to keep the premises reasonably clean. On 17 April 2014, DHHS representative, James Cassar, questioned Ms Sulieman about the gazebo and she advised him that it was for storage and no one was residing there.

6. On 4 June 2014, Mr Cassar attended the unit and noted that despite having issued a breach notice in May, Ms Sulieman had not removed any of the items from the common area. Mr Cassar reported that his next action would have been to seek a compliance order at the Victorian Civil and Administrative Tribunal.

7. At approximately 4.30 p.m. on 6 June 2014, Saber commenced drinking at the unit with his sister's ex-partner, Aging Ring. They were joined by one of Saber's friends for some time and continued to entertain themselves into the evening. Saber went out for approximately half an hour around 10 p.m. and Mr Ring went to sleep.

8. On 7 June 2014, at approximately 3 a.m., Ms Sulieman went outside and saw that her brother was intoxicated. They argued before she returned to bed. At approximately 4 a.m., Ms Sulieman and Mr Ring woke and heard noise from the garden. They ran outside and saw the gazebo on fire. They telephoned emergency services and attempted to extinguish the flames with a hose. Firefighters arrived shortly after and extinguished the fire, however Saber's body was located deceased in the fire affected area.

9. Dr Matthew Lynch, Forensic Pathologist with the Victorian Institute of Forensic Medicine, conducted an autopsy of Saber's body. There was evidence of significant thermal injury affecting the entire body surface area and sooty material within the trachea and bronchi consistent with Saber being alive when first exposed to the fire. Toxicological analysis of blood samples revealed a blood alcohol concentration of 0.26g/100ml and a carboxyhaemoglobin saturation of 8%.[1] The intoxicants cannabinoids and cathinone were also present in Saber's system. Dr Lynch reported the cause of death as 1(a) Effects of Fire.

10. An analysis of the fire by the MFB concluded that the fire was accidentally started by a lit cigarette making contact with the seated area of the couch in the gazebo. This resulted in a substantial fire enveloping Mr Sulieman while he was on the couch and then spreading to the remainder of the gazebo and its contents. I accept this conclusion.

11. I am satisfied, having considered the evidence, that further investigation is not required. There is no evidence to indicate that Saber's death was suspicious. Rather, the evidence indicates that Saber's death was the result of his smoking whilst intoxicated in a makeshift construction with abundant flammable material. It appears the extent of his intoxication was such that he did not rouse once the fire started.

12. I find that Saber Sulieman died on 7 June 2014 from the effects of fire.

---

[1] Dr Lynch noted that this level of saturation would not be considered toxic and is within the range seen in individuals who are smokers.

COMMENTS

Pursuant to section 67(3) of the Coroners Act 2008, I make the following comment(s) connected with the death:

1. During my investigation I made enquiries with DHHS as to the appropriateness of its response to Ms Sulieman's failure to heed the breach notices issued to her by Mr Cassar. DHHS submitted that it balanced its ability to take further action by way of issuing a notice to vacate the premises with policies in its Director's Tenancy Management Manual 2012. In particular, Ms Sulieman's disadvantaged status as a public housing tenant caused it to adopt a less restrictive approach than a private landlord might in similar circumstances.

2. Nevertheless, as DHHS noted, Saber Sulieman's death may not have occurred if he had been living in a dwelling with appropriately installed and operational smoke detectors and/or sprinklers (Ms Sulieman's house did have a working smoke alarm). Whilst I accept the legitimacy of DHHS policy position when dealing with public tenants and make no criticism of it, this case highlights the need for DHHS to be vigilant to identify those public tenancy breaches which *may* pose a safety risk to the tenant or members of the public. In this case the area in which Saber Sulieman lived was covered by a tarpaulin and Ms Sulieman informed DHHS that no-one lived there. DHHS therefore considered the common area to be unsightly, but not unsafe and proceeded accordingly.

3. DHHS submitted that it has devised fire risk management strategies that focus on mitigating the risk of fires in common areas in the setting of high rise estates. In this case, the fire occurred in the common area of a single storey outer metropolitan housing block, which was unusual.

RECOMMENDATIONS

Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendation(s) connected with the death:

1. 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.

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

The family of Saber Sulieman;

Interested parties;

The Secretary, Department of Health and Human Services;

Metropolitan Fire Brigade; and

Investigating Member, Victoria Police.

Signature:

ROSEMARY CARLIN
CORONER
DATE: 8 November 2015