IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 4614

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**ROSEMARY CARLIN, CORONER**
Deceased:	**DQ***
Date of birth:	22 November 2015
Date of death:	13 September 2018
Cause of death:	1(a) CARBON MONOXIDE TOXICITY
Place of death:	University Hospital Geelong, Bellerine Street, Geelong, Victoria

* This is a redacted version of the original signed finding. Names have been replaced with pseudonyms to preserve the privacy of DQ's family

HER HONOUR:

Background

1. On 13 September 2018 two young sisters DQ and LQ tragically died after a house fire which started in the bedroom they shared. DQ was born on 22 November 2015 and she was 2 years and 9 months old when she died. LQ was born on 23 November 2016 and she was 1 year and 9 months old when she died.

2. The sisters lived in East Geelong with their parents, MA and HQ, and younger sister, NQ.

3. MA moved to Australia from Iran in 2013. She later married HQ in Iran before returning to Australia. HQ moved to Australia in February 2015. The couple had limited English.

4. In September 2015 MA and HQ rented a house at 41 Loch Street, East Geelong, where they lived until the fire. Prior to moving in, 41 Loch Street was owner occupied. It became vacant when the elderly occupant moved into a nursing home. At that stage the owner's power of attorney, who was also his niece, was told about a couple (MA and HQ) who were interested in renting the premises. A solicitor drew up the rental agreement and the property was rented to them privately without the involvement of a real estate agent.

5. The house was fitted with one battery operated smoke detector, located just inside the front door on the ceiling. Apparently, the battery was removed from the detector just before HQ and MA moved in because it was beeping. As the detector was not hardwired, the removal of the battery rendered the device useless. The niece reported that she advised the couple to replace the battery in the detector when the rental agreement was signed. The rental agreement itself made no reference to the smoke detector.

The coronial investigation

6. The deaths of DQ and LQ were reported to the Coroner as they each 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.

7. Coroners independently investigate reportable deaths to find, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to

the death. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[1]

8. The law is clear that coroners establish facts; they do not cast blame, or determine criminal or civil liability.

9. 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.

10. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into DQ's death. The Coroner's Investigator investigated the matter on my behalf and submitted a coronial brief of evidence.

11. After considering all the material obtained during the coronial investigation I determined that I had sufficient information to complete my task as coroner and that further investigation was not required.

12. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

Identity of the deceased

13. DQ was visually identified by her father, HQ, on 13 September 2018. Identity was not in issue and required no further investigation.

Medical cause of death

14. On 14 September 2018, Dr Gregory Young, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted autopsies upon the bodies of DQ and LQ after reviewing post mortem computed tomography (CT) scans.

[1] In the coronial jurisdiction facts must be established on the balance of probabilities 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.

15. Toxicological analysis of post mortem specimens taken from DQ identified carboxyhaemoglobin (40% saturation) and atropine. Toxicological analysis of post mortem specimens taken from LQ identified carboxyhaemoglobin (45% saturation).

16. After reviewing toxicology results, Dr Young completed a report in relation to each girl, dated 12 October 2018, in which he formulated the cause of death as "*1(a) Carbon monoxide toxicity*". I accept Dr Young's opinion as to the medical cause of death.

Circumstances in which the death occurred

17. On the evening of 12 September 2018, the family drove to Melbourne for a religious gathering. They returned home at 1.00am the next morning and the children were put to bed.

18. DQ and LQ's shared bedroom was at the front of the house. DQ slept on a bed along the back wall and DQ slept in a cot to the left. Sometimes, DQ played before putting herself to bed. Recently, she had learned to climb into LQ's cot where she would fall sleep.

19. An electric heater with three heating elements, each with a separate power switch, was placed between the bed and the cot to keep the room warm. Sometimes, DQ turned the heater off by herself.

20. In the early hours of 13 September 2018, HQ placed LQ in the cot with a bottle of milk. DQ played with her toys. HQ turned the heater on, closed the bedroom door, and placed a red bath mat at the bottom of the door to stop draughts entering the bedroom.

21. At approximately 8.00am, MA awoke and walked down the hallway to check on LQ and DQ. She noticed that there was a light fog in the house but could not smell anything. She opened the girls' bedroom door and saw the room was filled with smoke. Both DQ and LQ were in the cot.

22. MA picked LQ up and yelled out to her husband.

23. HQ woke and ran to the bedroom to find it filled with smoke. He ran next door for help. His neighbour, PP, contacted emergency services.

24. When HQ returned to the house, MA was trying to resuscitate LQ in the front bedroom. HQ picked DQ up out of the cot and the couple ran out to their car with LQ and DQ and drove to

Geelong Hospital, which was only three minutes away. NQ remained in her cot in her parents' bedroom.

25. Sergeant Stephen Bull of Victoria Police was the first responder. When told there may be three children in the house, he entered through the front door. The house was filled with black smoke up to his chest. He searched the house but was unable to find the source of the smoke nor any occupants.

26. DQ and LQ arrived at the emergency department at Geelong Hospital at approximately 8.05am and were immediately tended to by hospital staff. Despite multiple rounds of advanced cardiac life support, LQ was pronounced deceased at 8.41am and DQ was pronounced deceased at 8.42am.

Fire brigade response and subsequent investigation

27. The Geelong City Fire Brigade arrived at the house. Firefighters found NQ and removed her from the house; she did not suffer any adverse effects from the fire or smoke but was taken to hospital for assessment.

28. In the front bedroom, Leading Firefighter David Riddell and Firefighter Scott Ware observed fire damage to the floor, but no fire. There was a glowing hole in the floor, upon which the firefighters poured water. Leading Firefighter Riddell observed a small electric heater directly behind the hole and concluded it was the heat source although it was not switched on. Firefighter Ware observed that a stuffed toy had been fire damaged and concluded it had combusted by being too close to the heater.

29. John Kelleher, scientist at the Victoria Police Forensic Services Centre, examined the scene. He found a smoke detector bracket in the hallway, approximately halfway between the door to the loungeroom and the bathroom door. There was no smoke detector fitted to the bracket and no other smoke detector in the house. He noted that the location of the bracket was reasonable for a single smoke detector; but given the relatively high ceilings believed it would have been preferable to have detectors in each of the main rooms.

30. The only room with any burning was the front bedroom. Here, the burning was limited to an area of approximately 0.25 square metres, immediately in front of the heater. There was a 30-centimetre hole burnt through the carpet, underlay, and floorboards. There was minor

damage to the front of the heater and also scorching of the closest leg of the cot. A suitcase on the floor beneath the cot had a small amount of melting and scorching.

31. There was extensive light sooting in the room. There were no significant heat effects, apart from the immediate vicinity of the hole in the floor. The sooting was evident on the blankets in the cot, but in quite an irregular pattern, suggesting that the blankets were crumpled at the time.

32. There was very little soot visible outside the front bedroom. It was clear that the door had been closed and there was a bathmat outside the door to stop draughts. With the windows closed, this was probably the main source of ventilation for the front bedroom. There were two wall vents, near the top of the southwestern wall, but these appeared to have been at least partially blocked with dust and cobwebs.

33. Mr Kelleher found part of a burnt stuffed animal in the burnt area.

34. The electric heater was substantially intact. Examination of the heater showed that two, possibly three of the elements had been in use.

35. Mr Kelleher concluded the cause of the fire was ignition of combustible material, namely a stuffed toy, on the floor in front of the heater. The stuffed toy had melted and burned and subsequently caused the carpet, underlay, and timber below to ignite. The fire appeared to have been a small, slow smouldering type fire, since there was insufficient flaming combustion to ignite the nearby bedding or the cot itself. The source of the ignition was probably the heater. Mr Kelleher was unable to conclude how the toy came to be near the heater.

36. Mr Kelleher noted that the level of carbon monoxide produced in these circumstances would probably approach five percent, which is lethal.

37. Goran Sokoleski from Energy Safe Victoria examined the electric heater and found no fault in the heater.

Findings

Pursuant to section 67(1) of the *Coroners Act 2008* I find as follows:

(a) the identity of the deceased was DQ, born 22 November 2015;

(b) DQ died on 13 September 2018 at University Hospital Geelong, Bellerine Street, Victoria, from carbon monoxide toxicity; and

(c) the death occurred in the circumstances described above.

Comments

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

1. At the time the house was rented to DQ and LQ's parents it had a single smoke detector, albeit without battery. At some point prior to the fire, the smoke detector was removed from the bracket, leaving only the empty bracket in the ceiling. There is no evidence before me to explain when, how, or by whom the smoke detector was removed. In her statement MA simply said *'I am unsure if there are any smoke alarms in the house'*.

Compulsory installation of smoke alarms in Victoria

2. The installation of smoke alarms in every residential building has been compulsory for a long time. For buildings built before 1 August 1997, the minimum requirement is that battery-powered smoke alarms be installed. For buildings built after that date, hard-wired smoke alarms with backup batteries need to be installed.

3. The reason for installation of smoke alarms is clear: they save lives. However, despite numerous public awareness campaigns and the requirements of the *Building Regulations 2018 (Vic)*, less than half of properties attended by fire services have smoke alarms and, of those almost one third are not working.[2] These figures are extremely concerning.

4. The Metropolitan Fire Brigade advises that smoke alarms should be located as follows:[3]

(a) between each bedroom area and the rest of the house;

(b) in addition, inside any bedroom where someone sleeps with the door shut;

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[2] Installation and replacement of smoke alarms – Country Fire Authority https://www.cfa.vic.gov.au/plan-prepare/installation-and-replacement, accessed 20 May 2019. In April 2019, the Metropolitan Fire Brigade reported that working smoke alarms were present in 49 percent of the homes where a fire occurred in the metropolitan district in 2018: Firefighters sound the alarm on smoke alarm maintenance – Metropolitan Fire Brigade, http://www.mfb.vic.gov.au/News/Media-releases/Firefighters-sound-the-alarm-on-smoke-alarm-maintenance-.html, accessed 20 May 2019.

[3] Smoke Alarms – Metropolitan Fire Brigade http://www.mfb.vic.gov.au/Community/Home-Safety/SmokeAlarms.html, accessed 20 May 2019.

(c) in a two-storey home, on every storey, in the path that people will use to evacuate.

Smoke alarms in rental properties: who is responsible?

5. Although it is clear that landlords and owners are responsible for ensuring that working smoke alarms are installed in their rental properties, the law is less clear as to who is responsible for ensuring that installed smoke alarms remain in working order during the period of a lease. Sometimes, individual rental agreements specify where the obligation falls, but not in this case.

6. Section 68(1) of the *Residential Tenancies Act 1997 (Vic)*, provides that a landlord must ensure that rented premises are maintained in good repair. The tension between this provision and a tenant's right to exclusive occupancy means that in practice, a landlord's obligation to conduct maintenance work is *only* enlivened when they become aware of a maintenance issue, which is usually when the tenant notifies them that one exists.[4] Thus, landlords may have no obligation to test smoke alarms throughout a tenancy, rather it may fall to tenants to check that smoke alarms are working and to report any faults accordingly. One may also query whether the need for a battery replacement amounts to something not being in good repair.

7. Section 66(1) of the *Residential Tenancies Act 1997 (Vic)* requires landlords to give a tenant a written statement setting out tenants' rights and duties. This document is a pamphlet produced by Consumer Affairs Victoria titled *Renting A Home: A Guide For Tenants.*[5] The pamphlet explains that landlords/agents or owners are responsible for fitting smoke alarms in rented properties and that smoke alarms should be tested regularly and replaced after 10 years. It does not clarify who should conduct the testing. It also states that tenants should not deactivate a smoke alarm or interfere with its operation and should notify the landlord/agent/owner if the smoke alarm is faulty or not working.

8. The Victorian Building Authority recommends tenants should:[6]

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[4] I note that the *Residential Tenancies Amendment Act 2018 (Vic)* comes into effect on 1 July 2020, which will classify repairs to smoke alarms as an urgent repair.

[5] Also see Smoke alarms and fire safety - advice for tenants and residents – Consumer Affairs Victoria https://www.consumer.vic.gov.au/housing/renting/during-a-lease-or-residency/safety-advice-for-tenants-and-residents/smoke-alarms-and-fire-safety, accessed 20 May 2019.

[6] Smoke Alarms – Victorian Building Authority https://www.vba.vic.gov.au/consumers/smoke-alarms, accessed 20 May 2019.

(a) check the smoke alarm is working by pressing the button on its outside;

(b) replace the smoke alarm battery on an annual basis (if the battery is lithium ion, every 10 years);

(c) replace the battery if the smoke alarm emits a warning sound (a high-pitched single beep every 30 seconds);

(d) clean the alarm regularly to remove dust particles; and

(e) familiarise themselves with the manufacturer's maintenance guidelines.

9. I would be surprised if many tenants are aware of these recommendations.

Fire safety education for non-English speaking tenants

10. Tenants from non-English speaking backgrounds or from countries where smoke alarms are not common are a particularly vulnerable group in our community. If it is assumed that English-speaking tenants are largely unaware that they may have an obligation to test smoke alarms, it seems even less likely that non-English speaking tenants would be aware of it.

11. Melbourne's Metropolitan Fire Brigade (**MFB**)[7] has recognised this particular vulnerability and initiated the Flames for Teens program. It teaches newly arrived teenagers about fire safety through English language schools and centres. This demographic has been targeted because their parents often rely on them to work through cultural differences.

12. The MFB also runs Flames for Adult Migrants, which is a partnership program with the Adult Multicultural Education Services Victoria. This program teaches adult migrant students fire safety and fire safe behaviours.

13. Both programs are commendable but, in my view, do not reach far enough.

[7] English Language Schools – Metropolitan Fire Brigade http://www.mfb.vic.gov.au/Community/Safety-Programs/English-Language-Schools.html, accessed 20 May 2019.

Previous recommendations

14. In the 2014 *Finding into Death Without Inquest of Sunil Ramanlal Patel* (and its associated findings),[8] Coroner Peter White examined the deaths of three Indian nationals who had died in a house fire in Footscray. The evidence revealed that the house was fitted with at least one smoke alarm but none of the surviving tenants knew what a smoke alarm was or whether any were installed and/or working. Most of the tenants, if not all, were migrants.

15. Coroner White assessed that the regulatory framework regarding the installation and maintenance of smoke alarms was not sufficiently clear or effective in protecting all segments of the renting public. Coroner White noted that it was clear a smoke detector must be installed but asked the same question I have asked above: who undertakes regular checks or tests? Should it be the landlord, the tenant, or the agent (if applicable)?

16. As I have done, Coroner White noted that there was no specific section or regulation that specified who was responsible for the maintenance and testing of a smoke detector in a rented residence.

17. Although the rental agreement in the *Patel* case created an obligation on the tenants to test the smoke alarms weekly, Coroner White identified the following ambiguity:

> *... what does that mean in practice? In rented properties constructed before 1 August 1997, is the landlord obliged to enter to change a battery? Is the tenant obliged to notify the landlord that the battery needs to be changed, or is it the tenant's obligation to do so? Is the tenant permitted to change the battery themselves, and if so, is the tenant required to give notice to the landlord of having done so, in order that the landlord can remain informed as to the state of repair of the demised premises?*[9]

18. Coroner White referred to the Consumer Affairs Victoria pamphlet, which was silent as to who was responsible for checking and maintaining the smoke alarm. It also did not contain information about why smoke alarms are important for safety, nor did it include any photographs of what a smoke alarm might look like.

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[8] COR 2008 0041 and connected with *Finding Into Death Without Inquest of Jignesh Kumar Ghanshyambas Sadhu* COR 2008 0042 and *Finding Into Death Without Inquest of Deepak Kumar Prajapati* COR 2008 0043, all handed down on 29 August 2014.

[9] *Finding Into Death Without Inquest of Sunil Ramanlal Patel* COR 2008 0041, at [75].

19. His Honour concluded there was a *'hiatus'* between the responsibilities of landlords and tenants, including what was likely to occur in practice. Unfortunately, this is still the case.

20. In addition, Coroner White identified that there are many tenants who come from different parts of the world who do not know what a smoke detector is, and indeed, what the tenants' role in maintaining or checking them is. This vulnerable group in the community need support and education to ensure their rental premises are safe.

21. Coroner White therefore made a number of recommendations, which included:

    (a) the *Building Regulations* be amended to ensure that all properties, regardless of when they were built, subject to a residential tenancy agreement be fitted with hard-wired smoke alarms with long-life batteries in a tamper-proof battery chamber;

    (b) the *Residential Tenancies Act 1997 (Vic)* be amended to clarify who bears responsibility for the testing and maintenance of smoke detectors. His Honour suggested landlords/agents annually certify smoke alarms are in working order, replace any smoke alarm before the end of its service life, and require checking of smoke alarms during annual inspections; and

    (c) that Consumer Affairs Victoria review and update its publication to clearly specify the rights and obligations of landlords and tenants in relation to the installation, maintenance, repair, and replacement of smoke alarms, include a diagram of a smoke alarm, and pictorial instructions as to how to test and clean them and check batteries, and what to do in the event the smoke alarm goes off.

22. The *Building Regulations* were updated after Coroner White's finding, however not so as to require hard-wired smoke alarms to be installed in all residential buildings.[10] Further, despite a recent review of legislation and a suite of new amendments, landlord and tenant obligations in relation to smoke detectors have not been clarified.

23. In its response to recommendation (c), Consumer Affairs noted that it was reviewing and updating its publication to include additional information on smoke alarm maintenance and testing together with general fire safety messaging. It was also working with the MFB

[10] The *Building Regulations 2018 (Vic)*

to develop a flyer about fire safety that would be inserted into the publications. I note that the April 2019 edition of this publication does not have any pictorial instructions or general fire safety information, nor does it clearly specify who should test smoke alarms. However, a flyer under the branding of the MFB and Country Fire Authority does give instructions for tenants on fire safety and smoke detector maintenance and I believe that flyer is inserted into the pamphlet.

24. It is unfortunate that Coroner White's recommendations supporting clarity in the legislation have not been implemented. The similarity of the circumstances in this case and the *Patel* finding highlights the ongoing lacuna in the legislation, which no doubt continues to confuse both landlords and tenants and possibly risk lives.

Conclusion

25. DQ and LQ's deaths were tragic and, sadly, entirely preventable. It seems likely that MA and HQ were poorly educated as to combustion hazards and fire safety generally. They may also have been unaware of the importance of having a working smoke detector. If the house had been fitted with working smoke detectors in accordance with the Metropolitan Fire Brigade recommendations above, there is a very real possibility if not a likelihood, that the girls' deaths would have been prevented.

Recommendations

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

1. I recommend the Minister for Consumer Affairs, Gaming and Liquor Regulation investigate the best way for smoke detectors in rented residential premises to be maintained and checked. This will involve consideration of whether landlords should be required to conduct annual inspections of smoke detectors in rental properties.

2. I recommend the Minister for Consumer Affairs, Gaming and Liquor Regulation and the Minister for Planning consider amending the *Residential Tenancies Act 1997 (Vic)* and the *Building Regulations 2018 (Vic)* so that:

    (a) all leased residential buildings are required to have hard-wired smoke detectors irrespective of when they were built;

(b) it is an offence for landlords to lease residential properties that do not have hard-wired smoke detectors in working order at the time a lease agreement is signed; and

(c) plainly specify the obligations and responsibilities of landlords and tenants as to who is responsible for maintaining and checking smoke detectors.

3. I recommend Consumer Affairs Victoria amend its publication titled *Renting A Home: A Guide For Tenants*:

(a) to clarify who should check smoke alarms;

(b) include pictorial explanations about how a smoke alarm works and how it can save lives;

(c) include pictorial instructions as to how to check and maintain a smoke alarm; and

(d) include pictorial instructions about what to do in the case of a fire.

4. I recommend the Metropolitan Fire Brigade consider:

(a) working with Geelong Fire Services, other regional fires services, and Consumer Affairs Victoria to expand their migrant education programs among multicultural organisations and other like community groups; and

(b) regularly publishing fire safety advice in ethnic newspapers and other like publications.

The loss of a child is always a tragedy. The loss of two children is unfathomable. I convey my sincere condolences to MA and HQ and their extended family.

I commend Sergeant Stephen Bull's actions in entering the smoke-filled house to search for occupants.

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

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

MA, Senior Next of Kin

HQ, Senior Next of Kin

Barwon Health

Metropolitan Fire Brigade

Victorian Building Authority

Consumer Affairs Victoria

The Hon. Marlene Kairouz, Victorian Minister for Consumer Affairs, Gaming and Liquor Regulation

The Hon. Richard Wynne, Victorian Minister for Planning

Sergeant Stephen Bull, Victoria Police

Senior Constable Daniel Hughes, Coroner's Investigator, Victoria Police

Signature:

ROSEMARY CARLIN
CORONER
Date: 29 May 2019

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 4615

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**ROSEMARY CARLIN, CORONER**
Deceased:	**LQ***
Date of birth:	23 November 2016
Date of death:	13 September 2018
Cause of death:	1(a) CARBON MONOXIDE TOXICITY
Place of death:	University Hospital Geelong, Bellerine Street, Geelong, Victoria

* This is a redacted version of the original signed finding. Names have been replaced with pseudonyms to preserve the privacy of LQ's family

HER HONOUR:

1. This finding is to be read in conjunction with the finding into the death of DQ COR 2018 4614 which is published on the internet.

Findings

Pursuant to section 67(1) of the *Coroners Act 2008* I find as follows:

(b) the identity of the deceased was LQ, born 23 November 2016;

(c) LQ died on 13 September 2018 at University Hospital Geelong, Bellerine Street, Victoria, from carbon monoxide toxicity; and

(d) the death occurred in the circumstances set out in the finding into the death of DQ.

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

MQ, Senior Next of Kin
HQ, Senior Next of Kin
Barwon Health
Metropolitan Fire Brigade
Victorian Building Authority
Consumer Affairs Victoria
The Hon. Marlene Kairouz, Victorian Minister for Consumer Affairs, Gaming and Liquor Regulation
The Hon. Richard Wynne, Victoria Minister for Planning
Sergeant Stephen Bull, Victoria Police
Senior Constable Daniel Hughes, Coroner's Investigator, Victoria Police

Signature:

ROSEMARY CARLIN
CORONER
Date: 29 May 2019