CASE STUDY

MILL PARK FIRE FATALITY 2019

PERFORMANCE AND ASSURANCE UNIT
STATE OPERATIONS DEPARTMENT
OFFICE OF THE FIRE RESCUE COMMISSIONER

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FIRE RESCUE VICTORIA

2019 Mill Park structure fire fatality

1.INTRODUCTION

Fire Rescue Victoria (FRV) is committed to our vision: safer and more resilient communities supported by a modern, professional, and inclusive fire and rescue service.

The Performance and Assurance Unit assists in achieving FRV's vision by supporting continuous improvement through effective monitoring and revision of operational response activities across FRV.

The sharing of knowledge and experience provides FRV with a learning mindset, and it also helps identify potential risks to the safety of firefighters and the community.

The following case study discusses a structure fire in Mill Park in 2019 that resulted in a fatality. The sole occupant and deceased person was 54 years old at the time of the fatality and had a disability for which they were receiving NDIS support services.

This case study outlines the events that culminated in the death of the deceased. There are valuable learnings from this event, and it is important that they are shared with FRV operational firefighters to improve its response to the community.

The fire occurred prior to the establishment of Fire Rescue Victoria, therefore the responding agencies in this case study will be appropriately referred to as the Metropolitan Fire Brigade (MFB) and the Country Fire Authority (CFA). Information in this case study has been taken from the Coroner's Findings (COR 2019 000309).

2.INCIDENT OVERVIEW

On Thursday, January 17, 2019, the service coordinator at a homecare nursing organisation was working an ‘on-call’ carer’s shift from her home, where her responsibility was to take urgent phone calls from clients after hours. At 2.42am, the carer received a phone call from a person who, sounding very distressed, said that ‘my blanket is on fire’.

The carer could hear a smoke alarm in the background, but the call was either disconnected or the caller hung up before further details could be obtained. When the call ended, the carer checked the caller’s number on her phone, but didn’t recognise it, so she called her supervisor to report the matter. She was advised to call 000 and to request emergency services response.

The carer believed that the caller may have been a client known to frequently call the on-call number late at night. A call was made to 000 at 2.46am, requesting the fire brigade to attend this client’s address in St Albans.

MFB responded to the address and arrived on scene in St Albans at 2.54am. Firefighters spoke to the residents at this address and were informed that there was no fire at the residence. MFB requested the number of the caller who originated the firecall for further information. During the conversation, MFB determined that they were at the correct address for this firecall, so they advised the carer that there was no fire at this location.

At 3.04am, the Incident Controller communicated a False Alarm to ESTA and appliances returned to station.

While MFB had been investigating the firecall in St Albans, the carer and her supervisor continued to call the client’s number and searched their records for the identity of the caller. The carer also contacted 000 and asked for assistance in identifying where the call had originated. ESTA was able to advise that their attempts to call the client’s number indicated that the call originated in Eltham, and not St Albans.

While the carer was discussing this with ESTA, the supervisor had found in her records that the caller was in fact another client, being the deceased person. At 3.22am, the carer called 000 again and requested the fire brigade to attend the deceased person’s address at 36 Maybury Drive in Mill Park.

MFB and CFA were dispatched to the address.

While enroute to the given address, ESTA provided further information to responding crews, stating that the carer had called them earlier in the evening ‘for another address for a similar thing’ and the call had turned out to be a false alarm. Prior to arriving on scene, the ESTA dispatcher updated the further information to confirm that the carer had called ‘not long ago’ to report a fire in St Albans ‘for a similar situation and that was a false alarm’.

At 3.31am, the first fire appliance booked on scene. They passed properties at number 40 and number 38 before stopping at the house next door, believing it to be 36 Maybury Drive. It was, in fact, 38A Maybury Drive. This house was on the corner of Maybury Drive and Pensbury Avenue, and its letterbox was damaged, so the number 8 was not visible.

The number 38A was stencilled on the curb next to the driveway of the property being investigated, and it was also attached to a post on the front patio, but neither was seen by the crews during their investigation.

Firefighters knocked on the door of the property and asked the residents if there was a fire at the address, and they were told by the residents that there was no fire.

A firefighter then walked down the street – past 36 Maybury Drive – to further investigate the firecall. They reported that there was nil sign of smoke or fire – not even the smell of smoke.

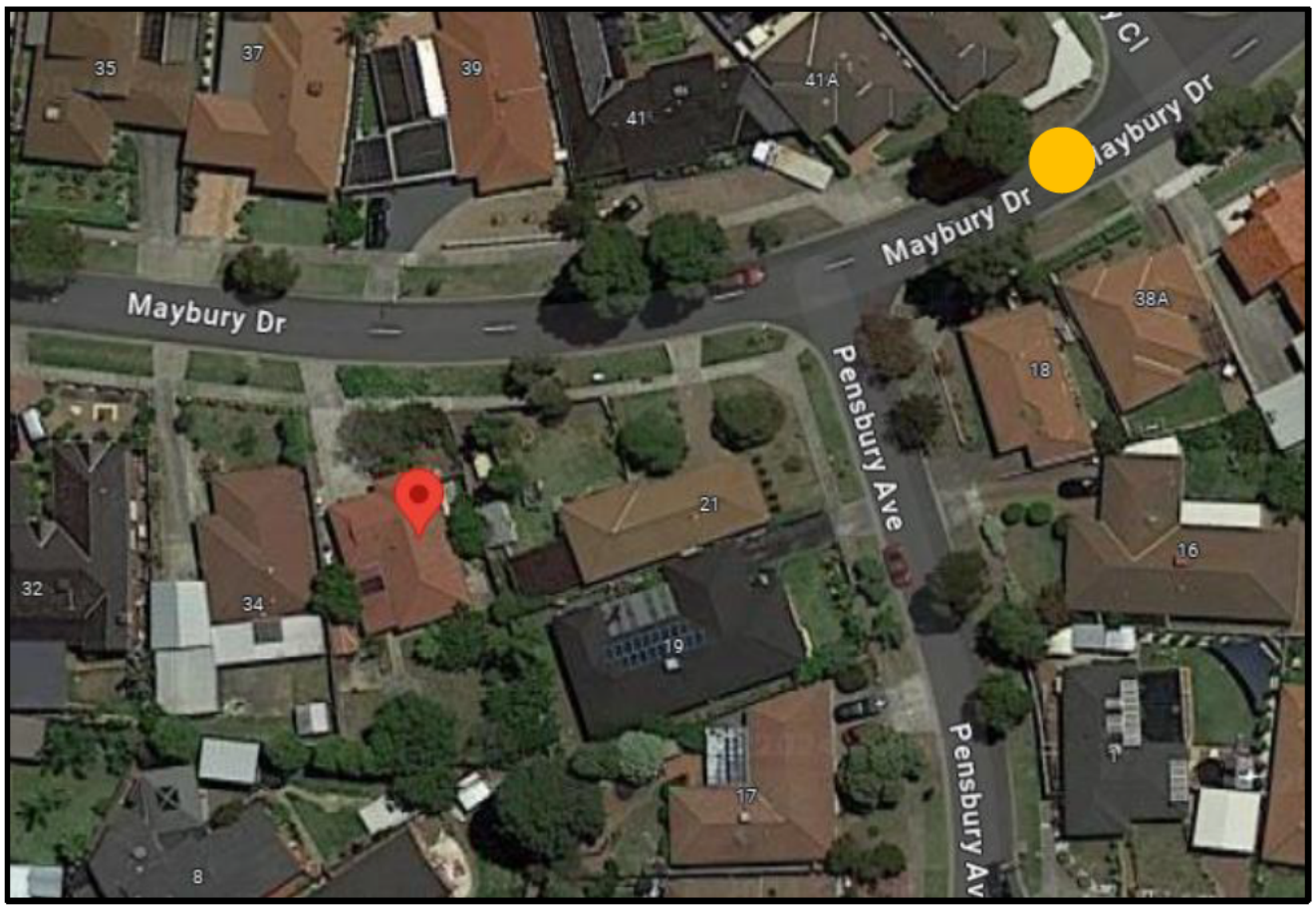

Figure 1: 36 Maybury Drive, Mill Park (identified with a pin drop) and where MFB appliances staged for its first firecall to Maybury Drive (indicated with a yellow circle), believing they were at the correct address.

At this point, the crews were confident - based on the further information from ESTA, their on-foot investigation and their inquiries with residents on Maybury Drive – that there was no fire at this location. At 3.35am, the Incident Controller notified ESTA of a False Alarm Malicious Hoax, before returning to station, slowly driving past 36 Maybury Drive as they left.

CCTV footage confirms MFB and CFA actions, and also reveals that there was no obvious sign of fire at 36 Maybury Drive at this time.

At 3.39am, the carer spoke to her supervisor, and they agreed that the carer would drive to the client's address at 36 Maybury Drive to check on her. On her arrival, the MFB appliances had already returned to station, there was no sign of fire and the Vic Emergency app no longer showed an incident at this location. The carer was advised by her supervisor not to enter the property, so she left.

At 4.59am, smoke and flames began issuing from 36 Maybury Drive in Mill Park, with multiple calls to ESTA.

MFB and CFA were dispatched to the call – this was, in effect, the third firecall, and more than two hours after the deceased person had originally called their carer.

At 5.07am, fire services arrived on scene and immediately commenced operations. About 10 minutes later, crews found the deceased person in their bedroom where they had already passed

away. The deceased person was noted to be wearing an emergency alert pendant, but the monitoring company later advised that they had not received an alert from the deceased person.

Once the fire had been brought under control and extinguished, the scene was secured for investigators. While the source of ignition could not be confirmed, investigators concluded that the fire started in the deceased person's bedding and was likely started by a cigarette.

In the subsequent investigations undertaken by the Coroner (which will be further discussed in the following section), it was recorded that the deceased person had been a long-time smoker who 'would often fall asleep in [their] bed or chair whilst smoking'.

They also received significant care due to their disability from a stroke in 2010 and required a wheelchair and assistance getting in and out of bed.

The deceased person's ability to exit their property in Maybury Drive once the fire had commenced on January 17, 2019 was extremely limited. Response to their property in such an emergency was time critical. At no point during any firecalls were fire crews alerted by ESTA to the fact that the deceased person had a disability.

Investigators also discovered that there were two battery-operated smoke detectors in the deceased person's residence, but neither were connected to their emergency alert pendant, which was a technology which was available at the time of the fire. This would have ensured an alert was immediately sent on detection of smoke and an accurate location provided for emergency response agencies. The installed smoke detectors had only been installed since 2017.

3.CORONIAL INVESTIGATION

In the course of the coronial investigation by the Coroner, FRV conceded that firefighters had attended the incorrect address when first responded to Maybury Drive, prior to any evidence of smoke or fire. FRV stated during the inquiry that attending the wrong address for a firecall was rare.

It was also reported that MFB doctrine at the time did 'not explicitly require firefighters to verify the reported address', but it was expected that the officer in charge 'will undertake a full investigation to obtain accurate situational awareness including a correct address'.

While the complexity of decision-making during a size-up enroute and on scene was communicated by FRV to the investigation, the investigation established that the fundamental issue for this incident was simple: **inability to correctly identify the property nominated in the firecall**.

Transcripts of the call show that the MFB and CFA appliances were only on scene for about three minutes on the second attendance, which did not constitute a thorough investigation of the scene, according to the investigation .

The investigation also established that the attending crews for the first call to Maybury Drive did not take adequate steps to correctly identify the address when speaking to the residents at the property on Maybury Drive by asking them to confirm their address. Further, crews did not notice the number 38A on the patio post when approaching the front door of this residence. When MFB/CFA walked past 36 Maybury Drive, the number was clearly on the letterbox at that address but was not noticed or communicated by the firefighter.

It was also heard during the investigation that while the officer in charge will often request the caller's details to verify information, there was no formal policy that required them to do so. This was evident when the crews attending the St Albans firecall requested the caller details, while the crews responding to the Mill Park firecall did not.

The Coronial investigation concluded that, on the available evidence, it was not possible to determine whether the deceased person would have survived if the fire brigade arrived before 3.31am, or if they were still alive immediately after this time when firefighters arrived for the first time at Maybury Drive.

4.KEY LEARNINGS

There were several factors that contributed to the tragic outcome of this incident, like most catastrophic events (Swiss-cheese effect).

The key learnings and the purpose of this case study is to highlight the importance of verifying the property address of the firecall if signs of fire are not apparent.

This can be achieved in the following ways:

- Thorough size-up of the location, including investigation of letterboxes, street curb marking, and pole markings.
- Questioning residents at the nominated address and asking them to confirm their address.
- Requesting the caller details and contacting with the original caller or asking Firecom (communications centre) to contact the caller to verify the address.
- To understand that street numbers are not always sequential, and that confirmation of the street numbering pattern is required.
- For the OIC to communicate the importance of address verification to crew, and for crew to assist with size-up and share intelligence.
- To allow sufficient time for accurate size-up and intelligence gathering.
- Communicating to Firecom all steps that have been taken to confirm the address before providing a ‘returning’ Wordback.

These steps must not be bypassed on a suspicion or assumption that the call is a false alarm or malicious call.

5.CONCLUSION

For Fire Rescue Victoria, False Alarms are not uncommon and the risk for familiarity and complacency is always a possibility. While the risk of false alarm is often present, OICs must treat every call as a call for alarm of fire until proven otherwise through a comprehensive size up.

While there are further actions required by FRV as a result of the Coronial investigation, immediate actions by operational crews in taking all necessary steps to confirm a nominated address is within the control of firefighters and can be implemented immediately.

The purpose of this study is for continuous improvement in firefighting doctrine, training and practice, so that FRV can better support our firefighters in their challenging roles in the future.

FRV continues to work with various stakeholders in order to ensure that operational enhancements are implemented effectively. FRV is also working together with other government bodies, such as the NDIS, to advocate for enhancements, such as domestic sprinkler systems for persons with disabilities, to best manage the environments that firefighters may be required to attend in future.

If this case study has raised any issues for you, FRV encourages you to contact the FRV Wellbeing Support line [redacted] for additional support.

6.PERFORMANCE AND ASSURANCE UNIT - KEY MESSAGES

- Undertake regular debriefing to discuss actions and outcomes from operational incidents.
- Share your knowledge with Performance and Assurance, so we can share information appropriately across FRV.
- Continue to update your knowledge by reading and understanding new doctrine when produced by FRV's Policy, Planning and Operational Guidance Department.
- Review doctrine references related to FRV - Incident Knowledge Shares.
- Continue to maintain skills through station drills and regular training.
- Continue to use the FRV Safe application to record incidents and hazards.

If you have any further questions, please contact FRV Performance and Assurance Unit at [redacted]

Performance and Assurance Unit
State Operations Department
Office of the Fire Rescue Commissioner