IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 000309

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	Vivianne May Rodger
Date of birth:	22 July 1964
Date of death:	17 January 2019
Cause of death:	1(a) EFFECTS OF FIRE IN A WOMAN WITH PAST RIGHT MIDDLE CEREBRAL ARTERY TERRITORY STROKE AND PULMONARY EMPHYSEMA
Place of death:	36 Maybury Drive, Mill Park, Victoria, 3082
Keywords:	Fire; disability; smoke alarm; personal alarm; monitoring of alarms; firefighter response to alarm of fire

INTRODUCTION

1. On 17 January 2019, Vivianne May Rodger was 54 years old when she died in a house fire at her home. At the time of her death, Ms Rodger lived alone at 36 Maybury Drive, Mill Park, Victoria.

THE CORONIAL INVESTIGATION

2. Ms Rodger's death was reported to the Coroner as it 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.

3. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

4. 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.

5. Coroner John Olle originally had carriage of this investigation and Detective Sergeant Weaver of the Victoria Police Arson and Explosives Squad acted as the Coroner's Investigator. Detective Sgt Weaver conducted inquiries on Coroner Olle's behalf, searching out sources of evidence and taking statements from witnesses – such as family members, forensic experts, and investigating officers – and submitted a coronial brief of evidence.

6. In October 2022 I took over carriage of this matter.

7. This finding draws on the totality of the coronial investigation into the death of Vivianne May Rodger including evidence contained in the coronial brief. While I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for

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

BACKGROUND

8. Ms Rodger was born in Melbourne on 22 July 1964 to Joyce Rodger. She had one older brother, and two sons who were aged 34 and 18 at the time of her death.

9. Ms Rodger attended Glenroy Primary School and Santa Sofia Catholic College. She worked in a variety of different jobs after finishing school.

10. Ms Rodger started smoking at an early age and continued to smoke throughout her life. Her mother reported that she would often fall asleep in her bed or chair whilst smoking, and her blankets had burn marks and holes in them from this.

11. In 2010, Ms Rodger suffered a stroke and sustained an acquired brain injury resulting in paralysis of the left side of her body, including her left arm and leg. As a consequence, she was unable to move about independently. She used a wheelchair and required assistance to get in and out of bed.

12. Between 26 October 2010 and 25 May 2017, Ms Rodger received disability support services funded by the then Department of Health and Human Services. From 26 May 2017, her support services, including self-care, community access and house cleaning, were funded by the National Disability Insurance Scheme (**NDIS**).

13. Ms Rodger was supported by Melbourne City Mission (**MCM**), who coordinated the supports that Ms Rodger received under her NDIS plan. These supports included home care assistance and services from Complete Nursing and Home Care and NEXTT Health. This included assistance with getting Ms Rodger into and out of her bed, showering and cleaning.

14. Ms Rodger also received assistance with house and yard maintenance from the Salt Foundation. The house maintenance included checking her smoke alarms during each visit.

15. Ms Rodger had a personal emergency alarm system provided by MePACS, a business unit of Peninsula Health. This system required Ms Rodger to press a call button between the hours of

[1] 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.

6.00am and 11.00am each day. Ms Rodger was reportedly very reliable with registering her daily call. Ms Rodger also wore a personal alarm pendant provided by MePACS that could be activated for medical emergencies.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

16. On Thursday 17 January 2019, Rikky Baird, a service coordinator with Complete Nursing and Homecare, was working an 'on call' shift at home. Her duties involved taking urgent phone calls from clients after hours.

17. At 2.42am, a female caller contacted Ms Baird. The caller sounded very distressed and stated 'my blanket is on fire.' Ms Baird could hear a smoke alarm in the background. The call was either hung up or disconnected before Ms Baird could obtain any further details. The caller's landline phone number was displayed on Ms Baird's phone but this number was unfamiliar to her and so she contacted her supervisor, Denise Evans, to seek advice about how to respond. Ms Evans advised Ms Baird to call emergency services.

18. Ms Baird initially believed the caller was another female client who was known to call the service frequently, often late at night. Ms Baird called '000' at 2.46am and requested the fire brigade attend at that client's address in St Albans (**first firecall**).

19. Between 2.49am and 2.57am, both Ms Evans and Ms Baird called back several times to the originating number that had been displayed during the initial call to Ms Baird. However, there was no answer and the call went through to a generic voicemail message which did not help to identify the caller. They also tried to call the client Ms Baird believed had made the initial call but there was no answer.

20. Metropolitan Fire Brigade (**MFB**)[2] units were dispatched to the address in St Albans and arrived at 2.54am. Firefighters spoke to the residents at this address and ascertained that there was no fire.

[2] On 1 July 2020, the Metropolitan Fire Brigade was incorporated into a new organisation, Fire Rescue Victoria, as part of Victoria's Fire Services Reforms. For the purposes of describing events at the relevant time, this service is referred to as the Metropolitan Fire Brigade (**MFB**). For the purpose of matters after 1 July 2020, the relevant entity is Fire Rescue Victoria (**FRV**) and is referred to as such.

21. At approximately 3.00am, the MFB contacted Ms Baird to advise her that there was no fire at the St Albans address.

22. At 3.03am, Ms Baird passed this news to Ms Evans, and they began checking their records to ascertain the identity of the caller who had reported the fire. Between 3.03am and 3.05am Ms Baird continued trying to contact the caller on the originating phone number without success. She also continued to update Ms Evans.

23. At 3.04am, the MFB contacted the Emergency Services Telecommunications Authority (**ESTA**) and advised them that there was no fire at the St Albans address.

24. At 3.07am, Ms Baird again contacted '000' and advised the ESTA operator that she only had a phone number and did not have an address for the client who had called her. The ESTA operator told Ms Baird that they would try to contact the caller via the available phone number. The operator called the number six times but was diverted to voicemail each time.

25. At 3.15am, ESTA contacted Ms Baird and left a voicemail. Ms Baird returned the call at 3.16am and asked whether ESTA could conduct a reverse search of the phone number to identify the caller. She was still unable to provide an exact address for the caller but advised ESTA that her mobile phone indicated the call had originated from Eltham.

26. As ESTA were unable to identify an exact location for the fire, they created an Ambulance event in the vicinity of Eltham. Ambulance Victoria reviewed the newly initiated event and advised that they would hold their response pending verification of a specific location to attend.

27. While Ms Baird was on the phone to ESTA, she received a message from Ms Evans advising that she had identified the caller as Ms Rodger from a search of Complete Nursing and Homecare records.

28. At 3.20am, Ms Baird again tried to call Ms Rodger but the call went through to the generic voicemail.

29. At 3.22am, Ms Baird contacted ESTA and requested that the MFB attend Ms Rodger's address at 36 Maybury Drive, Mill Park (**second firecall**). The MFB were dispatched, and whilst en route, the ESTA dispatcher advised MFB that Ms Baird had called them earlier in the evening 'for another address for a similar thing' and that call had turned out to be a false alarm.

30. The ESTA dispatcher contacted the MFB a second time, again confirming that Ms Baird had called 'not long ago' for to report a fire in St Albans 'for a similar situation and that was a false alarm'.

31. At 3.28am, Ms Baird again tried to call Ms Rodger and again the call went through to voicemail.

32. At 3.31am MFB units from Epping and South Morang arrived at Maybury Drive, Mill Park, entering the street from the northeast end. They passed the properties at number 40 and number 38 and then stopped at the house next to number 38, believing it to be number 36. However, this address was in fact 38A Maybury Drive. The property at 36 Maybury Drive is situated 70 metres west, past the two corner properties at the intersection of Pensbury Avenue and Maybury Drive.

33. The number on the mailbox at 38A was damaged, so the numeral 8 was not visible. However, the number '38A' was clearly stencilled on the curb next to the driveway for the property. The number '38A' had also been affixed to a vertical post supporting the front patio and this was clearly visible from the top of the driveway. Statements in the coronial brief from a resident at 38A and Ms Rodger's family indicate that number 38A was often confused with number 36, and that parcels and letters directed to number 36 were often delivered to number 38A. The property at number 36 has a letterbox very close to the footpath with '36' painted on it in white. It is legible and visible from the footpath.[3]

34. The resident at 38A Maybury Drive advised the attending firefighters that there was no fire at their property.

35. CCTV footage of the exterior of 36 Maybury Drive recorded a firefighter walking down Maybury Drive at 3.34am, past number 36, before returning to the fire truck. The firefighter reportedly did not see any sign of a fire and did not smell smoke or hear an audible alarm.

36. The MFB classified the call as a malicious false alarm, notified ESTA of their assessment and left, driving slowly along Maybury Drive and past number 36 at approximately 3.35am. CCTV footage shows that, at that time, no obvious signs of a fire at Ms Rodger's residence could be seen.

[3] CB 239 and 551

37. At 3.38am, Ms Baird spoke with Ms Evans, and they agreed that Ms Baird would drive past Ms Rodger's residence to check on her.

38. At approximately 3.52am, Ms Baird arrived at Ms Rodger's address. When she arrived, she saw that the lights were off and there were no emergency services present. Ms Evans was monitoring the Vic Emergency app and advised Ms Baird that there had been a structural fire reported at the address eight minutes earlier, but the notification had since been removed. Ms Baird assumed this meant that the fire had been put out. She asked Ms Evans if she could go inside, but Ms Evans advised her against it and Ms Baird then left.

39. At 3.57am, Ms Baird tried calling Ms Rodger two more times, unsuccessfully. She then tried to contact the direct number for the Epping Fire Station but the call went to voicemail. She also tried the direct number for the Mill Park Fire Station but there was no answer.

40. At 4.03am, Ms Baird tried contacting Ms Rodger's number twice more, and was again unsuccessful.

41. At 4.59am, flames and smoke began issuing from the premises at 36 Maybury Drive and were visible on CCTV from a nearby property.

42. At the same time, other residents in Maybury Drive were alerted to the fire and called emergency services (**third firecall**). MFB units were again despatched as neighbours tried to douse the flames using a garden hose and attempted to gain entry to the property but were unable to do so because of the smoke.

43. MFB units attended at 5.07am and extinguished the fire. At approximately 5.17am Ms Rodger was located deceased in her bedroom. She was noted to be wearing her emergency alarm pendant.

44. MePACS later advised that they did not receive any emergency notifications from Ms Rodger's alarm pendant on 17 January 2019. The most recent event they had recorded prior to this date was on 5 January 2019 when Ms Rodger had pressed her emergency alarm after a fall.

45. Forensic Scientist John Kelleher, of the Victoria Police Forensic Science Centre, Fire and Explosion Unit, conducted an examination of the scene and concluded that the fire started in Ms Rodger's bedding. The source of the ignition could not be determined but Mr Kelleher opined that a smouldering cigarette igniting the bedding was the most likely cause.

46. A Fire Investigation and Analysis report (**FIA Report**) completed by the MFB also found that the fire started in Ms Rodger's bedding and suggested that dropped or discarded smoking material was the most likely cause of the fire. I accept this conclusion.

Identity of the deceased

47. On 21 January 2019, Vivianne May Rodger, born 22 July 1964, was identified via fingerprint analysis.

48. Identity is not in dispute and requires no further investigation.

Medical cause of death

49. Forensic Pathologist, Dr Linda Iles of the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 18 January 2019 and provided a written report of her findings on 15 March 2019.

50. The post-mortem examination revealed extensive thermal damage to Ms Rodger's body, as well as soot particles in her airways. Ms Rodger was noted to have an occipital scalp laceration associated with a small amount of bruising, however there was no associated intracranial injury, and Dr Iles noted that it was likely this was the result of falling debris or masonry. There was no evidence of other significant trauma.

51. The autopsy report also noted a large area of stroke likely to have been the consequence of aneurysm and its treatment. A background of prominent pulmonary anthracosis and pulmonary emphysema (smoking related lung disease) were also noted. However, no acute natural disease processes were identified.

52. Toxicological analysis of post-mortem samples indicated the presence of codeine, oxycodone, benzodiazepines (diazepam, nordiazepam and temazepam), paroxetine, quetiapine, doxylamine and paracetamol, although not at elevated concentrations.

53. The toxicological analysis did not demonstrate elevated levels of carboxyhaemoglobin or hydrogen cyanide which are common products of combustion and may be present in association with smoke inhalation. Despite these combustion products not being present, there was post-mortem evidence of inhalation of soot, indicating that Ms Rodger was alive at the time of the fire.

54. Dr Iles provided an opinion that the medical cause of death was 1 (a) EFFECTS OF FIRE IN A WOMAN WITH PAST RIGHT MIDDLE CEREBRAL ARTERY TERRITORY STROKE AND PULMONARY EMPHYSEMA.

55. I accept Dr Iles's opinion.

FURTHER INVESTIGATIONS, REPORTS AND REVIEWS

Metropolitan Fire Brigade Operational Assurance Review

56. The MFB completed an Operational Assurance Review of its response to the reports of fire on 17 January 2019 (**MFB Review**). The MFB Review identified various factors that may have impacted upon the operational response provided by the MFB when they were called to 36 Maybury Drive at 3.22am, these included:

    a) a lack of clarity in the communication between Ms Baird and ESTA, which may have impacted upon how ESTA communicated with the MFB;

    b) the communication from ESTA to the MFB regarding the previous false alarm, which may have influenced the operational response provided by attending MFB members;

    c) MFB attending at the incorrect address, and not verifying that the address attended was the address provided by ESTA;

    d) the potential use of a Melways map by the MFB to navigate to the address;

    e) the MFB scene investigation following their attendance at the incorrect address;

    f) the lack of contact with Ms Baird by MFB when they could not locate a fire; and

    g) the classification of the alarm of fire as a malicious false alarm, which was potentially influenced by the information provided to the MFB by ESTA.

57. The MFB Report outlined the existing policies and procedures governing the above matters and noted that, at the time, there was no formal policy or Standard Operating Procedure (**SOP**):

    a) requiring MFB members to verify the address provided by ESTA when responding to an alarm of fire;

b) governing what constitutes effective scene investigation to verify that there is no alarm of fire; or

c) regarding a requirement to contact the ESTA caller during a firecall where there is no obvious alarm of fire.

58. The MFB report noted that, under the MFB *Integrated Risk Management Plan 2018/19* (**IRMP**), the MFB was planning to develop a suite of SOPs founded on the Operational Risk Assessment (**ORA**) for all reasonably foreseeable incident types. This included the ORA for *Fires in the Built Environment – Structure Fires* which contains risk controls that include verifying the address at an incident. It noted that the implementation of these SOPs would also provide an essential framework for the development of training and education for MFB firefighters on actions to take in circumstances where there are no obvious signs of smoke or fire.

59. The report noted that the MFB was working to introduce these SOPs in conjunction with the United Firefighters Union and made a range of recommendations to improve operational responses in the interim until the SOPs could be introduced.

60. The MFB Report noted that at the time of this incident, under usual processes the relevant fire station would receive an A4 printout of a firecall as part of the dispatch process. The printout included the call information, the address of the alarm of fire and a Melways map reference for the address.

61. MFB acknowledged that having access to electronic information via a mobile data terminal installed on each MFB appliance would improve the speed at which attending firefighters were provided with incident details, the quickest route, and visual identification of street names and addresses. The MFB Report noted that MFB was in the process of updating its navigation systems and was in the final stages of a Mobile Data for Vehicles (**MD4V**) project which would trial and evaluate the use of mobile data terminals. If successful, the trial would be rolled out across the entire operational fleet over two years.

62. With respect to the coding of false alarms, the MFB Report noted that the MFB provides training for firefighters on how to assess and code false alarms and has a pocket guide which provides guidance on the different false alarm codes.

63. After reviewing the above, the MFB Report made nine recommendations (**MFB Report Recommendations**) to improve the operational response of the MFB:

a) That, as an interim measure prior to the introduction of the SOPs, the MFB Operations Procedure *ER 008 Communications – Emergency Response* be amended to include a process requiring MFB firefighters to verify the address provided by ESTA when responding to an alarm of fire.

b) That, as an interim measure prior to the introduction of the SOPs, the MFB Operations Procedure *ER 008 Communications – Emergency Response* be amended to include a requirement that the Officer-in-Charge confirms with ESTA that the address provided by ESTA has been verified.

c) The MFB training doctrine related to response to an alarm of fire, for all firefighting ranks, be updated to include a process for address verification.

d) That MFB consults with the UFU[4] regarding the interim measure of using a GPS mapping application on each MFB appliance mobile phone until the MD4V, or equivalent, is introduced to the entire MFB operational fleet.

e) That MFB proceeds with the development of SOPs and implements training for all firefighting ranks to include a process of investigating and recording the steps undertaken when investigating an alarm of fire where there are no obvious signs of smoke or fire.

f) That, as an interim measure prior to the introduction of the SOPs, the MFB Operations Procedure *ER 008 Communications – Emergency Response* be amended to include a requirement that the Officer-in-Charge provides a wordback[5] via VKN8[6] to ESTA identifying what steps they took to verify that the firecall is a false alarm where there are no obvious signs of smoke or fire.

g) That the proposed MFB SOP developed for *Fires in the Built Environment – Structure Fires* contains a risk control that during a firecall with no obvious alarm of fire, where there is an available CLI[7] number, the Officer-in-Charge either requests VKN8 to call, or directly calls the CLI number to verify the address and status of the person requiring emergency assistance.

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4 United Firefighters Union
5 An initial structured situation report
6 The call sign for the MFB radio communications centre until July 2020 – replaced by the call sign for Fire Rescue Victoria, 'Firecom'.
7 Calling Line Identification

h) That the MFB Operations Procedure *ER 008 Communications – Emergency Response* be amended to include a requirement that, as part of reporting a false alarm, the Officer-in-Charge provides a wordback via VKN8 if they have attempted to contact or have spoken with the ESTA caller using the CLI number.

i) That, as an interim measure prior to the introduction of SOPs, the MFB Operations Procedure *ER 008 Communications – Emergency Response* be amended to include a requirement that the Officer-in-Charge provide a wordback via VKN8 identifying reason/s for providing a false alarm code 711 (malicious false alarm).

Peer review of the MFB Report

64. At the request of the then Minister for Police and Emergency Services, Lisa Neville, the MFB Report was subject to an independent peer review conducted jointly by the Victorian Emergency Management Commissioner and an independent expert, Fire and Rescue New South Wales Assistant Commissioner, Paul McGuiggan.

65. A copy of an initial draft of the peer review report (**the Draft Review Report**) prepared by Assistant Commissioner McGuiggan in May 2020, was provided to the court.

66. The Victorian Emergency Management Commissioner, Andrew Crisp, stated that the peer review report was not finalised further beyond the initial draft due to a range of issues, including the prioritisation of the COVID-19 response by Emergency Management Victoria at the time the Draft Review Report was completed, and in the following months.

67. Commissioner Crisp noted that the recommendations and issues identified in the Draft Review Report were substantially similar to those in the MFB Report and that the Draft Review Report concluded that the MFB Report recommendations were acceptable.

68. Commissioner Crisp also noted that the Inspector-General for Emergency Management Victoria had assessed ESTA's internal review of its management of call-taking and dispatch in this incident and was satisfied that ESTA was taking appropriate actions to mitigate identified risks, including the risks raised by both the MFB Report and the Draft Review Report.

Fire Investigation Assessment Report

69. The FIA Report completed by the MFB noted that there were two battery powered smoke alarms installed in Ms Rodger's residence, one at the front of the house on the ceiling outside the master bedroom, and one at the rear of the house in the hallway outside the toilet, main bathroom and third bedroom doors. These were not hardwired or connected to Ms Rodger's MePACS personal alarm system, despite both these measures being possible at the time.

70. The FIA Report noted that *'hardwired smoke alarms/detectors connected to personal alarm systems are available and would eliminate the need for a phone call or activation of a personal alarm button in the event of a fire. This would immediately identify the location where an emergency response was required'*.

71. I also note that guidance relating to smoke alarms on the FRV website suggests that for persons with a disability, smoke alarms should be connected to a personal alarm system.

72. In documents provided to the court, MCM noted that they had identified Ms Rodger's insistence on smoking inside as a longstanding risk, both to her personal safety in the event of a fire, and to the safety of workers in her home due to second-hand exposure to cigarette smoke. This risk was identified at the beginning of their provision of services, in the Home Visit Risk Screening tool.

73. In July 2017, MCM arranged for an assessment of Ms Rodger's home, which revealed there were no working smoke alarms at the premises. They arranged for a worker to install smoke alarms at the residence, however they did not personally review or inspect the smoke alarms at the property. MCM stated that they advised Ms Rodger to seek assistance from her community supports to monitor and maintain these alarms.

74. MCM also stated that they took the following steps to address the risks created by Ms Rodger smoking indoors – they:

    a) held discussions with Ms Rodger in relation to the dangers of smoking inside;

    b) requested home maintenance staff to check her smoke alarms during each visit;

    c) provided a fire resistant blanket for Ms Rodger to sleep under;

    d) created a smoking room in her home so she could smoke inside when support staff were in the house;

e) recorded Ms Rodger's habit of smoking inside on the MCM Home Visit Risk Screening Tool;

f) created a smoking agreement to address Ms Rodger smoking when staff were present; and

g) involved Ms Rodger's psychologist in the conversation around smoking in the home.

75. MCM also advised that they sought verbal agreement from Ms Rodger that she would only smoke in one room of the house.

76. MCM otherwise stated that they were not responsible for monitoring the state of the property, as it was not an MCM owned or leased property. Their role was to find services and supports for Ms Rodger and have them put in place. They did not undertake regular home visits and usually only conducted three visits with a client, at the beginning, middle and end of their engagement.

77. MCM also stated that they did not consider having the smoke alarms connected to Ms Rodger's personal alarm as this was relatively new technology and they believed that the technology providers did not have the ability to connect fire alarms to personal alarms at that time. They also considered it was unlikely that such a connection would have been funded by the NDIS as it may not have met the 'reasonable and necessary' criteria, noting that such connections are usually only considered for participants who experience difficulties with their hearing.

Statements of Deputy Commissioner, Operations North and West, Fire Rescue Victoria

78. Two statements were provided to the court by the Deputy Commissioner, Operations North and West, Fire Rescue Victoria, David Bruce. These statements were based on a review of the FIA Report, the MFB Review, and notes taken by DSC Anderson from Victoria Police recording discussions he had with MFB members at the scene of the fire.

79. Deputy Commissioner Bruce acknowledged that there was a delay in the attendance of firefighters at 36 Maybury Drive, stating that some of the delay was beyond the control of the MFB and related to communication and other issues. However, he conceded that firefighters attended at the incorrect address following the second firecall at 3.22am and this error was not identified until they attended after the third firecall at 4.59am, when a fire was obvious.

80. Deputy Commissioner Bruce outlined the protocols applicable to MFB members in relation to identifying the correct address of a reported fire and the training members receive on this subject, as well as the protocols for situation reports and declarations that a reported fire is a false alarm.

81. Deputy Commissioner Bruce noted that attending the wrong address on a call is quite rare and that the training doctrine and procedures 'do not explicitly require firefighters to verify the reported address'. However it is expected that the officer in charge will 'undertake a full investigation to obtain accurate situational awareness including a correct address'.

82. He noted that when MFB members attended Maybury Drive following the second firecall, they 'attempted to investigate the scene of a reported fire based on their interpretation of the street scape and suboptimal communications received from ESTA.' He also stated that, whilst not all information received by ESTA was passed onto the responding MFB crews, it was the responsibility of the officer in charge to 'interrogate all sources of information from ESTA en route and on scene and investigate thoroughly to establish accurate situational awareness to make informed decisions.'[8]

83. Deputy Commissioner Bruce identified other features in the communication related to the second firecall which may have impacted the approach taken by the firefighters who attended. He stated:

> *Additional information not conveyed from ESTA to MFB in this instance is critical, as responding crews are trained to gather intelligence from the time of call to arrival on scene and during scene interrogation. This initial thought process helps to build situational awareness and begin the process of unpacking consideration based on facts and information provided en route. The additional information, including that the initial caller had a disability and was quite distressed, may have triggered additional interrogation of the scene and occupancy by the OIC[9] before making the assessment that the call was a false alarm.[10]*

84. Whilst it is possible that a different approach may have been taken at the scene, had the responding MFB members possessed the missing information, this speculation is not terribly persuasive. Furthermore, Deputy Commissioner Bruce's description of the intelligence

8 CB 056
9 Officer in Charge
10 CB 057

gathering process suggests a complexity that is not apparent in the circumstances of this case. The critical issue is simple: correctly identifying the property nominated in the second firecall, namely 36 Maybury Drive.

85. It is in the very nature of emergency response that first responders often have to work with incomplete or inaccurate information until they are on scene and can build a better picture of the situation. Although the information provided by ESTA to MFB was incomplete, this does not account for the inadequate efforts to locate the correct property once the MFB units were at Maybury Drive.

86. The MFB / ESTA radio transmissions reveal the following:

    (a) 0325:53 – Pumper Tanker 11 (Epping) notifies that it is en route to 36 Maybury Drive.

    (b) Whilst the responding units were en route, ESTA made two transmissions concerning that fact that the first firecall was similar and was a false alarm.

    (c) 0331:32 – Pumper Tanker 11 reports arriving on scene.

    (d) 0331:59 – South Morang Pumper reports arriving on scene.

    (e) 0334:23 – Pumper Tanker 11 reports its intention to leave scene: *VKN8, Pumper Tanker 11, we'll head back.*

    (f) 0334:31 – Pumper Tanker 11 reports the result of the second firecall as a code '711' (malicious false alarm).

    (g) 0335:16 – South Morang Pumper reports leaving the scene.

    (h) There is no inquiry made by any responding unit to ESTA for further information, either whilst en route or at the scene.

    (i) The time between the arrival of the first unit and the departure of the last unit was less than 4 minutes.

87. The MFB members attending the second firecall did not take appropriate steps to locate the correct property. They did not confirm the property number they were at when they spoke with the occupant at number 38A. They did not ask the occupant of number 38A to direct them to number 36. It appears they did not identify the property at 38A as such despite the stencilled number on the curb and the number being prominently displayed on the patio post

they must have walked past to get to the front door. They did not identify the property at number 36 despite at least one MFB member walking past the property, and despite the house number appearing on a letterbox next to the driveway and very close to the footpath. These failures are striking – the total time at the scene of less than four minutes is also striking. In all, the MFB response to the second firecall was manifestly inadequate. Almost one and a half hours would elapse before the third firecall.

88. Deputy Commissioner Bruce noted that, at the time of these events, there was no formal policy for calling back when there is no obvious alarm or fire. He highlighted the MFB Report Recommendations and further stated that the MFB was determined to improve the quality of its training and would incorporate the learning from this incident to strengthen its curriculum including address verifications and effective scene investigation when there are no obvious or visible signs of fire or smoke present.

89. Deputy Commissioner Bruce observed that it may have assisted in this case if Ms Rodger's personal alarm had been connected to her smoke alarms so that the alarm triggered a notification to Ms Rodger's care providers with accurate address details and a visible alert on the outside of the house. This logic cannot be doubted, but the reality remains that emergency responders often have to operate without ideal information – they must identify the critical information gaps and act diligently to try to fill them.

ESTA Review

90. ESTA conducted an internal review of their response to the fire reports on 19 January 2019 and completed a preliminary investigation report on 1 March 2019 (**ESTA Report**). This report was noted by Thomas Dunbar, Quality Improvement Investigator in the Quality Improvement Team, to be the final report of the ESTA review.

91. The ESTA Report identified several risks in relation to the way ESTA responded to calls it received on 19 January 2019. In particular, it noted risks with ESTA not providing information to emergency services personnel in a timely manner, being directed by emergency services personnel to perform actions detrimental to their ability to deliver their services in accordance with service delivery requirements, and not appropriately classifying a situation in a timely manner. In examining these risks, the ESTA report noted that some information provided by Ms Baird was not recorded in the CAD[11] event chronology.

[11] Computer Aided Dispatch

92. Mr Dunbar stated that, following completion of the ESTA Report, ESTA had initially planned to improve its existing procedures to obtain address information using landline phone numbers when the address is unknown, which would involve requesting this information from Victoria Police. However, Mr Dunbar suggested this would not have significant merit for a range of reasons, explaining that:

> *in 2021, the majority of 000 calls made to ESTA are made by mobile phone and not landline phones. The proportion of calls made from a landline is also expected to decrease going forward. ESTA already has in place systems that allow for location information to be retrieved based on mobile phone numbers.*

93. Mr Dunbar also noted that Victoria Police would not always have the access to the address information, in which case such requests would need to be forwarded to Telstra. He suggested that such requests could not be processed sufficiently quickly, and this process would only have utility in relatively unique circumstances where a caller is only able to provide a landline phone number and not an address. I accept this to be the case.

94. The court was advised that the Inspector-General for Emergency Management Victoria had assessed ESTA's internal review and was satisfied that ESTA was taking appropriate action to mitigate the risks raised by the MFB Report and the Draft Review Report.

FINDINGS AND CONCLUSION

95. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the overlay of caution required by *Briginshaw v Briginshaw*.[12] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

[12] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

96. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

a) the identity of the deceased was Vivianne May Rodger, born 22 July 1964;

b) the death occurred on 17 January 2019 at 36 Maybury Drive, Mill Park, Victoria, 3082, from the effects of fire in a woman with past right middle cerebral artery territory stroke and pulmonary emphysema; and

c) the death occurred in the circumstances described above.

97. There were significant delays in the attendance of emergency services to Ms Rodger's address following her initial call for assistance. Over two hours had elapsed between the initial call at 2.42am, and 5.07am, when MFB arrived and extinguished the fire. Part of this delay was unavoidable, namely the delay attributable to the lack of initial information regarding Ms Rodger's location. However, the delay arising between the time of the first attendance of the MFB at 3.31am and the third firecall at 5.01am was clearly avoidable.

98. It is not possible, on the evidence available, to determine whether Ms Rodger was likely to have survived if emergency services had arrived at her home earlier than 3.31am – with the potential for an earlier response made possible by a smoke alarm linked to her personal alarm. At the very least, her chances of survival would have been improved.

99. It cannot be known if Ms Rodger was still alive when the MFB units were at Maybury Drive for the second firecall, or if she would have survived if rescued from the fire at that time. Furthermore, any expression of likelihood cannot proceed beyond speculation. Nonetheless, the failure to identify the correct address at the second firecall was a missed opportunity to try to rescue Ms Rodger.

100. Ms Baird and Ms Evans acted promptly to try to identify the origin of the first call. Their persistence led to the identification of Ms Rodger as the caller and, once they had established this, they communicated her address to emergency services as quickly as possible.

101. I am also satisfied that relevant information, including the information that the caller had a disability, was not passed on to the MFB units when they were called out to Ms Rodger's address, either verbally or via the CAD chronology. This was important information which should have been included in the communications.

102. I accept the findings of the ESTA internal review and I am satisfied that ESTA have implemented appropriate measures to address the issues and risks identified in that review,

which includes the issues noted above. I also accept that ESTA have explored options to enable operators to identify addresses from landline telephone numbers, and that the implementation of such measures is not practicable at this time.

103. I conclude that the communications from ESTA to the MFB regarding the previous false alarm likely influenced the operational response by the attending MFB members. However, despite such information, it remained essential for the MFB to make reasonable inquiries to determine whether they were at the correct address for the report. Whilst such an inquiry may, strictly speaking, fall within the rubric of a 'scene investigation', this title should not suggest that it is something more complex that it really is. There was no substantial barrier to the identification of the correct property associated with the second firecall.

104. The complexity of the street numbers in Maybury Drive is not uncommon in urban areas. Sequential property numbering is often interrupted by corner properties or land that has been subdivided to create a new block between existing numbers. These are hardly novel or difficult challenges, and the failure to locate the correct property in this instance is more striking when one considers the property numbers that were visible.

105. It is also concerning that reliance on a Melway map may have contributed to the failure to identify the correct property. A GPS based map application has the capacity to show the user's location, usually within a circle of error small enough to discriminate between the frontages of individual properties. These aids also have the capacity to show in the mapped background, the individual allotment numbers and shapes. All FRV appliances should be equipped with modern navigational equipment. I am however satisfied that the FRV are taking the necessary steps to implement appropriate technology across their operational fleet.

106. At the time of these events, there were no applicable policies or procedures which required MFB members to verify the address provided by ESTA when responding to an alarm of fire, governing what constitutes effective scene investigation, or requiring MFB members to contact the ESTA caller during a firecall when there is no obvious alarm or fire.

107. I am satisfied that the MFB Review Recommendations are appropriate interim measures for the necessary additions to policy and procedure. However, FRV must ensure that these measures are incorporated into the final form of its relevant policies and procedures. It is essential that sufficient and appropriate steps are taken to ascertain the correct location for response to a firecall when the signs of fire are not apparent. These steps must not be bypassed on a suspicion or assumption that the call is a false alarm.

108. Properly located hardwired smoke alarms which are connected to personal alarm systems or external monitoring services are likely to reduce the delay before notification of emergency services. A smoke alarm connected to a monitored personal alarm is particularly important for persons with a disability who have reduced mobility or who may not otherwise be able to respond to a smoke alarm or contact emergency services. I note that FRV recommend that smoke alarms should be connected to a personal alarm system for persons with a disability.

109. I am satisfied that MCM were aware of the risks posed to Ms Rodger by her smoking, and particularly the risk of fire. Whilst I accept that MCM took a number of appropriate steps to mitigate this risk, the connection of Ms Rodger's personal alarm to the smoke alarms in her residence was clearly not adequately explored. MCM believed that the technology for such a connection was not available at the time. However, there is nothing to suggest it actually investigated to determine if it was possible.

110. I see no reason why the connection of smoke alarms to a personal alarm system for a person with a disability who is non-ambulant would not meet the 'reasonable and necessary' criteria for assistance items under the NDIS. Such connections are an important safety measure, and I would urge NDIS service providers to endeavour to arrange these connections for their clients, particularly those with significantly restricted mobility or who are otherwise unable to hear or respond to smoke alarms.

RECOMMENDATIONS

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

Recommendation 1

That the National Disability Insurance Scheme Quality and Safeguards Commission ensure that training and information provided to NDIS service coordinators and providers includes information regarding the importance of ensuring appropriate fire safety measures are put in place for clients, including hardwired smoke alarms connected to monitored personal alarm devices.

Recommendation 2

That Fire Rescue Victoria implement appropriate policies, procedures and training to ensure that firefighters responding to a firecall, where the signs of a fire are not apparent, take

appropriate and sufficient steps to identify the correct location associated with the firecall, and that these steps are confirmed with the Fire Rescue Victoria communication centre.

I convey my sincere condolences to Ms Rodger's family for their loss.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

David Rodger, Senior Next of Kin

Amber Salter, Peninsula Health

Karen Liu, K&L Gates, on behalf of ESTA

Andrew Crisp, Emergency Management Victoria

Giorgia Kinloch, Fire Services Victoria

Melbourne City Mission

Complete Nursing and Home Care

Samantha Dooley, National Disability Insurance Scheme Quality and Safeguards Commission

Detective Sergeant Glen Weaver, Coroner's Investigator

Signature:

Coroner Paul Lawrie
Date: 18 December 2023

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after

the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.