IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 005734

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Rosendo Ortiz
Date of birth:	18 July 1949
Date of death:	20 October 2019
Cause of death:	1(a) Smoke inhalation
Place of death:	6 / 79 South Road, Braybrook, Victoria, 3019
Keywords:	Fire, public housing, DFFH, Fire Rescue Victoria, Country Fire Authority, smoke alarms, fire sprinklers, hoarding and squalor

INTRODUCTION

1. On 20 October 2019, Rosendo Ortiz was 70 years old when he died in a fire at his home. At the time of his death, Rosendo lived alone in Braybrook.

2. Rosendo was born in Argentina, where he worked as a member of the police force until the late 1970s. He, his wife Maria and their four children migrated to Australia in January 1981, where Rosendo worked as a panel beater. The family returned to Buenos Aires in 1989.

3. Rosendo and Maria separated in 1996, after which his relationship with his children deteriorated. He moved to Australia in 2001, while the rest of his family remained in Argentina until 2005.

4. Rosendo's medical history included stomach cancer, diabetes, hyperlipidaemia, hypertension and polymyalgia rheumatica. He had a longstanding history of panic attacks for which he took clonazepam, and he was treated with venlafaxine for depression.

Tenancy at 6 / 79 South Road, Braybrook

5. Rosendo began living at his Braybrook home on 22 August 2004. The property owner and landlord was the Director of Housing[1] (established by the *Housing Act 1983* (Vic)), with its administrative functions and public housing tenancy management provided by the Department of Health and Human Services (**DHHS**)[2].

6. The evidence indicates that Rosendo demonstrated a lengthy history of hoarding and uncooperative behaviour while living in Braybrook.

7. In 2011, neighbouring tenants complained to the Director of Housing about the state of the gardens at Rosendo's property. The Director of Housing repeatedly attempted to engage with him during and around this time, but he did not answer the door to their visits and mail was returned to sender as unclaimed. Rosendo was served with several breach notices for not permitting persons to enter for inspection and not keeping the premises clean.

8. On 21 May 2014, electricity to the property was disconnected by AGL Energy following a dispute with Rosendo regarding the bill. The evidence indicates that Rosendo was assisted by

[1] Since Rosendo's death, amendments to the Housing Act had the effect of replacing the Director of Housing with Homes Victoria.

[2] A Machinery of Government change took place on 1 February 2021 creating the Department of Health and Department of Families, Fairness and Housing from the former Department of Health and Human Services (DHHS).

his family and the Director of Housing to have the electricity reconnected, though this did not occur because he did not complete the required paperwork.

9. On six separate occasions between 2015 and 2019, technicians from the DHHS Fire Services Team were unable to access Rosendo's property to check the smoke alarms as Rosendo was either not home or did not answer the door. However, they were able to enter and check the smoke alarms once, on 2 February 2016.

10. On 19 January 2016, a plumber attended at 79 South Road as there were three other units on the property without water. The plumber identified that the issue stemmed from Rosendo's unit. The plumber was given permission by the Director of Housing to enter Rosendo's unit through an open kitchen window, where they found the unit to be in a state of squalor and Rosendo present in the bedroom. The Director of Housing subsequently referred Rosendo to the Salvation Army Social Housing Advocacy Support Program. It is unclear whether he engaged with the program.

11. In January 2018, Rosendo was admitted to Footscray Hospital with left-sided chest pain. An Emergency Department team member established that Rosendo was living in squalor, without electricity and had no family support. She submitted a Hoarding Notification system (**HNS**)[3] referral to the Metropolitan Fire Brigade (**MFB**).

12. It appears that around this time, Rosendo was refusing assistance from his family.

13. On 17 July 2019 and 11 February 2019, a Housing Services Officer from the Director of Housing submitted a maintenance order to conduct a smoke alarm compliance check at Rosendo's home. The order was cancelled on both occasions by the electrician, citing "no access" to the property.

14. On 2 April 2019, a Housing Services Officer submitted a maintenance order to replace all smoke alarms due to expire within the next 12 months at Rosendo's home. The order was again cancelled by the electrician due to no access.

15. In May 2019, Tenancy and Property Officer Elizabeth Lawrence became aware of Rosendo's situation after receiving a memorandum from the Department's contractor regarding the

[3] The HNS was established in 2014. It places a discreet notification on any fire call to an address where hoarding is present, alerting crews *en route* that the property they have been dispatched to is affected by hoarding/a high fuel load.

smoke alarm replacement. Ms Lawrence made several attempts to contact Rosendo including by phone and home visit.

16. On 21 June 2019, Rosendo attended at the Tenancy Office having received a text message from Ms Lawrence. He advised that his gas and electricity had been cut off for over three years following a dispute with AGL Energy regarding his bill, that he had no family and no support, that his mental health was struggling, and he found it difficult to seek help.

17. Ms Lawrence referred Rosendo to the Support for High Risk Tenancies Coordinator, Daniel Martin.

18. On 4 July 2019, Ms Lawrence and Mr Martin conducted a home visit to Rosendo's property, where they observed a large build-up of household rubbish and plastics, with limited space to walk inside and no access to the kitchen or lounge. During the visit, Ms Lawrence contacted AGL who advised that Rosendo's power could be reconnected once an electrical safety inspection was conducted and a compliance certificate issued. Mr Martin arranged for a team to attend the following day to clean the property.

19. On 5 July 2019, the cleaning team arrived at Rosendo's home as planned, however he was either not home or did not answer the door, and they were unable to access the property.

20. On 8 July 2019, Ms Lawrence and Mr Martin attended at Rosendo's home however he did not appear to be home. They looked at the local shops and support agencies for him, to no avail.

21. On 1 August 2019, Ms Lawrence referred Rosendo to Tenancy Plus Sunshine for the purposes of them advocating on his behalf in relation to a range of matters such as the cleaning and maintenance of the property, access to health services, payment of bills and other financial services. There is no evidence that Rosendo engaged with Tenancy Plus.

22. Between July and October 2019, Ms Lawrence and Mr Martin attended at Rosendo's unit on three or four occasions, but he was not home or did not answer the door. On each of these visits, they spent around one hour looking around the local area for him, to no avail.

THE CORONIAL INVESTIGATION

23. Rosendo'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.

24. 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.

25. 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.

26. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Rosendo's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

27. Coroner John Olle originally held carriage of this investigation. I assumed carriage of this investigation for the purposes of conducting additional investigative steps, finalising the case, and making findings.

28. This finding draws on the totality of the coronial investigation into the death of Rosendo Ortiz including evidence contained in the coronial brief. 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. In the coronial jurisdiction, facts must be established on the balance of probabilities.[4]

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

Circumstances in which the death occurred

29. At around 10:30pm on 20 October 2019, a member of the public was driving home when he observed smoke coming from the chimney area of Rosendo's home. He called Triple Zero.

[4] 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.

30. MFB firefighters arrived soon after and forced the door to gain access. They located Rosendo unconscious on the floor of the dining area near to the rear door of the property. They removed him to the lawn where CPR was performed until the arrival of paramedics.

31. Sadly, Rosendo was unable to be revived and was declared deceased at 11:05pm.

Identity of the deceased

32. On 22 October 2019, Rosendo Ortiz, born 18 July 1949, was visually identified by his son, Maximiliano Ortiz, who completed a Statement of Identification.

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

Medical cause of death

34. Forensic Pathologist and Head of Forensic Pathology Dr Linda Iles from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on the body of Rosendo Ortiz on 22 October 2019. Dr Iles considered the Victoria Police Report of Death (Form 83), post mortem computed tomography (CT) scan and Victoria Police Request for Immediate Autopsy and provided a written report of her findings dated 18 March 2020.

35. The findings at autopsy demonstrated evidence of inhalation of smoke during life with soot located throughout the airways within the tracheobronchial tree.

36. Additionally, Dr Iles identified features of previous gastric surgery but no evidence of recurrent tumour, benign prostatic hyperplasia, chronic small vessel cerebrovascular disease likely hypertensive in origin and mild fatty changes in the liver along with mild focal chronic pancreatitis. These did not directly contribute to death.

37. Toxicological analysis of post mortem blood samples identified the presence of the following:

    i. Hydrogen cyanide ~ 2.0 mg/L

    ii. Carboxyhaemoglobin ~ 48% saturation

    iii. Clonazepam ~ 0.01 mg/L

    iv. 7-Aminoclonazepam ~ 0.2 mg/L

    v. Venlafaxine ~ 0.5 mg/L

vi. Desmethylvenlafaxine ~ 0.04 mg/L

vii. Propranolol ~ 6 mg/L

38. A carboxyhaemoglobin concentration of 48% and hydrogen cyanide in blood indicate inhalation of products of combustion.

39. Dr Iles provided an opinion that the medical cause of death was 1 (a) SMOKE INHALATION.

FAMILY CONCERNS

40. Rosendo's daughter Noelia Ortiz raised concerns with the Court regarding her father's living conditions and the safety of his home. She suggested that her father's death could have been prevented *"had the right action been taken in due time"*. She suggested that DHHS should have escalated Rosendo's case when it was identified that he lived in squalor, that they should have made attempts to locate his family to alert them of the situation, and that more training should be provided to DHHS staff on what action should be taken when a tenant does not respond to a property inspection.

FURTHER INVESTIGATION

41. Rosendo's home was a semi-detached unit at the northern end of a large, single level block of three units. It was of brick veneer construction, with plasterboard inner walls, concrete slab flooring, carpet lined throughout most rooms and with a tiled roof.

42. The internal layout comprised of a main lounge area across the north-eastern quarter, a bedroom at the south-eastern quarter with an en-suite bathroom at the south-western quarter, and a kitchen and open alcove area at the north-western quarter.

Victoria Police

43. Forensic Officer George Xydias of the Victoria Police Fire and Explosion Unit conducted an examination of the scene and provided a statement detailing his findings. He observed that *"fire had moderately damaged the dining area at the western end of the one-bedroom apartment."*

44. Mr Xydias observed that the unit was evidently occupied and *"heavily congested with a variety of contents through most rooms"* and said that the quantity and distribution of the

contents were indicative of hoarding. The clutter appeared to have partially restricted access to the exterior doorways and regions within several rooms.

45. In addition to the clutter, he noted a large quantity of white candle wax (mainly coarse shavings and/or melted masses) and many makeshift candles (waxed poured into used metal food cans) in several rooms, including the kitchen, dining room and bedroom.

46. Mr Xydias observed a hardwired smoke alarm which was heavily burnt but noted that given the apparent disconnection of the mains power and the heat damage to the fitted battery, it was not possible to comment on its functionality.

47. Mr Xydias opined that a single fire had started in the dining area of the home which was a *"small alcove type room",* with the point of origin being in the northern quarter of the room in front of a computer stand/desk. The damage across the remaining areas of the room and the other rooms in the unit decreased with distance from the determined point of origin. Mr Xydias noted that the remaining rooms sustained comparatively light to negligible damage.

48. The cause of the fire appeared to have been the ignition of the *"relatively abundant available materials"*, including papers and cardboard, homemade candles and other items of rubbish. There was no indicated of the presence of any flammable liquid for the purpose of initiating, spreading or fuelling the fire.

49. There were no electrical appliances, outlets or wires near the point of origin. Mr Xydias considered the possible means of ignition and determined that the most likely means of ignition was a candle or similar improvised means of lighting, found in the area of origin.

Metropolitan Fire Brigade

50. A Fatal Fire Investigation Report was completed by MFB fire investigator Acting Station Officer (**ASO**) Paul Villani. ASO Villani observed several fire safety issues, including:

    i. Significant hoarding and squalor at the home, classified as 7 on the Clutter Image Rating Scale (**CIRS**)[5]

[5] <https://www.health.vic.gov.au/publications/clutter-image-rating-scale-cirs>

ii. No electricity connected to the home. A large supply of homemade candles and wax were located. Rosendo appeared to be using a camping LPG burner for food production.

iii. The smoke detector was hard wired with a discharged battery, rendering it inoperable due to the lack of electricity.

iv. The hoarding and clutter in the home prevented rapid egress from the property.

51. ASO Villani considered that as the home was not supplied with electricity and homemade candles, candle recycling and manufacture was present, it could be reasonably hypothesised that Rosendo had been dependent on the use of candlelight.

52. ASO Villani considered that the volume of candle material with the hoarding, clutter and squalor would have placed Rosendo at a greater risk of fire occurring. This increased risk of fire occurrence, in conjunction with diminished capacity for egress, would have been significant factors contributing to Rosendo's death. The death was classified as accidental.

53. Geoff Kandoorp, Acting Manager of the At Risk Groups team of the MFB completed an At Risk Groups Report identifying the risk factors in this matter, including hoarding and squalor.

54. Mr Kandoorp's report made recommendations for the coroner to consider, including:

i. Maintaining a watching brief on deaths which occur in homes in which hoarding and/or squalor are identified; and

ii. That the coroner recommends that the Victorian Government reconvene the Hoarding and Squalor Taskforce to:

- Review and update the hoarding and squalor practical resource for service providers document; and

- Explore how agencies across various sectors may be able to further coordinate their efforts to reduce risk for people affected by hoarding and/or squalor.

COMMENTS

Family concerns

1. I acknowledge Noelia's concerns regarding her father's living conditions and the response of DHHS.

2. The available evidence indicates that Rosendo was reluctant to receive help for his living situation; he continuously ignored attempts by the Director of Housing to inspect or maintain the home, and he withdrew from his family's attempts to assist him.

3. I am not convinced that it would have been appropriate for DHHS to alert Rosendo's family about his living conditions. The evidence is that he advised them (and other agencies) that he was estranged from his family and had no contact with them. There was no evidence that he consented to information being shared with his family, nor that he would have consented to this information being shared if asked. There was also no evidence that Rosendo was cognitively impaired to an extent that contacting a family member against his express wishes to the contrary would have been appropriate or permitted.

4. It is possible that Rosendo's situation could have been earlier identified had someone entered the home for scheduled maintenance or inspections rather than cancelling when they were not given access by Rosendo. It is unclear why this did not occur – the *Residential Tenancies Act* does allow for rental providers to access a property for specified reasons, including inspections and repairs, provided the required notice is given to the tenant. However, there is no evidence upon which I can form a belief that earlier intervention would have changed the course of events.

5. When the issue of hoarding and squalor and the lack of electricity was identified, Director of Housing staff took fast and appropriate action. Ms Lawrence and Mr Martin tried to assist Rosendo, including by contacting AGL Energy, making referrals to appropriate agencies and urgently arranging for cleaning and maintenance at the property. Despite this, Rosendo did not engage.

6. Ultimately, and sadly, Rosendo's unwillingness to accept assistance and cooperate with agencies attempting to help him appears to have been a major contributing factor to the ultimate outcome, rather than the lack of action by the Director of Housing or DHHS.

7. Therefore, in considering prevention opportunities, I considered what systemic improvements could be made.

Fatal house fires and prevention opportunities

8. Fire deaths in residential properties are unfortunately not a rare occurrence and are a significant public health issue. A 2019 report by the Bushfire and Natural Hazards Cooperative Research Centre, *Preventable residential fire fatalities: July 2003 to June 2017*[6], identified that on average, more than one fire-related death occurs in a residential context every week in Australia.

9. Deaths from residential fires have wide ranges impacts – socially, economically and emotionally – on individuals, families, communities and the emergency services who respond.

10. In rental properties in Victoria specifically, 55 deaths occurring due to fires were reported to the Court for the period of 1 January 2010 to 16 June 2025.

11. The Bushfire and Natural Hazards CRC study highlighted that the conceptualisation of fire fatality risk is complex, and it follows that so too is preventing it. The report noted that single risk factors alone are unlikely to significantly increase someone's risk of dying, but *it is the co-occurrence of a range of factors surrounding the person, their behaviours, their residential environment and other external factors that is likely to impact their overall level of risk of having a fire that results in their death.*

12. The report identified that most preventable residential fire fatalities were found to be caused by human errors or unsafe behaviours. Preventable fires are defined as *fires where individuals, fire services or other stakeholders may have been able to identify the risks (related to a person and/ or a physical environment) and take actions or develop intervention strategies which, if applied, may have reduced the risk of a fire taking place.*

13. Rosendo's death appears to me to fall within the above definition of a preventable fire. He had several risk factors contributing to his increased risk of dying in a fire, including that he appeared to be a vulnerable person living in public housing and that he experienced hoarding and squalor. I have kept these risk factors front of mind in considering the prevention opportunities that arise from his death.

[6] Coates, L et al. 2019, *Preventable residential fire fatalities in Australia: July 2003 to June 2017*, Bushfire and Natural Hazards CRC.

14. I was assisted in my investigation and prevention role by Fire Rescue Victoria and the Country Fire Association, who I was grateful to meet with to discuss my investigation, and five other cases occurring in similar circumstances around the same time as Rosendo's death. They provided me with important knowledge and insight and put forward recommendations for me to consider.

Public/social housing

15. Of the 55 fire related deaths occurring in rental properties investigated by the Court, 18 occurred in properties owned by the Director of Housing or Homes Victoria, as it is now.

16. Homes Victoria owns considerable property. At December 2022, Homes Victoria owned approximately 72,300 properties, of which approximately 64,300 are used as public housing. Public housing properties owned by Homes Victoria are single dwellings (Class 1a), small and large rooming houses and crisis accommodation (Class 1b and 3(a)) and multi-storey dwellings (Class 2).[7]

17. The fact that someone lives in public or social housing is not necessarily a risk factor in and of itself. Moreso, the nature of public housing is that many of its residents have unique vulnerabilities and risk factors that may make them more at risk of a fatal residential fire than the general population.

18. The Final Report of the Victorian Government's Social Housing Regulation Review[8] acknowledged that social housing tenants represent a disproportionate share of victims in preventable house fires. It noted the following factors that can be attributed to the higher incidence of house fires in social housing:

- Hoarding, recorded as an issue in around 8% of properties, which increases the fuel load available to any fire and assists fire to spread. It can also make escape difficult.

- Chronic illness, mental and physical disability and old age, which can contribute to the starting of fires and can also make escape difficult.

[7] Buildings are classified under the National Construction Code (NCC) 2022. See https://www.vba.vic.gov.au/building/regulatory-framework/building-classes.

[8] Engage Victoria, Social Housing Regulation Review, Final Report < file:///C:/Users/vicrv3r/Downloads/social-housing-regulation-review-final-report_f0bb.pdf>.

19. Homes Victoria, or the Director of Housing as it then was, has a unique responsibility in considering their tenants' health and wellbeing. As stated in the DHHS operational guidelines in force at the time of Rosendo's death:

As a Social Landlord the Director has an obligation to combine responsibilities for property management and tenant well-being. Some of the Social Landlord principles that are relevant for home visits and inspections are:

- *to actively visit tenants to consider the repairs or works needed so their properties are maintained to a reasonable standard*
- *where underlying causes for tenancy issues are understood or risks to a person's well-being are identified (for example during home visits), the best efforts are made to arrange referrals to relevant services*.[9]

20. As I have previously noted, the Director of Housing made appropriate efforts to arrange referrals for Rosendo when it was identified that he was living in hoarding and squalor. Although the issues could have been identified earlier had representatives entered the property, it is not certain that Rosendo would have engaged with services or altered his behaviour such to change the ultimate course of events.

21. Homes Victoria manages Capital Development Guidelines for its own operations and on behalf of DFFH, which detail the policies, procedures and processes to manage the risk to life due to fire in its properties, including public housing. The Guidelines were developed in collaboration with fire authorities and jointly signed off and endorsed.

22. Guideline 7.8 requires the following fire safety inspections and testing:

All fire safety equipment must be inspected and tested:

- *Prior to the commencement of a new tenancy*
- *As part of any upgrade works*
- *Within 24 hours of a fault being reported*
- *At least once every five years*

[9] Home Visits and Inspections in Public Housing Operational Guidelines, 1 January 2020. Available at <https://providers.dffh.vic.gov.au/home-visits-and-inspections-public-housing-operational-guidelines>

Smoke alarms (dusting and testing) should be checked by tenants on a regular basis and should be a requirement included in the tenant agreement unless otherwise expressed.

For single dwellings owned by Homes Victoria, each property will be subject to a compliance check at least once every five years.

23. The smoke alarms in Rosendo's unit were last checked in February 2016.

24. Homes Victoria advised that all existing properties have been upgraded by installing mains powered smoke alarms complying with the applicable standard, AS3786-2014, and comprising of an inbuilt, non-removable rechargeable battery with an expected lifespan of 10 years. Tenants are unable to remove the battery from the device to stop it from working. This also reduces reliance on the tenant to regularly test smoke alarms.

25. Homes Victoria have advised that since Rosendo's death[10], they have implemented several other measures to reduce the risk of fire related deaths in Homes Victoria owned public housing properties, including:

- Developing a new Client Risk Assessment Form that Housing Officers can use for public housing tenants who are identified as posing a potential fire risk to themselves or need assistance to evacuate. The completed form is referred to the DFFH Fire Services Team who arrange for a fire risk assessment, to assess the required fire safety measures.

- Working with FRV and the CFA to develop fire safety brochures to warn renters of potential fire risks in their homes, including portable heaters and smoking.

- Regularly engaging with FVA, the CFA, Victoria Police, Institute of Engineers Australia and Victorian Public Tenants Association through the Public Housing Fire Safety and Arson Committee. These meetings are aimed at determining how Homes Victoria can improve fire safety in public housing and discuss any new policies and new fire safety issues that may be apparent in their properties.

- Retrofitting fire sprinklers and other fire safety measures to properties where it was assessed that renters were unable to physically evacuate in the event of a fire.

[10] These measures were not implemented as a response to Rosendo's death but rather occurred around the same time period.

- Retrofitting fire sprinklers to the common corridors of high-rise public housing towards (where units were already protected) and installing smoke lobbies in front of the lifts.

- Updating the standard specification for all new builds (including Class 1a properties) to prohibit the use of combustible aluminium composite panels and rendered Expanded Polystyrene on external walls.

- Developing a program to sprinkler protect all family violence refuges.

26. I am satisfied that Homes Victoria and DFFH are cognisant of the risks of fatal fire in their residential properties. I encourage them to continuously consider whether improvements can be made to their policies and processes and housing stock to reduce the risk of a fatal fire in their properties, particularly for those tenants with vulnerabilities.

Hoarding and squalor

27. Hoarding is defined by the Department of Health as *..the persistent accumulation of and lack of ability to relinquish, large numbers of objects or living animals, resulting in extreme clutter in or around premises.* Hoarding was classified as a distinct disorder with its own diagnostic criteria in the 2013 edition of the Diagnostic and Statistical Manual published by the American Psychiatric Association (DSM-5).

28. Squalor describes an unsanitary living environment that has arisen from extreme/prolonged neglect and poses substantial health and safety risks to people living in the affected premises and their neighbours.

29. Hoarding significantly increases the risk of fire in the home because for several reasons:

    i. The accumulation of items increases both the opportunity for ignition of a fire, and the fuel load for any fire that does occur;

    ii. Accumulated items block exits and narrow pathways, inhibiting egress of occupants and access for firefighters; and

    iii. Accumulated items and lack of maintenance may lead to unsafe or non-functioning utilities and unorthodox and high fire risk practices related to cooking, heating, lighting and electrical use.

30. Fires in properties affected by hoarding also present an increased risk to firefighters responding:

    i. High fuel load means a faster developing fire;

    ii. Inhibited egress means the increased likelihood that a person may become trapped and require rescuing, which is an inherently risky activity; and

    iii. Rescues in the context of hoarding are undertaken in an environment where access is limited and where structural damage from fire, resulting in building collapse, is more likely.

31. The Metropolitan Fire Brigade (**MFB**) (as it was then known) first identified hoarding as an emerging trend in late 2007, following three fatal residential fires in Melbourne within a four-month period where hoarding and/or squalor were identified as common features. Since then, the MFB and now FRV have undertaken a range of activities seeking to understand the risk and prevalence of fires associated with hoarding, engage agencies with a shared interest in and broader responsibility for addressing the needs of affected people, and reduce the risks to firefighters responding to fires in properties affected by hoarding.

32. FRV has a current, significant programme of work aimed at addressing the issues associated with hoarding and squalor. For example, agencies and individuals are able to make referrals to FRV where an increased fire risk has been identified at a residential property due to hoarding and/or squalor. A member of the At Risk Groups Unit will then provide advice on how to reduce the fire risk in the home environment. They also provide practical advice to the community via their website.

33. The Victorian Government had previously convened a Hoarding and Squalor Taskforce (**HST**) whose role it was to establish a framework and publish a guide to assist in the coordination of services to address hoarding and squalor in residential settings. It sought to promote a multidisciplinary approach and coordination across service providers and experts to address the individual risks and needs of people affected by hoarding.

34. In 2013, the HST published a guide *Hoarding and squalor: a practical resource for service providers*. The guide provided resources for service providers and promoted best practices for responding to hoarding and squalor. To my knowledge the guide has not been updated since its inception in June 2013.

35. Effective treatment and risk reduction in hoarding and/or squalor situations is highly complex. It often requires a service coordination approach to support the affected person over a long period of time, with engagement across multiple agencies. In many situations people with hoarding behaviour or who live in a squalid environment are not receptive to receiving services into the home, due to possible embarrassment, the condition of the property, as well as an overwhelming sense of the living environment being out of control. This appears to have been the case with Rosendo.

36. I consider that a body such as the Hoarding and Squalor Taskforce is best placed to develop and identify the appropriate responses to hoarding and squalor. I will make a recommendation that such a body be reconvened, and that the 2013 hoarding and squalor resource is updated.

Smoke alarms

37. Smoke alarms are arguably the most important fire safety device – they are reliable, inexpensive and are mandated by law to be present in residential properties.

38. The Bushfire and Natural Hazards CRC report noted that the risk of death in a residential fire is higher in homes which do not have a smoke alarm. The Australian and New Zealand National Council for fire and emergency services (AFAC) reported in 2005 that the absence of smoke alarms can increase the possibility of a fatal fire by 60%, and low-income households are least likely to have a smoke alarm installed.

39. In 37 of the fire deaths in rental properties investigated by the Court, information was known about the presence of smoke alarms. In 19 of those 37 deaths, a smoke alarm was either not present or was inoperable, as in Rosendo's case due to the lack of electricity to the property.

40. It cannot be said with certainty that a working smoke alarm would have prevented Rosendo's death. The hoarding in his home was such that egress would have been difficult, and high fuel load would have caused the fire to develop rapidly. However, it would have provided him an early warning and allowed him a chance to escape.

41. All Victorian residential properties must have smoke alarms installed on every level. If the property was built before 1 August 1997, they must be battery powered. If the property was built or majorly renovated after that time, they must be hard wired and have a back-up battery. Properties constructed or majorly renovated after 1 May 2014 are required to have interconnected, hard wired smoke alarms and have a back-up battery.

42. In rental properties, section 68AA of the *Residential Tenancies Act 1997* (Vic) requires that:

> (2) A residential rental provider must ensure that any smoke alarm installed in rented premises is—
>
> (a) correctly installed and in working condition; and
>
> (b) fitted with batteries or replacement batteries; and
>
> (c) tested at least once every 12 months in accordance with any instructions by the manufacturer of the smoke alarm.

43. Tenants must notify the rental provider if a smoke alarm is faulty or not working, and they must not deactivate or remove a smoke alarm or interfere with its operation in any way.

44. FRV advised me that they believe there are gaps in the current legislative and technical frameworks, which have been in the same form for many years and reflect minimum requirements. They noted that other Australian jurisdictions have additional requirements around smoke alarms such as requiring smoke alarms in bedrooms, interconnected smoke alarms in all residential buildings, and compliance checks upon property sale.

45. FRV and the CFA suggest that smoke alarms must:

- Meet the applicable Australian Standard (AS3786-2014);
- Be less than 10 years old;
- Operate when tested; and
- Be interconnected with every other required smoke alarm within the dwelling so all activate together.

46. They suggest that smoke alarms be installed in every living area and bedroom, including hallways and stairways, and be required in any garage that is connected to a building.

47. Of course, the utility of a smoke alarm relies on it being operable, which is not the case where the alarm has been tampered with or removed by the resident. FRV and the CFA have suggested measures that make removing or tampering with the smoke alarm more difficult, including flush mounting the alarm to the ceiling, the installation of damage stoppers over the alarm, and the use of 10-year batteries that are unable to be removed.

48. I will make a recommendation that the Victorian Government consult with FRV and the CFA to improve smoke alarm requirements.

Residential fire sprinklers

49. I consider improved smoke alarm requirements to be a significant prevention opportunity to reduce the risk of deaths in residential fires. However, the risk certainly still exists, particularly where the resident tampers with that smoke alarm or has other risk factors impeding on their ability to escape the fire, such as mobility issues or hoarding blocking egress.

50. In such cases, home fire sprinklers appear to be an obvious infrastructure improvement that may reduce fatalities, by allowing occupants extra time to escape or be rescued.

51. Fire sprinklers control the spread of fire significantly by reducing its size and damage but also have a positive environmental impact by reducing the size and amount of combustible material consumed by the fire, subsequently reducing the carbons and toxic gases released.

52. The evidence is clear that fire sprinklers save lives. According to a 2020 study by the US National Fire Protection Association that examined structure fires between 2017 and 2021, civilian death and injury rates in home structure fires where sprinklers were present were 89% and 31% lower, respectively, than in home structure fires with no sprinklers.[11]

53. The issue of fire sprinklers in residential buildings has previously been identified and discussed by Victorian coroners.

54. In November 2022, Coroner Simon McGregor handed down his finding into the death of DVR[12], a young boy who died at the Royal Children's Hospital from smoke inhalation from a fire at his apartment, owned by DFFH. Coroner McGregor made three recommendations, including, relevantly:

I recommend that the Department of Families, Fairness, and Housing (DFFH) consult with relevant organisations and conduct a feasibility study into whether fire sprinkler systems could be installed in all current (and future) public housing premises.

[11] McGree, T. 2024, *US Experience with Sprinklers*, National Fire Protection Association. Available at <https://homefiresprinklers.org.au/wp-content/uploads/2025/04/ossprinklers.pdf>.
[12] COR 2020 004470.

55. DFFH advised the Court that it supported the recommendation and agreed to work closely with relevant organisations to investigate whether it is feasible to install fire sprinklers in all current and future public housing properties.

56. In 2023, Coroner John Olle made a recommendation to the Australian Building Codes Board, which produces and maintains the National Construction Code:

I recommend that the Australian Building Codes Board commence consultation with other appropriate organisations to consider whether there is a strong rationale to amend the National Construction Code 2019 to require all new residential buildings, regardless of storeys or height, to have fire sprinkler systems installed to significantly reduce the risks and consequences from fire.

57. The Australian Building Codes Board replied to the recommendation, stating:

The [Australian Building Codes Board] recently commenced a process of stakeholder and community consultation on the opportunities and challenges related to new buildings in Australia. We have included a topic on Sprinklers, with a particular focus on home sprinklers, within that dialogue and we will work with relevant stakeholders and organisations to consider options.

58. Fire sprinklers are currently mandated in Class 2 and 3 buildings with a rise of four or more storeys, but not required in Class 1a dwellings[13], as was Rosendo's home, and 1b dwellings[14].

59. FRV and the CFA have been advocating for home fire sprinklers, particularly in social housing, and have worked with the Home Fire Sprinkler Coalition Australia (**HFSCA**), the leading national resource for independent, non-commercial information about home fire sprinklers.

60. In doing so, FRV, the CFA and the HFSCA have identified barriers to the cost-effective installation of home fire sprinklers, including:

[13] A single dwelling being a detached house; or one of a group of attached dwellings being a town house, row house or the like.

[14] A boarding house, guest house or hostel that has a floor area less than 300 m^2 and ordinarily has less than 12 people living in it.

- Water pipes and meters to a residential property are generally 20mm in diameter. Home fire sprinklers require a 25mm diameter pipe and meter to be effective. Water authorities do not have policies that support the installation of home fire sprinklers.

- A lack of clarity as to who can design, install and certify home fire sprinklers.

61. I intend to make recommendations aimed at addressing these barriers. I also support the recommendations made by my colleagues. I encourage DFFH to install fire sprinklers in its properties where feasible, and for the Australian Building Codes Board to consider expanding the requirements for fire sprinklers to other classes of buildings in the next edition of the National Construction Code, expected to be released in 2028.

RECOMMENDATIONS

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

(i) With the aim of preventing like deaths and promoting public health and safety, I recommend that that the Department of Families, Fairness and Housing consider reconvening the Hoarding and Squalor Taskforce with the aim of promoting best practice and inter-agency responses to hoarding and squalor.

(ii) With the aim of preventing like deaths and promoting public health and safety, I recommend that the Department of Families, Fairness and Housing update and reissue the 2013 publication *Hoarding and squalor: a practical resource for service providers* or compile a similar publication for service providers.

(iii) With the aim of preventing like deaths and promoting public health and safety, I recommend that the Victorian Building Authority consult with Fire Rescue Victoria and the Country Fire Authority to introduce improvements to the smoke alarm requirements within the Victorian Building Regulations.

(iv) With the aim of preventing like deaths and promoting public health and safety, I recommend that Consumer Affairs Victoria consult with Fire Rescue Victoria and the Country Fire Authority to introduce an auditable regulatory compliance inspection process for domestic smoke alarms as part of the sale of residential property.

(v) With the aim of preventing like deaths and promoting public health and safety, I recommend that the Department of Energy, Environment and Climate Action work with Victorian water authorities to develop policies that streamline the approval process to allow for the cost-

effective installation of water meters that meet the pressure and flow requirements for home fire sprinklers to be installed.

(vi) With the aim of preventing like deaths and promoting public health and safety, I recommend that the Department of Transport and Planning and the Australian Building Codes Board conduct research (either jointly or individually) in consultation with Fire Rescue Victoria, the Country Fire Authority and the Home Fire Sprinkler Coalition Australia into adopting home fire sprinklers to the FPAA101D technical specification within the National Construction Code (NCC), where not currently required under the NCC.

FINDINGS AND CONCLUSION

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

   a) the identity of the deceased was Rosendo Ortiz, born 18 July 1949;

   b) the death occurred on 20 October 2019 at 6 / 79 South Road, Braybrook, Victoria, 3019;

   c) I accept and adopt the medical cause of death ascribed by Dr Linda Iles and I find that Rosendo Ortiz died from smoke inhalation;

2. AND, after considering the available evidence, I find that the residential fire causing Rosendo Ortiz's death was most likely caused by a homemade candle being used as a light source setting alight abundant clutter in the home, in circumstances where there was no electricity connected to the property and no operable smoke alarm.

I convey my sincere condolences to Rosendo'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:

Noelia Ortiz, Senior Next of Kin

Department of Families, Fairness and Housing

Victorian Building Authority

Consumer Affairs Victoria

Department of Energy, Environment and Climate Action

Department of Transport and Planning

Australian Building Codes Board

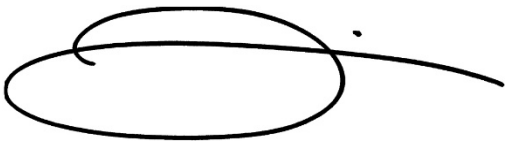
Fire Rescue Victoria

Country Fire Authority

Home Fire Sprinkler Coalition Australia

Leading Senior Constable David Clarke, Coroner's Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 3 March 2026

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.