IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 001821

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Peter Collin Wells
Date of birth:	2 January 1961
Date of death:	3 April 2020
Cause of death:	1a: Effects of fire
Place of death:	The Alfred 55 Commercial Road Melbourne Victoria 3004
Keywords:	Fire, DFFH, public housing, Fire Rescue Victoria, Country Fire Authority, smoke alarms, fire sprinklers, smoking

Aboriginal and Torres Strait Islander readers are respectfully advised that this content contains the name of a deceased Aboriginal person. Readers are warned that there are words and descriptions that may be culturally distressing.

INTRODUCTION

1. On 3 April 2020, Peter Collin Wells was 59 years old when he passed away[1] from injuries sustained in a residential fire. At the time of his passing, Peter lived on his own in Hampton East.

2. The owner and landlord of Peter's home was the Director of Housing[2] (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**)[3].

Background

3. Peter was a proud Gamilaraay man and grew up in what is now known as Morree, New South Wales. He was married to his partner Carolyn for 35 years and they had two sons, Trent and Nathan.

4. Peter had a history of long-term alcohol use and dependence, and depression. He suffered from chronic insomnia and suicidal ideation. He was also a long-term smoker and smoked about a packet of cigarettes per week.

5. Peter worked for a long period for the Department of Community Services in NSW in child protection. He was drawn to this work because of a strong sense of justice, particularly related to racism and his own experiences of racism growing up in Morree as a Gamilaraay man. However, this work exposed him to traumatic incidents which negatively impacted on his mental health and alcohol dependence, particularly cases where he was involved with the removal of Aboriginal children.

6. Peter moved to Melbourne in 2017, following his marriage breaking down the year prior. Soon after moving he was admitted to the Galiamble Men's Recovery Centre[4]. Following his

[1] The term 'passing' is generally more accepted and sensitive terminology to use when discussing the death of Aboriginal and Torres Strait Islander people due to the spiritual belief around the life cycle (see 'Sad News, Sorry Business: Guidelines for caring for Aboriginal and Torres Strait Islander people through death and dying', Queensland Government, December 2015, available here)

[2] Since Peter's passing, amendments to the Housing Act had the effect of replacing the Director of Housing with Homes Victoria.

[3] 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).

[4] Galiamble Men's Recovery Centre is a 24-hour residential alcohol and rehabilitation centre for Aboriginal men located in St Kilda.

discharge, Galiamble manager Mark Hammersley assisted him in finding accommodation in Hampton East, where he lived until his passing.

7. Peter had ongoing contact with, and support from, Galiamble over the following years, including periods of inpatient admission. According to Mr Hammersley Peter felt lonely living in Hampton East and would visit Galiamble 2-3 times a week.

8. Peter's social isolation increased as a result of the COVID-19 pandemic lockdowns, especially as he was unable to visit Galiamble. His alcohol use increased, to the extent that he was calling Mr Hammersley while drunk *"non stop"*.

THE CORONIAL INVESTIGATION

9. Peter's passing 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.

10. 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.

11. 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.

12. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Peter's passing. The Coronial 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.

13. This finding draws on the totality of the coronial investigation into the passing of Peter Collin Wells 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.[5]

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

Circumstances in which the death occurred

14. At 1:24 am on 2 April 2020, Peter's neighbour called Triple Zero to report smoke and fire coming from his unit.

15. Shortly after, firefighters from the Metropolitan Fire Brigade (**MFB**) arrived and observed that the fire was centralised in the front room of Unit 3. The neighbour was attempting to use a garden hose to help put the fire out and alerted firefighters that Peter was inside the property.

16. Firefighters accessed the property by breaking a window and located Peter on the floor of the lounge room. They removed him from the residence to the lawn area where they provided first aid until the arrival of paramedics.

17. At 2:07 am, Peter was conveyed to the Alfred Hospital. His injuries included serious burns to 43% of his body. He was admitted to the Intensive Care Unit (**ICU**) and was intubated requiring mechanical ventilation. Peter's blood alcohol level was noted to be 0.23g/100mL.

18. Hospital staff noted that Peter had sustained an unsurvivable injury and transitioned him to palliative care. Peter Wells passed away at 4:55 am on 3 April 2020.

Identity of the deceased

19. On 17 April 2020, a DNA sample from the deceased was compared with a DNA sample from Trent Wells, Peter Wells' son. The results of the DNA analysis supported the view that Trent Wells was a child of the deceased.

20. On the same date, Coroner Caitlin English considered the available evidence and determined that the cogency and consistency of all evidence relevant to the identification of the deceased supported a finding that the deceased was Peter Collin Wells, born 2 January 1961. Accordingly, she signed a Determination by Coroner of Identity of Deceased (Form 8).

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[5] 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.

Medical cause of death

21. Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on the body of Peter Wells on 7 April 2020. Dr Beer considered materials including the Victoria Police Report of Death (Form 83), post mortem computed tomography (**CT**) scan and E-Medical Deposition Form from the Alfred and provided a written report of his findings dated 18 June 2020.

22. The autopsy identified extensive partial skin burns to ~45-50% of the total body surface, marked oropharyngeal, upper and lower airways thermal injury and carbon sooting consistent with the effects of fire.

23. There were no underlying injuries and no evidence of significant natural disease.

24. Toxicological analysis of post mortem blood samples identified the presence of the following medications administered by paramedics and clinicians:

    i. Morphine ~ 0.9 mg/L

    ii. Ketamine

    iii. Midazolam ~ 0.6 mg/L

    iv. Lignocaine

    v. Laudanosine ~ 0.03 mg/L

    vi. Paracetamol ~ 15 mg/L

25. Dr Beer provided an opinion that the medical cause of death was 1(a) EFFECTS OF FIRE.

FURTHER INVESTIGATIONS

26. Peter's unit was one in a complex of units. It was constructed with a brick exterior, a tile roof, walls and ceiling and a concrete floor. The front door opened into an open plan lounge/dining room. On the southern side of the loungeroom was a bedroom and there was a combined bathroom/laundry on the western side of the bedroom. Between the bathroom and the dining room was the kitchen.

27. A Property Condition Report was most recently completed by DHHS on 25 February 2020. During this inspection the smoke alarm was inspected and tested.

Victoria Police

28. Scientist Rachel Noble from the Victoria Police Forensic Services Centre conducted an examination of the scene on 30 June 2020 and provided a statement detailing her findings.

29. Ms Noble observed that the loungeroom had sustained the most fire damage, particularly the northeastern corner. There was a heater in the centre of the eastern wall, however there was no fire damage to the heater, and it was excluded as a possible source of ignition.

30. The remainder of the room had sustained minor heat and fire damage, mainly to the upper walls and ceiling and there was sooting throughout. There were no other areas that Ms Noble regarded as likely seats of fire.

31. Wires were observed from the lounge room ceiling near the door to the bedroom, which had been covered at the time of the fire, possibly by a smoke detector, but this could not be confirmed. There was a smoke detector hanging from the ceiling in the bedroom, which appeared to have been attached to the ceiling at the time of the fire.

32. The unit had been cleared prior to Ms Noble's examination, and she was unable to identify what furniture and appliances were located in the area of fire origin. Photographs provided to Ms Noble by the MFB indicated, relevantly:

    - There was a couch against the northern wall of the loungeroom, in front of the window.
    - A cigarette packet was located on the floor near the western area of the couch.
    - There was a coffee table in the centre of the room with personal belongings including what appeared to be rolling papers.
    - A cigarette lighter was located on the floor beside the coffee table.
    - There was an unidentifiable electrical appliance on the floor near the eastern end of the couch, possibly a radio/speaker. There was some unburnt material on the end of the couch near the appliance, indicating that the fire had spread to this area and not originated from the electrical appliance.
    - The fire had essentially been contained to the couch, in particular the eastern end. There were cushions remaining at the western end, and the partial remains of a cushion along the front of the eastern end.

33. Ms Noble concluded that the fire started in the northeastern corner of the loungeroom, by ignition of available materials such as the couch. The source of ignition was not determined, however Ms Noble noted that smoking related materials were observed in the lounge room and a carelessly discarded cigarette butt was therefore a possible source of ignition, and perhaps the most likely source. Direct ignition using a match or cigarette lighter could not be excluded, but it was not possible for her to form an opinion on the likelihood of this type of ignition.

Metropolitan Fire Brigade

34. Acting Station Officer (**AS**O) Mick Shanahan of the MFB completed a Fire Investigation Report, after having attended the scene on the night of the fire.

35. ASO Shanahan observed a hard-wired smoke alarm fitted to the ceiling of the lounge outside the bedroom door, however the body of the smoke alarm had been removed and placed on top of the fridge in the kitchen, rendering it inoperable. An additional strobe indicator was installed on the ceiling of the bedroom. It was unknown whether this was interconnected with the smoke alarm. The remains of a carbon monoxide detector were located in the debris near the bedroom door.

36. Like Ms Noble, ASO Shanahan determined the area of origin of the fire to have been the northeast corner of the loungeroom, with the point of origin being the couch. He considered that an accidental ignition was most probable, likely due to an improperly discarded cigarette igniting the available combustibles on the couch.

37. Geoff Kandoorp, Acting Manager of the At Risk Groups team in the Fire Rescue Victoria (**FRV**) Community Resilience Department, completed an At Risk Groups Report. Mr Kandoorp identified several risk factors, including the fact that Peter was a smoker and the smoke alarm in the loungeroom had been removed.

38. Mr Kandoorp suggested that the coroner consider taking the following actions:

    i. Maintain a watching brief on fire related deaths which occur as a result of an ignition caused by a cigarette; and

    ii. Consider the efficacy of reduced fire risk cigarettes in reducing the occurrence of fire related deaths which occur as a result of an ignition caused by cigarettes.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

1. 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 2016[6], identified that on average, more than one fire-related death occurs in a residential context every week in Australia.

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

3. In rental properties in Victoria specifically, 55 fire-related deaths were reported to the Court for the period of 1 January 2010 to 16 June 2025.

4. The Bushfire and Natural Hazards CRC report 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 passing away, 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.*

5. The report identified that the majority of 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.*

6. Peter's case appears to me to fall within the above definition of a preventable fire fatality. Several risk factors contributing to his increased risk of passing away in a fire, including smoking and an inoperable smoke alarm. I have kept these risk factors front of mind in considering the prevention opportunities that arise from his passing.

7. I was assisted in my investigation and prevention role by Fire Rescue Victoria and the Country Fire Association (**CFA**), who I was grateful to meet with to discuss my investigation, and five

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

other cases occurring in similar circumstances around the same time period as Peter's passing. They provided me with important knowledge and insight and put forward recommendations for me to consider.

Public/social housing

8. 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.

9. 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]

10. The fact that someone lives in public 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.

11. 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.

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

[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>.

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]

13. 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.

14. 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*

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.

15. Peter's property, including the smoke alarm, was inspected in the months prior to his passing.

16. Homes Victoria advised that all existing properties have been upgraded by installing mains powered smoke alarms complying with the applicable standard, AS3786-2014, and

[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>

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.

17. Homes Victoria have advised that since Peter's passing[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.

- 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.

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

18. I am satisfied that Homes Victoria and DFFH are cognisant of the risks of fatal fires 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.

Smoking

19. Smoking is a significant risk factor. The Bushfire and Natural Hazards CRC report identified that smokers are over-represented to a large extent in residential fire fatalities. For cases where the fire cause was known, 26.7% were caused by smoking materials and over a third related to smoking in bed.

20. Smoking and alcohol use are interconnected as risk factors – research from Victoria found that the odds of smoking materials being the cause of the fire were 4.4 times greater where the victim had consumed alcohol.[11]

21. It is difficult to envision how to reduce or prevent fire deaths associated with smoking as it involves human choice, behaviour and addiction.

22. I note that as of 2010, all cigarettes manufactured or imported into Australia must be reduced fire risk cigarettes, which are designed to self-extinguish if the smoker does not draw on them. While this was certainly a positive step, I am unsure the extent to which this has contributed to a reduction in fires, fatal and non-fatal. While there is limited data, the Bushfire and Natural Hazards CRC report suggested that they may not have had a significant impact in reducing the number of fatal fires caused by cigarettes. I also note the huge upshot in the prevalence of illegal tobacco in recent years – which I assume are not subject to the same standard as legal imports.

23. There is ample information available about safe smoking practices, including on the FRV website which suggests:

- If you can, smoke outside the home in a single location.
- If smoking occurs in the home, there should be a smoke alarm in every room.
- Never smoke in bed.

[11] Bruck, D, et al. 2011, *Fire Fatality and Alcohol Intake: Analysis of Key Risk Factors,* Journal of Studies on Alcohol and Drugs, 72(5), pp 731 – 736.

- Don't smoke when affected by alcohol, drugs or medications that may cause drowsiness.

- Use heavy, high-sided, non-combustible ashtrays to dispose of cigarette butts. Pour some water on the ash and butts to make sure they're out.

- "Stick it don't flick it" – never flick cigarette butts, either inside or outside.

- Never leave a lit cigarette unattended and butt out your cigarette before you walk away.

- Keep matches and cigarette lighters out of reach of children.

24. People are evidently not taking heed of such advice, and I would assume are even less likely to do so while also under the influence of alcohol.

25. I intend to make a recommendation to the Department of Health around the inclusion of fire warnings on cigarette packaging, so that the risk is front of mind. However, again, these would only apply to cigarettes legally sold in Australia.

Smoke alarms

26. 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.

27. 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.

28. In 37 of the fire-related deaths in rental properties investigated by the Court, information was known about the presence of smoke alarm in 37 deaths. In 19 of those 37 deaths, a smoke alarm was either not present or was inoperable.

29. 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.

30. 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.

31. 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.

32. 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.

33. 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.

34. 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.

35. 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.

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

Fire sprinklers

37. 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.

38. 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.

39. 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.

40. 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 were sprinklers were present were 89% and 31% lower, respectively, than in home structure fires with no sprinklers.[12]

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

42. In November 2022, Coroner Simon McGregor handed down his finding into the death of DVR[13], 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:

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

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.

43. 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.

44. 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.

45. 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.

46. 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[14], as was Peter's home, and 1b dwellings[15].

47. 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.

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

[15] 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.

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

- 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.

49. 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 the Victorian Government consult with Fire Rescue Victoria and the Country Fire Authority to introduce improvements to the smoke alarm requirements within the Victorian Building Regulations.

(ii) With the aim of preventing like deaths and promoting public health and safety, I recommend that the Victorian Government 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.

(iii) With the aim of preventing like deaths and promoting public health and safety, I recommend that the Victorian Building Authority publishes guidance to clarify who can design, install and certify home fire sprinklers to the FPAA101D specification.

(iv) 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.

(v) 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.

(vi) With the aim of preventing like deaths and promoting public health and safety, I recommend that the Australian Government Department of Health, Disability and Ageing consider whether warnings about the risk of fire/and or burns should be included as part of the mandatory health warnings on cigarette packaging.

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 Peter Collin Wells, born 2 January 1961;

   b) his passing occurred on 3 April 2020 at the Alfred Hospital, 55 Commercial Road, Melbourne, Victoria 3004;

   c) I accept and adopt the medical cause of death ascribed by Dr Brian Beer and I find that Peter Collin Wells died from the effects of fire;

2. AND, having considered the available evidence including that provided by Victoria Police and the Metropolitan Fire Brigade, I am satisfied that the residential fire causing Peter Collin Wells' passing was caused by an improperly extinguished/discarded cigarette setting alight the couch, in circumstances where the smoke alarm in the room had been removed.

3. AND FURTHER, I find that Peter Collin Wells' high blood alcohol concentration at the time of the fire may have impeded his reaction to the fire, in effect preventing him from being able to escape in a timely manner.

I convey my sincere condolences to Peter'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:

Trent Wells

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

Department of Health, Disability and Ageing

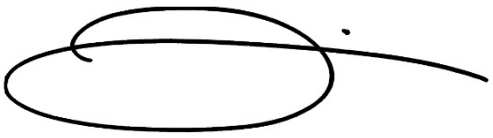
Fire Rescue Victoria

Country Fire Authority

Home Fire Sprinkler Coalition Australia

Senior Constable William Lordanic, Coronial 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.