IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 001125

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	Stephanie Rebernik
Date of birth:	18 January 1954
Date of death:	27 February 2023
Cause of death:	1(a) EFFECTS OF FIRE
Place of death:	1/57 Bellnore Drive, Norlane, Victoria, 3214

INTRODUCTION

1. On 27 February 2023, Stephanie Rebernik was 69 years old when she died in a house fire. At the time of her death, Ms Rebernik lived with her son, Eric Rebernik, in Norlane, Victoria.

2. In 1980, Ms Rebernik sustained an acquired brain injury (**ABI**) following a motor vehicle collision. She received disability support for daily living seven days a week (excluding overnight care). Eric Rebernik suffers from an intellectual disability and receives disability support.

3. Ms Rebernik had suffered cognitive decline following the ABI. She suffered emotional dysregulation, and she was unable to identify risk, had poor insight and decision-making skills and memory loss. She had significantly reduced mobility and used an electric wheelchair.

4. According to Ms Rebernik's disability support workers she had a history of fire lighting behaviours over at least five years. She frequently smoked in bed and made previous attempts to burn her mattress using cigarettes.

5. Approximately one month prior to her death, Ms Rebernik deliberately set fire to her bed.

6. On 13 February 2023, a support worker observed burns to Ms Rebernik's hands. Ms Rebernik explained that she had set an item on fire and used fruit juice to extinguish it. She refused the carer's offer to attend a general practitioner for treatment.

7. Ms Rebernik suffered anxiety and depression for which she was prescribed antidepressants. She had previously attempted suicide but was considered to be at a low risk of harm following a risk assessment in February 2023.

THE CORONIAL INVESTIGATION

8. Ms Rebernik'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.

9. 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.

10. Sergeant[1] Nathan Johnstone acted as the Coronial Investigator for the investigation of Ms Rebernik's death. Sergeant Johnstone conducted inquiries on my behalf and compiled a coronial brief of evidence.

11. This finding draws on the totality of the coronial investigation into the death of Stephanie Rebernik, 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.[2]

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

Circumstances in which the death occurred

12. On 27 February 2023, at 11.36pm, Erik Rebernik was at home when he discovered a fire in his mother's bedroom. He called 000 Emergency and told the call taker there was 'one person inside. . . unable to get out. . . in bed'. He was only able to give limited information, and the effect of his intellectual disability is evident in the audio recording of the call.

13. Fire Rescue Victoria (**FRV**) firefighters arrived a short time later and by 11:54pm, the fire was under control.

14. Victoria Police members and Ambulance Victoria paramedics also arrived and located Ms Rebernik in her bedroom on her bed. She appeared to have sustained significant burn injuries and was confirmed to be deceased at the scene.

Identity of the deceased

15. On 20 March 2023, Stephanie Rebernik, born 18 January 1954, was identified by means of DNA comparison.

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

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[1] Whose police rank was Detective Senior Constable at the time of compiling the coronial brief.

[2] 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

17. Forensic Pathologist Registrar Dr Michael Duffy, supervised by Forensic Pathologist Dr Hans de Boer, both of the Victorian Institute of Forensic Medicine, conducted an autopsy on 1 March 2023 and provided a written report of their findings dated 11 July 2023.

18. The autopsy revealed extensive thermal injuries to the body. There was evidence of soot in the upper and lower airways, indicating the inhalation of the products of active combustion.

19. There was no post-mortem evidence of natural disease which may have caused or contributed to the death.

20. Toxicological analysis of post-mortem samples identified the presence of oxazepam[3], mirtazapine[4], sertraline[5], cyanide and a mildly elevated carboxyhaemoglobin saturation of 13%. No ethanol (alcohol) was detected.

21. Dr Duffy explained that carboxyhaemoglobin is formed when carbon monoxide gas, a component of incomplete combustion, combines with red blood cells. The average carboxyhaemoglobin level in urban non-smokers and smokers is 1% to 2% and 5% to 6%, respectively. A level of 13% indicated the inhalation of combustion products.

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

23. I accept Dr Duffy's opinion.

FURTHER INVESTIGATIONS AND REPORTS

Victoria Police Investigation

24. On 28 February 2023, Victoria Police Forensic Officer Rachel Noble attended Ms Rebernik's residence and produced a report dated 30 March 2023.

25. The fire damage was largely confined to Ms Rebernik's bedroom and especially her bed and mattress. Biological material supported the proposition that Ms Rebernik was on the bed at the time of the fire.

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[3] Oxazepam is a benzodiazepine indicated for anxiety. It may also be used in the management of alcohol withdrawal symptoms. It is also a metabolite of diazepam, nordiazepam, prazepam and temazepam.
[4] Mirtazapine is indicated for the treatment of depression.
[5] Sertraline is an anti-depressant drug for use in cases of major depression.

26. Various items of clothing were collected from the scene and tested for the presence of flammable liquids – all of which yielded negative results.[6]

27. Ms Noble identified an ashtray, cigarette butt, lighter and carton of cigarettes on the floor next to the bedroom. She concluded that a carelessly discarded cigarette butt was perhaps the most likely source of ignition.

Fire Rescue Victoria Fatal Fire Investigation Report

28. FRV Acting Station Officer Shane Jenkin also attended the scene and located two smoke alarms. When tested, one alarm was operational, and the other was not. I note the recollections of firefighters that a smoke alarm was sounding during the fire. Both alarms were more than 12 months overdue for replacement and their batteries were also past their expiry date.[7]

29. Mr Jenkin identified several fire safety issues. These included Ms Rebernik's poor mental and physical health (including her regular medications which carried a potential side effect of drowsiness), significant mobility issues and dangerous behavioural patterns including smoking in bed.

30. Mr Jenkin echoed Ms Noble's conclusion that the fire was likely due to discarded smoking materials or direct ignition of combustible materials on the bed.

FRV Fatal Fire Prevention Supplementary Statement

31. In a supplementary statement, FRV At Risk Groups Manager, Mr Geoff Kaandorp, stated that people with disabilities are most at risk of dying in preventable residential fires and comprise 61.8% of fatalities. He explained that people with disabilities may be unable to quickly recognise a fire and may be slower or unable to escape from their residence.

32. Mr Kaandorp stated that disability care providers are well placed to identify fire safety risks and support their clients in improving fire safety:

> *It is FRV's view that where services are being provided to support a person to live independently and safely in their home, that home fire safety must be a*

[6] Ms Noble noted however that this may mean that there was no flammable liquid originally present or that any flammable liquid had burnt or evaporated to below the detectable level.

[7] Expiry date of Feb 2022

critical consideration and should form part of a service provider's initial and ongoing risk assessment for their client.

33. Mr Kaandorp also considered that:

> *… in-home service providers may have been well placed to identify fire safety risks (e.g. smoking inside the home, old/non-functioning smoke alarms, inability to self-evacuate if a fire occurs) and support their Ms Rebernik to improve fire safety in line with their organisations service provision policies and/or with the support of FRV.*

Smoke Alarm Requirements

34. In Victoria, smoke alarms must be installed on every storey of a building and outside of sleeping areas.[8] However, they are not required to be installed in bedrooms. Fire Rescue Victoria and the Country Fire Authority recommend that all bedrooms be equipped with smoke alarms, noting that 'research has revealed that when a fire starts in a bedroom with doors closed, the smoke alarm outside the bedroom will not activate'.[9]

35. In Queensland, since 1 January 2017, all homes approved for construction or substantially renovated are required to have additional alarms fitted to each bedroom and interconnected throughout the house. Furthermore, since 1 January 2022, it is mandatory to retrofit smoke alarms to each bedroom and interconnect to the rest of the house for all rental properties and properties sold.[10] This same requirement will be extended to all properties in Queensland by 1 January 2027. Alarms retrofitted in existing properties may be powered by a 10-year non-removable battery or hard-wired.[11]

36. Ms Rebernik's unit was fitted with two smoke alarms. Although they required replacement, the subsequent testing by FRV revealed that the alarm fitted in the hallway (and nearest to the bedroom) was operational[12] and I am satisfied it was operational at the time of the fire. The second smoke alarm was fitted inside the front door and was found to be nonoperational.

37. I am satisfied that if a smoke alarm had been fitted in Ms Rebernik's bedroom, it is likely she would have been alerted to the fire earlier. However, in light of Ms Rebernik's disabilities,

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[8] *National Construction Code,* Part 3.7.2.3 Location — Class 1a buildings.
[9] *See for example* 'Country Fire Authority – Smoke alarms are a bedroom essential' – https://www.cfa.vic.gov.au/plan-prepare/fires-in-the-home/smoke-alarms/smoke-alarms-are-a-bedroom-essential#:~:text=Some%20people%20think%20the%20smoke,the%20bedroom%20will%20not%20activate.
[10] Regulations 13AC of *Building Regulation 2006* (Qld).
[11] Unless the property is subject to a significant renovation, in which case the smoke alarms must be hard-wired.
[12] This smoke alarm was damaged by heat but found to be operational.

and particularly, her limited mobility, I cannot say that a working smoke alarm fitted in her bedroom was likely to have led to a different outcome.

Fire Sprinklers in Residential Buildings

38. The National Construction Code requires sprinkler systems in buildings over 25 metres in height and in residential buildings of four storeys or higher. While no Australian state or territory has mandated sprinkler systems in all residential buildings, this is the recommendation of multiple fire safety authorities.

39. Fire & Rescue New South Wales suggest that all new residential buildings up to 25 metres in height should have sprinkler systems installed. Their research indicates that while smoke alarms play an important role and have had a significant impact in reducing the number of fatalities in residential fires over the past 10 years, a combination of sprinkler systems and smoke alarms markedly improves the safety of occupants in the event of a fire.[13]

40. In 2023, Coroner John Olle made a recommendation directed 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.*[14]

41. On 4 October 2023, Gary Rake, Chief Executive Officer of the Australian Building Codes Board stated that:

> *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.*

[13] Fire & Rescue New South Wales, 'Fire research report – Residential Sprinkler Research', <https://www.fire.nsw.gov.au/gallery/files/pdf/research/FRNSW%20Residential%20Sprinkler%20Research%20Report.pdf>.
[14] COR 2020 003017.

42. In May 2024, the Australian Building Codes Board invited public submissions on the 'significant amendments' which they propose to make in the 2025 edition of the National Construction Code. Of the 17 changes, home sprinkler systems were not listed. Public comment closed on 1 July 2024. The next edition of the National Construction Code will be released in 2028.

Fire Safety and NDIS Providers

43. Ms Rebernik's NDIS support provider, All in One Support Services Pty Ltd (**All in One**), was responsible for identifying and mitigating risks to her health, safety and wellbeing which may arise in an emergency (or disaster).[15] That being said, I acknowledge that fire safety planning is a shared responsibility between individuals, NDIS support providers, relevant governmental organisations and local fire services.

44. On 18 December 2023, I handed down a Finding Without Inquest into the Death of Vivian Rodger[16] and recommended:

> [*t]hat 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*.

45. In December 2024, the Commission published a Fire Safety Measures Provider Alert[17] highlighting how NDIS providers can help reduce fire safety risk as well as noting the obligations of NDIS providers and NDIS support workers to prevent such risks to NDIS participants.

46. The Fire Safety Measures Provider Alert states that:

> *NDIS support workers have an obligation under the NDIS Code of Conduct to act on any reasonable or obvious fire risks they observe and raise the issues with their*

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[15] NDIS Quality Safeguards Commission, *NDIS Practice Standards and Quality Indicators Version 4*, November 2021, p 11-12. Accessible at: NDIS Practice Standards | NDIS Quality and Safeguards Commission; NDIS Quality and Safeguards Commission, *Fire Safety Measures,* December 2024, p 2. Accessible at: NDIS Quality and Safeguards Commission Provider Alert - Fire Safety Practice.

[16] Court Reference: COR 2019 000309. This Finding is available on the Coroners Court of Victoria website at: COR 2019 000309 Form 38-Finding into Death without Inquest_Signed.pdf.

[17] NDIS Quality and Safeguards Commission, *Fire Safety Measures Provider Alert,* December 2024. https://www.ndiscommission.gov.au/sites/default/files/2024-12/Fire-Safety-Provider-Alert-PDF-Dec-2024.pdf.

provider' and that *'fire safe'* means having *'working smoke alarms [. . .] and having a home fire escape plan and an emergency plan'.*

47. In the records and reports provided by All in One, there is no mention of any fire safety planning or management despite the fact that the support workers were aware of Ms Rebernik's unsafe behaviour of lighting fires and smoking in bed.

48. On 6 June 2025, the Court wrote to All in One to invite its submission on this issue.

49. On 9 June 2025, the Director of All in One, Mark James, replied as follows:

> *When supporting Stephanie staff took reasonable and necessary steps to ensure risk was mitigated regarding fire lighting behaviours in line with NDIS restrictive practice guidelines. Including, reporting risk to her care team, allied health staff, educating Stephanie around appropriate and inappropriate use of lighters, providing training to staff around risk minimisation relative to lighters, stoves, combustible materials, and objects that they may come into contact with.*
>
> *Supports delivered to Stephanie were collaboratively implemented and recommended by her treating Occupational Therapist at the time in terms of behavioural strategies, risk mitigating, fire safety, NDIS compliance and ensuring safe practices. It is our view this was never compromised; we consistently maintained the highest level of care when supporting Stephanie.*
>
> *Staff were purely there to provide personal care assistance to Stephanie in line with her NDIS goals and recommendations by her treating Occupational Therapist. Organisationally, it is our view that we are unable to control or mitigate circumstances within Stephanie's home environment if we are not there.*
>
> *We are certainly of the view that fire safety planning is a shared responsibility of all parties. We believe we acted within our scope of practice in line with NDIS code of conduct when staff were supporting Stephanie. When staff completed their shift for day with Stephanie; any intentions, acts, behaviours, or unintended consequences as a result are/were entirely out of our control.*

50. It is striking that none of the steps referred to by Mr James were recorded in any of the material provided by All in One. Moreover, the reply from All in One suggests a failure to appreciate the obligations contained in the Fire Safety Measures Provider Alert. While it may be true to say that an NDIS support services provider cannot 'control' circumstances within the home environment when they are absent, the denial of any ability to 'mitigate circumstances' is unsustainable. At the very least, Ms Rebernik should have had working smoke alarms.

51. Despite the assertions contained in the reply from All in One, I am not satisfied that proper fire safety planning was undertaken by the support service for Ms Rebernik's benefit.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Stephanie Rebernik, born 18 January 1954;

    b) the death occurred on 27 February 2023 at 1/57 Bellnore Drive, Norlane, Victoria, 3214, from – 1(a) EFFECTS OF FIRE; and

    c) the death occurred in the circumstances described above.

53. I accept the conclusions of Ms Noble and Mr Jenkin and find that the likely source of the fire was direct or indirect ignition of combustible bedding material in Ms Rebernik's bedroom, most likely caused by a cigarette or other smoking materials.

54. I acknowledge Ms Rebernik's history of self-harm and suicidal ideation, however the evidence does not support a finding that the fatal fire was a deliberate act of self-harm or suicide.

55. I am satisfied that Ms Rebernik's death was the unintended result of her own actions.

ACKNOWLEDGEMENTS

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

I thank the Coronial Investigator and those assisting for their work in this investigation.

DIRECTIONS

Pursuant to section 73(1A) of the Act, I direct that these findings be published on the Internet in accordance with the rules.

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

Eric Rebernik, Senior Next of Kin

National Disability Insurance Scheme Quality and Safeguards Commission

All in One Support Services Pty Ltd

Barwon Health

Sergeant Nathan Johnstone, Coronial Investigator

Signature:

Coroner Paul Lawrie

Date: 03 July 2025

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.